UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

JANE DOE on behalf of BABY DOE, a minor, and PATRICIA CAVALLARO-KEARINS, on behalf of themselves and all others similarly situated, Plaintiffs, v. ANTHEM HEALTHCHOICE ASSURANCE, INC., d/b/a ANTHEM BLUE CROSS AND BLUE SHIELD, and d/b/a ANTHEM BLUE CROSS, and ANTHEM HP, LLC, d/b/a ANTHEM BLUE CROSS AND BLUE SHIELD HP, and d/b/a ANTHEM BLUE CROSS HP, Defendant.	Civil Action No. 1:24-cv-08012

DEFENDANT ANTHEM HEALTHCHOICE ASSURANCE, INC.'S NOTICE OF MOTION TO DISMISS

PLEASE TAKE NOTICE that Defendant Anthem HealthChoice Assurance, Inc. ("Anthem"), shall move this Court before the Honorable John P. Cronan of the United States District Court for the Southern District of New York, located at 500 Pearl St., New York, NY 10007, on such date and time as the Court may direct, for an Order pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure to dismiss the Plaintiffs' complaint with prejudice. Anthem requests the Court hear oral argument on the Motion to Dismiss.

PLEASE TAKE FURTHER NOTICE that in support of its Motion to Dismiss, Anthem will rely upon the accompanying Memorandum of Law, the Declaration of Brendan G. Stuhan, the pleadings, papers, and other documents on file, and such further evidence or argument as the Court may consider.

Dated: March 28, 2025

Respectfully Submitted,

By: /s/ Matthew J. Aaronson

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by CM/ECF to all counsel of record on this 28th day of March 2025.

/s/ Matthew J. Aaronson
Matthew J. Aaronson

UNITED STATES DISTRICT COURT
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JANE DOE on behalf of BABY DOE, a minor, and PATRICIA CAVALLARO-KEARINS, on behalf of themselves and all others similarly situated, Plaintiffs, v. ANTHEM HEALTHCHOICE ASSURANCE, INC., d/b/a ANTHEM BLUE CROSS AND BLUE SHIELD, and d/b/a ANTHEM BLUE CROSS, and ANTHEM HP, LLC, d/b/a ANTHEM BLUE CROSS AND BLUE SHIELD HP, and d/b/a ANTHEM BLUE CROSS HP, Defendant.	Civil Action No. 1:24-cv-08012

DEFENDANT ANTHEM HEALTHCHOICE ASSURANCE, INC.'S MEMORANDUM OF LAW IN SUPPORT OF ITS MOTION TO DISMISS

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Defendant, Anthem HealthChoice Assurance, Inc. ("Anthem")[1], through its undersigned counsel, submits this Memorandum of Law in Support of its Motion to Dismiss the Complaint (ECF No. 1) ("Complaint" or "Compl.") filed by "Jane Doe" on behalf of her child "Baby Doe," a minor, and Patricia Cavallaro-Kearins (collectively, "Plaintiffs") pursuant to Fed. R. Civ. P. 12(b)(6).

INTRODUCTION

Plaintiffs are enrollees in the Service Benefit Plan (the "Plan"), a health insurance plan for federal employees, retirees, and their families, which is governed by the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901–8914. The Plan is created by a federal government contract between the U.S. Office of Personnel Management ("OPM") and the Blue Cross and Blue Shield Association ("BCBSA"), the latter of which enters into the contract as agent for and on behalf of Anthem and other local Blue Cross and Blue Shield companies that administer the Plan in their individual localities. Anthem administers the Plan in parts of New York.

Plaintiffs allege that Anthem's provider directory for the Plan is inaccurate, thwarting Plaintiffs' efforts to obtain mental health coverage under the Plan and causing them to pay higher "out-of-network" rates for their mental health care, instead of the lower "in-network" rate they thought they would receive under the Plan. Plaintiffs bring various state law claims focusing on these supposed misrepresentations in the Plan's provider directory, and a breach-of-contract claim as purported third-party beneficiaries of the contract between OPM and BCBSA.

Plaintiffs' claims—all brought under state law—must be dismissed with prejudice because they are fundamentally inconsistent with FEHBA and the regulations and contracts thereunder.

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[1] Anthem HP, LLC, d/b/a Anthem Blue Cross And Blue Shield HP, and d/b/a Anthem Blue Cross HP was voluntarily dismissed from the action on January 23, 2025 (ECF No. 15).

FEHBA includes a broad preemption provision, 5 U.S.C. § 8902(m)(1), under which the terms of OPM's contracts with carriers like BCBSA expressly preempt state law. Additionally, Congress gave OPM broad authority over FEHBA carriers and plans, including the authority to police the conduct of FEHBA carriers. OPM has exercised that authority by adopting regulatory and contractual provisions giving OPM enforcement authority over FEHBA carriers' marketing materials and other Plan literature. Congress's grant of broad supervisory and enforcement authority to OPM thus also implicitly preempts state law claims that would interfere with OPM's exercise of this authority.

Congress also assigned to OPM the authority to make benefits determinations in individual cases and, pursuant to that authority, OPM has created a mandatory administrative remedy for Plan enrollees who believe they were improperly denied benefits. That remedy requires exhaustion of administrative review before filing suit and allows for suits against OPM only, expressly disallowing suits against FEHBA administrators such as Anthem.

Plaintiffs' claims as Plan enrollees, if permitted to proceed, would violate FEHBA and OPM's related authority. Indeed, courts have repeatedly concluded in highly analogous decisions that dismissal is required in these circumstances. As detailed below, all of Plaintiffs' claims must be dismissed with prejudice for three independent reasons: (1) Plaintiffs' state law claims are expressly preempted by FEHBA, (2) those claims are also implicitly preempted by FEHBA, and (3) Plaintiffs failed to exhaust available administrative remedies. In addition, the third-party breach of contract claim must be dismissed because Plaintiffs are not intended third-party beneficiaries with the right to sue; OPM is the only one with the right to enforce the contract against Anthem. Finally, to the extent any portion of Plaintiffs' claims survive this motion, Plaintiffs concede they cannot pursue benefit-of-the-bargain damages for their claims.

BACKGROUND

A. Statutory, Regulatory, and Contractual Background Regarding FEHBA and the Service Benefit Plan

FEHBA. In 1959, Congress enacted FEHBA to create "a comprehensive program of health insurance for federal employees." *Empire HealthChoice Assurance, Inc. v. McVeigh*, 547 U.S. 677, 682 (2006). To accomplish that goal, Congress vested "significant authority" in OPM. *Muratore v. OPM*, 222 F.3d 918, 920 (11th Cir. 2000). That includes broad discretion for OPM to establish insurance plans with many different insurers, which are known under FEHBA as "carriers." *See* 5 U.S.C. §§ 8901(7), 8902–03, 8913.

The Service Benefit Plan. One such plan is the nationwide Service Benefit Plan. *See* 5 U.S.C. § 8903(1). The Plan is formed, pursuant to FEHBA, by federal government contract No. CS 1039, between OPM and BCBSA (the "OPM-BCBSA Contract");[2] 2024 Statement of Benefits for the Service Benefit Plan at 4 (Ex. O to Stuhan Decl.) [hereinafter, "2024 Statement of Benefits"].[3] "OPM's contract with [BCBSA] describes the benefits that employees are eligible for, and on what terms." *Gonzalez v. Blue Cross Blue Shield Ass'n,* 62 F.4th 891, 896 (5th Cir. 2023). BCBSA is the carrier of the Plan, and contracts on behalf of local participating Blue Cross and Blue Shield companies ("BCBS Companies") that administer the Plan in their respective

[2] Periodically, the OPM-BCBSA Contract is restated in full. Stuhan Decl. ¶ 5. In other years, OPM and BCBSA enter into amendments to the most recent version of the contract. *Id*. ¶ 6. The relevant provisions upon which Anthem relies for purposes of this motion are substantively unchanged between the versions of the OPM-BCBSA Contract in effect during the relevant period, and appear in the same numbered sections of the contract. Attached to the Stuhan Declaration are the versions of the OPM-BCBSA Contract or applicable annual amendments that were operative during the period of 2018 through 2024 in which Plaintiffs allege their claims arose. *See* Exs. A through H to Stuhan Decl. (2013 and 2023 Contract and 2018-2021 and 2023-2024 Amendments).

[3] The prior versions of the Statement of Benefits for 2018 through 2023 are also attached to the Stuhan Decl. as Exhibits I through N.

localities. OPM-BCBSA Contract § 4.3; *Health Care Serv. Corp. v. Methodist Hosps. of Dallas*, 814 F.3d 242, 247 (5th Cir. 2016). Anthem is a BCBS Company that administers the Plan in parts of New York.[4]

OPM's Authority. Congress vested OPM with broad authority to police FEHBA carriers, *see, e.g.*, 5 U.S.C. §§ 8902(e), 8910(b), 8913(a), and OPM has adopted extensive regulations to that effect, *see, e.g.*, 48 C.F.R. §§ 1609.7001, 1652.203-70, 1652.222-70, 1652.246-70. Consistent with these provisions, the OPM-BCBSA Contract expressly gives OPM authority to evaluate Anthem's work under the contract and to take enforcement action against Anthem to protect the interests of federal enrollees. *E.g.*, OPM-BCBSA Contract §§ 1.9, 1.10, 1.11, 1.12, 1.14.

Congress also vested OPM with sole authority to contract for the provision of FEHBA health plans, to determine the benefit structure of each plan, and to promulgate the official description of a plan's terms in a Statement of Benefits, which is sometimes referred to as a "Brochure." *See* 5 U.S.C. §§ 8902(a), (d), 8907. The Statement of Benefits is "[a]uthorized for distribution by" OPM and is incorporated into the government contract between OPM and BCBSA. *See* 2024 Statement of Benefits cover page; § 2.2(a); *Empire*, 547 U.S. at 684. Under the contract's terms, FEHBA carriers "shall provide the benefits as described in the agreed upon

[4] The OPM-BCBSA Contract and Statement of Benefits (and other documents) are properly considered by the Court on this motion to dismiss. The Complaint repeatedly references and relies on the OPM-BCBSA Contract and the incorporated Statement of Benefits. *E.g.*, Compl. ¶¶ 71, 84, 117–18, 152–54, 170, 240, 253, 229, 262–63, 269. The Court may consider those documents because they are "integral to the complaint and [are] specifically referenced in th[e] pleading." *In re Bear Stearns Cos., Inc. Secs., Derivatives, & ERISA Litig.*, 763 F. Supp. 2d 423, 565 (S.D.N.Y. 2011) (citation omitted); *see also Goel v. Bunge, Ltd.*, 820 F.3d 554, 558–59 (2d Cir. 2016); *Levy ex rel. Immunogen Inc. v. Southbrook Int'l Invs., Ltd.*, 263 F.3d 10, 13 n.4 (2d Cir. 2001). Separately, the Statement of Benefits is available on OPM's official government website: https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plans/pdf/2024/brochures/71-005.pdf (last visited Mar. 28, 2025), and thus is a matter of public record of which the Court can take judicial notice.

brochure text." OPM-BCBSA Contract § 2.2(a). And such carriers must also "produce and make available an FEHB Summary of Benefits and Coverage (SBC)." *Id*. § 1.13(e).

The contract requires the "verbatim" use of the OPM-approved Statement of Benefits and requires FEHBA carriers' marketing materials, supplemental literature, and other materials—including the SBC—to "be truthful and not misleading" and to meet other requirements set forth in OPM's regulations or other guidance. *Id*. § 1.13(b), (c), 1.14(a), (b). If a FEHBA carrier violates those duties, the contract gives OPM the power to direct the carrier to take corrective actions "to protect the interests of Federal Members." *Id*. § 1.13(d), 1.14(c), (d). Those corrective actions include cease-and-desist orders, orders to reissue nonconforming materials, orders to provide corrective notices to enrollees, allowing enrollees to transfer to another plan, and termination of the Plan. *Id*. Most of OPM's contractual rights are also mandated by regulation. 48 C.F.R. § 1652.203-70.

The Plan's Preferred and Participating Provider Network. The Plan offers a "Preferred Provider Organization," which is a network of "certain hospitals and other healthcare providers" that have been designated as "Preferred" providers or "PPO" providers and with whom Anthem (or another BCBS Company) contracts. *E.g.*, 2024 Statement of Benefits at 12; *see also* Compl. ¶ 104. In addition, the Plan also offers "Participating" providers, which are not Preferred providers but other providers contracted with Anthem (or another BCBS Company). *Id*. Anthem must notify OPM when a provider contract is added or terminated. OPM-BCBSA Contract § 1.10(a)(4); 48 C.F.R. § 1652.222-70.

The Plan pays Preferred providers and Participating providers at negotiated rates. *E.g., id*. at 12, 29–31, 156–58. Plaintiffs refer to such providers as "in-network." *E.g.*, Compl. ¶ 104. Because there is no limit to what out-of-network providers (*i.e.*, providers that are neither Preferred

nor Participating) can charge, enrollees typically pay more in cost-sharing (*e.g.*, coinsurance, copayments, and deductibles) if they use such providers. 2024 Statement of Benefits at 13, 29–31, 157; Compl. ¶¶ 105-09, 116.

The Plan's Mental Health Coverage. The Statement of Benefits describes the Plan's mental health coverage, including the amounts the Plan will pay for in-network and out-of-network providers. 2024 Statement of Benefits at 93–97. The Statement of Benefits also contains a link where enrollees can locate Preferred providers. *Id*. at 94. That link takes the user to the "Find a Doctor" website referenced in the Complaint. Compl. ¶ 71 & n.61.

The OPM-BCBSA Contract's Incorporation of the No Surprises Act. OPM requires FEHBA contractors, including Anthem, to comply with certain provisions of the No Surprises Act ("NSA"), including a provision of the NSA designed to ensure that health plans' provider directory information is accurate.[5] OPM-BCBSA Contract § 2.18(a); Compl. ¶ 119; 42 U.S.C. § 300gg-115 (PHSA § 2799A-5).[6] That NSA provision requires a health plan issuer to maintain accurate provider directory information. 42 U.S.C. § 300gg-115(a).

If a health plan's provider directory mistakenly lists a provider as in-network, the plan cannot impose on an enrollee who receives the inaccurate information a cost-sharing amount that is higher than the amount that would have applied had the provider actually been in-network. 42 U.S.C. § 300gg-115(b).

[5] By its terms, the NSA does not apply to FEHBA plans, as those provisions apply only to a "group health plan" or a "health insurance issuer offering group or individual health insurance coverage." *See, e.g.*, 42 U.S.C. § 300gg–115(a)(1).

[6] The NSA added nearly identical provisions to three statutes: the Public Health Service Act ("PHSA"), the Employee Retirement Income Security Act ("ERISA"), and the Internal Revenue Code. For simplicity, we cite to the PHSA provisions, which are found in Title 42 of the U.S. Code.

FEHBA's Administrative Remedies. Under FEHBA, each health plan contract requires the carrier "to pay for or provide a health service or supply in an individual case" if OPM "finds that the employee . . . is entitled thereto under the terms of the contract." 5 U.S.C. § 8902(j). OPM has implemented this provision by establishing a mandatory administrative remedy for those who believe that a carrier has wrongfully denied benefits. 5 C.F.R. § 890.105; *see also id.* § 890.107(d)(1).[7] An enrollee who is dissatisfied with a carrier's benefits decision must first request that the carrier reconsider its decision and, if the carrier upholds its decision, seek review by OPM. *Id.* § 890.105(a)-(d). If OPM finds that the denial by the carrier was incorrect, the carrier must pay the benefits and "honor any case-by-case determinations that OPM makes for an individual employee." *Gonzalez*, 62 F.4th at 896 (citing 5 U.S.C. § 8902(j)).

If OPM upholds the denial of benefits, then the enrollee may sue OPM. *Id.*; *Bridges v. Blue Cross & Blue Shield Ass'n*, 935 F. Supp. 37, 42 (D.D.C. 1996); 5 C.F.R. § 890.107(c). However, no lawsuit may be brought "prior to exhaustion of the administrative remedies provided in § 890.105." 5 C.F.R. § 890.107(d)(1); *see also id.* § 890.105(a)(1) ("A covered individual must exhaust both the carrier and OPM review processes . . . before seeking judicial review of the denied claim."). And such lawsuits "must be brought against OPM and not against the carrier or carrier's subcontractors." 5 C.F.R. § 890.107(c). In other words, "a patient who wishes to challenge a denial may sue only OPM, not [the carrier]." *Gonzalez*, 62 F.4th at 896 (citing 5 C.F.R. § 890.107(c)). The remedy in such a lawsuit "shall be limited to a court order directing OPM to require the carrier to pay the amount of benefits in dispute." 5 C.F.R. § 890.107(c).

[7] The administrative remedy is also described in detail in the Statement of Benefits. *See* 2024 Statement of Benefits at 139–41; *see also Gonzalez*, 62 F.4th at 896 ("The Plan documents describe all of these procedures.").

B. Plaintiffs' Allegations[8]

Plaintiffs allege that Anthem's directory of in-network providers for the Plan contains inaccurate information regarding mental health providers, including by listing providers that are not, in fact, in-network and by listing inaccurate information for those who are. *E.g.*, Compl. ¶¶ 1–3, 10, 126–28. Plaintiffs allege these inaccuracies render the Plan materials "deceptive," including the OPM-approved Statement of Benefits and the "Find a Doctor" website referenced therein. *Id.* ¶¶ 10, 152, 165–71. And Plaintiffs allege they were harmed because the claimed inaccuracies caused them to delay or forgo treatment or forced them to incur the costs of using out-of-network providers. *E.g., id.* ¶¶ 4, 13, 76. Plaintiffs also claim these alleged inaccuracies effectively denied them the mental health benefits promised under the Plan, which they claim individually induced them into enrolling in the Plan in the first place. *E.g., id.* ¶¶ 6, 71, 87, 156, 198, 214.

Although Plaintiffs assert that Anthem's allegedly inaccurate provider directory violates several laws regarding provider networks, including the NSA, Plaintiffs do not bring any causes of action under those laws. Instead, Plaintiffs assert state law causes of action for: (1) breach of the OPM contract (specifically, the NSA provider directory provisions incorporated therein); (2) violation of N.Y. Gen. Bus. Law ("GBL") § 349; (3) violation of GBL § 350; (4) violation of N.Y. Ins. Law § 4226; (5) fraudulent misrepresentation; and (6) unjust enrichment. Compl. ¶¶ 227–84.

ARGUMENT

I. PLAINTIFFS' STATE LAW CLAIMS ARE EXPRESSLY PREEMPTED BY FEHBA

All of Plaintiffs' claims—brought solely under state law—are preempted by FEHBA's express preemption provision, 5 U.S.C. § 8902(m)(1).

[8] As it must, Anthem assumes the well-pled allegations in the Complaint to be true for purposes of this motion. However, Anthem notes that several allegations are not accurate and does not concede the truth of any allegation for any other purpose.

A. The Text and Purpose of FEHBA's Preemption Provision

FEHBA contains the following express preemption provision, which gives preemptive effect to the terms of the OPM-BCBSA Contract (including the terms of the incorporated Statement of Benefits):

> The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

5 U.S.C. § 8902(m)(1). The Supreme Court has explained that "under § 8902(m)(1) as it now reads, state law—whether consistent or inconsistent with federal plan provisions—is displaced on matters of 'coverage or benefits.'" *Empire*, 547 U.S. at 686.

With FEHBA's preemption provision, Congress sought to "strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live." H.R. Rep. No. 105-374, at 9 (1997); *accord* S. Rep. No. 95-903, at 2 (1978) (legislative history of FEHBA's original preemption provision); *see also Empire*, 547 U.S. at 686. The "policy underlying § 8902(m)(1) is to ensure nationwide uniformity of the administration of FEHBA benefits." *Burkey v. Gov't Emps. Hosp. Ass'n*, 983 F.2d 656, 600 (5th Cir. 1993) (citing *Hayes v. Prudential Ins. Co.*, 819 F.2d 921, 925 (9th Cir. 1987)).

Among other things, FEHBA's preemption provision was specifically intended to preempt state laws that purport to regulate the content of written materials distributed to FEHBA enrollees about their benefits. OPM's predecessor, the U.S. Civil Service Commission, explained that FEHBA's preemption provision was designed in part to solve the "problem" of state "legislation and regulations" purporting to govern "the format and type of informational material that must be furnished, including in some instances the type of language to be used" in materials provided to

enrollees. S. Rep. No. 95-903, at 7 (1978); *Mahajan v. Blue Cross Blue Shield Ass'n*, No. 16-cv-6944, 2017 WL 4250514, at *9 (S.D.N.Y. Sept. 22, 2017) (discussing legislative history).

The Supreme Court has thus interpreted FEHBA's preemption provision broadly, noting that "Congress' use of the expansive phrase 'relate to'" in defining the scope of the preemption provision "'express[es] a broad pre-emptive purpose'" and is "notably 'expansive [in] sweep.'" *Coventry Health Care of Mo., Inc. v. Nevils*, 581 U.S. 87, 95–96 (2017) (quoting *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 383, 384 (1992)) (alterations added by *Nevils* Court). The Supreme Court concluded that a broad reading of § 8902(m)(1) was appropriate considering FEHBA's "statutory context and purpose":

> FEHBA concerns benefits from a federal health insurance plan for federal employees that arise from a federal law in an area with a long history of federal involvement. Strong and distinctly federal interests are involved, in uniform administration of the program, free from state interference, particularly in regard to coverage, benefits, and payments.

Id. (internal quotation marks and citations omitted).

B. The Requirements for Express Preemption Are Met Here

There are two requirements for express preemption under FEHBA's preemption provision: (1) the state law at issue must implicate contract terms "which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)"; and (2) the state law must "relate[] to health insurance or plans." 5 U.S.C. § 8902(m)(1); *see also Nevils*, 581 U.S. at 94 (discussing the "two preconditions on federal preemption" under FEHBA). Both requirements are readily met by the allegations in this lawsuit.

Plaintiffs appear to concede that the first requirement for preemption is met, as they acknowledged, but did not contest, that element in their pre-motion briefing. *See* ECF No. 18 at 2. Plaintiffs' claims implicate numerous contractual provisions that relate to coverage or benefits, including the aforementioned mental health coverage and benefits provisions, the provisions

relating to benefits when using Preferred and Participating providers and when using non-participating providers, the provisions governing the materials describing coverage and benefits, and the NSA provisions that apply to the Plan only by virtue of the terms of the OPM-BCBSA Contract (which are found in a part of the contract entitled "Benefits," OPM-BCBSA Contract at p. II-1). There is no question these contract terms "relate to the nature, provision, or extent of coverage or benefits," 5 U.S.C. § 8902(m)(1), and Plaintiffs have not contended otherwise.

Plaintiffs instead contest the second requirement for preemption: that the state law in question relates to health insurance or plans. Plaintiffs' sole argument is that "state 'laws of general application that make absolutely no reference to health insurance or plans' do not fall within the second preemption requirement." ECF No. 18 at 2 (quoting *Empire HealthChoice Assurance, Inc. v. McVeigh*, 396 F.3d 136, 146 (2d Cir. 2005)). This assertion fails on its face. As an initial matter, N.Y. Ins. Law § 4226—the basis of Plaintiffs' Fourth Cause of Action—specifically applies to "insurer[s] authorized to do in this state the business of life, or accident and health insurance," and thus plainly references "health insurance." N.Y. Ins. Law § 4226(a). Plaintiffs offer no explanation as to how FEHBA's second requirement for preemption is unmet as to N.Y. Ins. Law § 4226, and Plaintiffs' attempt to apply N.Y. Ins. Law § 4226 to regulate Anthem's administration of the Plan belies any argument that it is not related to health insurance or plans.

As to their remaining causes of action, however, Plaintiffs are wrong in their assertion that laws of general application that do not reference "health insurance or plans" fall outside of FEHBA's express preemption provision. The only authority Plaintiffs cite on this point is the Second Circuit's opinion in *Empire*. But that statement is pure dicta, because that case related solely to whether federal question jurisdiction existed, not whether express preemption occurred.

See Mahajan, 2017 WL 4250514, at *8.

More importantly, whether dicta or not, the statement from the Second Circuit's *Empire* decision cannot survive the Supreme Court's subsequent decision in *Nevils*, holding that FEHBA expressly preempted Missouri's common-law doctrine precluding subrogation and reimbursement. 581 U.S. at 93. That doctrine is not specific to health insurance or plans; indeed, the case the Supreme Court cited as representative of that doctrine involved business insurance. *Id.* (citing *Benton House, LLC v. Cook & Younts Ins., Inc.*, 249 S.W.3d 878, 881–82 (Mo. App. 2008)). Nonetheless, the Court held that the state's rule was preempted by FEHBA. In fact, this Court has previously held that *Nevils* teaches that state laws of general application that do not reference health insurance or plans still trigger FEHBA's second requirement for preemption, and other courts have reached the same conclusion. *See Mahajan*, 2017 WL 4250514, at *7–8; *Ray v. Tabriz*, No. 23-cv-1467, 2025 WL 306175, at *2 (N.D. Ill. Jan. 27, 2025); *see also Kaiser Foundation Health Plan, Inc. v. Maylone*, No. 55585-9-II, 2022 WL 3754902, at *7 (Wash. Ct. App. Aug. 30, 2022).

Numerous other courts have also held state laws of general application to be preempted by FEHBA. *See, e.g., Gonzalez*, 62 F.4th at 904 (plaintiff's state common law claims preempted by FEHBA even though those laws "do not specifically relate to health insurance," because "preemption reaches even a state's general laws when their application relates to the scope or administration of federal healthcare plans," a result "compel[led]" by the Supreme Court's interpretation of similar preemption provisions) (citing *Morales*, 504 U.S. at 384, 386); *Bryan v. OPM*, 165 F.3d 1315, 1320 (10th Cir. 1999) (FEHBA preempts Oklahoma attorney fee statute applicable to many types of insurance other than health); *Hayes v. Prudential Ins. Co.*, 819 F.2d 921, 926 (9th Cir. 1987) (finding various state common law and statutory claims to be preempted

under FEHBA's original, narrower preemption provision, including breach of contract and breach of fiduciary duty claims); *Russell v. Gennari*, No. 1:07cv793, 2007 WL 3389998, at *5 (E.D. Va. Nov. 8, 2007), *aff'd*, 284 F. App'x 98 (4th Cir. 2008) (professional negligence and breach of fiduciary duty claims preempted by FEHBA); *see also Morales*, 504 U.S. at 383 ("a State's general consumer protection laws" qualify as laws "relating to rates, routes, or services of any air carrier" so as to fall within the ambit of the Airline Deregulation Act's preemption provision); *id*. at 386 (dismissing the argument that the preemption provision "imposes no constraints on laws of general applicability," a theory this Court has "consistently rejected" in the ERISA context); *Metro. Life Ins. Co. v. Christ*, 979 F.2d 575, 576, 579 (7th Cir. 1992) (finding "state divorce decree and state law equitable principles" to be preempted by a preemption provision nearly identical to FEHBA's original, narrower provision).

Plaintiffs' claims here are much like claims this Court and other courts have found to be preempted. In *Mahajan*, just like this case, a Plan enrollee alleged that BCBSA's misrepresentations about the Plan's provider network violated GBL §§ 349 and 350, fraudulently induced her to enroll in the Plan, and constituted negligent misrepresentation. *See* 2017 WL 4250514, at *5. This Court held that each of those claims were expressly preempted by FEHBA. *See id*. at *6-9. *Gonzalez* involved allegations that BCBSA breached the OPM-BCBSA Contract by imposing a process that was not contained in the Plan terms and fraudulently or negligently misrepresented the Plan terms. *See* 62 F.4th at 903. The court found those claims, among others, to be preempted. *See id*. at 903-04. Plaintiffs' claims here are likewise preempted by FEHBA.

II. PLAINTIFF'S CLAIMS ARE IMPLIEDLY PREEMPTED BY FEHBA

Even if the statute had no express preemption provision, FEHBA would still preempt Plaintiffs' claims impliedly. Implied preemption occurs when the state law claims "'stand[] as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.'"

In re Trib. Co. Fraudulent Conv. Litig., 946 F.3d 66, 81 (2d Cir. 2019) (quoting *Hillman v. Maretta*, 569 U.S. 483 (2013)). Here, Plaintiffs' claims are also impliedly preempted because they interfere with OPM's exclusive authority over FEHBA and because they undermine the uniform nationwide administration of a FEHBA plan.

As described above, Congress delegated to OPM the exclusive authority to police the conduct, policies, and practices of FEHBA carriers, and OPM has promulgated extensive regulations on the topic. *See* 5 U.S.C. §§ 8902(e), 8910, 8913(a); 48 C.F.R. § 1600 *et seq.*; *see also Bridges*, 935 F. Supp. at 42–43; *Kight v. Kaiser Found. Health Plans of Mid-Atl. States, Inc.*, 34 F. Supp. 2d 334, 342 (E.D. Va. 1999). In this case, Plaintiffs' attempt to use state law to regulate the conduct of a FEHBA carrier and the terms of a FEHBA plan conflicts with the broad enforcement powers Congress gave to OPM. The court in *Kight* reached just that conclusion: "Congress already adopted an enforcement scheme in FEHBA whereby it delegated the power to police the administration of FEHBA plans to OPM." 34 F. Supp. 2d at 342. Where a plaintiff "attempt[s] to seek state law review of Plan administrative policies," it "directly conflicts with the OPM powers," resulting in preemption "under traditional conflict preemption principles." *Id.*; *accord Mahajan*, 2017 WL 4250514, at *11.

Plaintiffs' state law claims interfere with several aspects of OPM's exclusive authority. First, OPM has broad power to ensure that a FEHBA carrier's marketing materials are "truthful and not misleading" and to punish a carrier's failure in that regard through financial penalties, suspending new enrollment under the contract, or terminating the contract entirely, among other actions. 48 C.F.R. § 1652.203-70(a), (c), (d). OPM also has the authority to order "corrective action to protect the interest of Federal Members" like Plaintiffs, including by "[d]irecting the Carrier to cease and desist" use of the marketing material and to issue corrections to enrollees. *Id.*

§ 1652.203-70(c); *see also* OPM-BCBSA Contract §§ 1.13, 1.14. Plaintiffs' state law claims seeking to regulate the content of Anthem's "advertising, marketing, and program materials," Compl. ¶ 170; *see also id.* ¶¶ 71, 87, 167, conflict with OPM's authority. That is particularly true to the extent that alleged misrepresentations are in the Plan's Statement of Benefits, *see, e.g.*, *id.* ¶ 170, which is a document that is "[a]uthorized for distribution by" OPM, 2024 Statement of Benefits at cover page; *Jacks v. Meridian Res. Co.*, 701 F.3d 1224, 1233 (8th Cir. 2012), and which was intended by Congress to contain provisions that *the Office* [*i.e.*, *OPM*] "considers necessary or desirable," 5 U.S.C. § 8902(d) (emphasis added).

Second, OPM has broad authority over the Plan's provider network. Under the OPM-BCBSA contract, any "[a]ddition or termination of provider agreements" is a "Significant Event" of which OPM must be notified within ten days. OPM-BCBSA Contract § 1.10(a)(4). Further, with respect to any Significant Event, OPM has broad remedial powers, including the ability to direct BCBSA or Anthem to take corrective action, to withhold payments, to suspend new enrollments in the Plan, to allow impacted enrollees to transfer to another FEHBA plan, or to terminate the contract entirely. *Id.* § 1.10(b). Those OPM enforcement powers are specifically meant "to protect the interest of Members" like Plaintiffs. *Id.* Plaintiffs' claims seeking to regulate the scope of the Plan's provider network conflict with that OPM authority.

Aside from interfering with OPM's exclusive authority, Plaintiffs' state law claims also stand as an obstacle to Congress's intent that each FEHBA plan be administered uniformly nationwide. *See Mahajan*, 2017 WL 4250514, at *10. The application of 50 different sets of state laws to the Plan would make it impossible to administer the Plan uniformly in each state and would drive up costs as the carrier would need to stay abreast of, and in compliance with, each of those laws. *See id.* "'[F]ederal programs that by their nature are and must be uniform in character

throughout the Nation necessitate formulation of controlling federal rules.'" *Helfrich v. Blue Cross and Blue Shield Ass'n*, 804 F.3d 1090, 1099 (10th Cir. 2015) (quoting *United States v. Kimbell Foods, Inc.*, 440 U.S. 715, 728 (1979)). In *Helfrich*, the court held that when state laws conflict with the "strong federal interest in uniformity" under FEHBA, such state laws are displaced by federal law. *Id*.; *see also id*. at 1095–1103.

Because Plaintiffs' state law claims stand as an obstacle both to OPM's exclusive authority over FEHBA plans and to the nationwide uniformity Congress envisioned, their claims are impliedly preempted by FEHBA.

III. PLAINTIFFS' CLAIMS MUST BE DISMISSED BECAUSE PLAINTIFFS FAILED TO UTILIZE AVAILABLE ADMINISTRATIVE REMEDIES

As set forth above, FEHBA explicitly calls for OPM to decide benefits issues, 5 U.S.C. § 8902(j), and the agency has promulgated detailed regulations for doing so, 5 C.F.R. §§ 890.105, 890.107. Plaintiffs say that remedy does not apply because they "are not disputing Anthem's decision to deny coverage on any particular benefit claim." ECF No. 18 at 1. Plaintiffs' argument misses the mark. To begin with, OPM's regulations cover more than benefit disputes. 5 C.F.R. § 890.107(b) allows for suits against OPM over OPM's regulations. That provision allows for suits by enrollees stemming "from dissatisfaction with the OPM's general programmatic decisions," but requires such suits be brought against OPM. *Bridges*, 935 F. Supp. at 42. Thus, "the detailed enforcement scheme of the FEHBA leaves no room for" an action against Anthem here. *See id*. at 43.

Additionally, where, as here, an enrollee alleges that a health plan carrier made misrepresentations about the enrollee's coverage or benefits under the terms of the plan, those claims must also be pursued through FEHBA's remedy for benefits disputes. *See, e.g.*, *Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390 (9th Cir. 2002), *opinion amended on*

denial of rehearing, 319 F.3d 1078 (9th Cir. 2003); *Cicio v. Vytra Healthcare*, 321 F.3d 83, 96–97 (2d Cir. 2003), *vacated on other grounds*, 542 U.S. 933 (2004); *cf. Cicio v. Vytra Healthcare*, 208 F. Supp. 2d 288, 296 (E.D.N.Y. 2001) (concluding "negligent misrepresentations about the scope of coverage under the Policy" fall within the scope of ERISA's similar remedies provision, *aff'd*, 385 F.3d 156 (2d Cir. 2004)).

In *Botsford*, for instance, a Plan enrollee underwent a "$3,036.00 medical procedure" performed by an out-of-network provider and "received a reimbursement check for only $915.74" from the Plan. 314 F.3d at 392. Instead of utilizing FEHBA's administrative remedy, the plaintiff in *Botsford* filed suit in federal court, alleging a "state statutory claim," under the Montana Unfair Trade Practices Act ("MUTPA"), Mont. Code Ann. § 33-18-201(1), premised on the theory that the FEHBA carrier "misrepresent[ed] the policy regarding reimbursement of non-participating providers." *Id*. at 392–93.[9] The Ninth Circuit concluded that "Montana Code Section 33-18-201(1) conflicts with, and is therefore preempted by, FEHBA." *Id.* at 393. "[A]lthough [the enrollee] stated his claim as a breach of state law, it really amounts to an alternative method of remedying a contractual breach" of the Plan terms. *Id*. at 396. The court went on to hold that the enrollee's exclusive remedy was the one offered under FEHBA. *See id*. at 396–99. Accordingly, any remedies available under MUTPA were displaced. *See id*. at 396; *see also Kight*, 34 F. Supp. 2d at 336, 340 (in action against FEHBA carrier "for concealing a physician financial incentive program" that "allegedly encouraged physicians to reduce the quality of medical care to patients," plaintiff's claims for "direct negligence for failure to establish policies and guidelines," for "tortious interference with contract," and for fraud all fell under FEHBA's administrative remedy

[9] *Botsford* also alleged "various state common law causes of action, such as fraud" and "negligent misrepresentation," but voluntarily dismissed all but the MUTPA claim. *Id*. at 392, 393.

because all "are in essence a claim that plaintiff was denied medical benefits because of the alleged physician financial incentive program").

The Supreme Court addressed the same issue in the analogous ERISA context in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004). A key issue there was whether the plaintiffs' claims fell within ERISA's civil remedies provision—ERISA § 502(a)(1)(B)—which allows for suits by ERISA participants "to recover benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B). The plaintiffs alleged that they had suffered physical injuries because of their ERISA plan's denial of coverage for certain treatment. 542 U.S. at 204–05. The plaintiffs elected not to pursue their remedies under ERISA and instead filed suit for tort damages they alleged followed from the denial of coverage. *See id*. at 204–06; *see also id*. at 214–15. The Supreme Court held that the plaintiffs' only remedy was under ERISA § 502(a)(1)(B): "Upon the denial of benefits, [plaintiffs] could have paid for the treatment themselves and then sought reimbursement through [ERISA's civil remedies provision], or sought a preliminary injunction," which, if successful, would have avoided all injuries alleged. *Id*. at 211.

Plaintiffs are wrong that their claims here do not constitute disputes that fall within 5 C.F.R. § 890.105's administrative remedy. Plaintiff Cavallero-Kearins alleges that she was unable to identify an in-network provider using the Plan directory, and she was "left with no other option than to go out-of-network." Compl. ¶¶ 74-76, 79. She alleges that she "had to spend thousands of dollars on out-of-network providers" and "the reimbursement from Anthem was a tiny fraction of her out-of-pocket costs." *Id*. ¶ 76. And she further alleges Anthem "[o]n numerous occasions" stated it had not received her requests for reimbursement. *Id*. ¶ 80. But Ms. Cavallero-Kearins's complaints about inadequate, delayed, or denied reimbursement of out-of-network costs are

precisely the sort of benefits disputes that must be addressed through FEHBA's mandatory administrative dispute process. *See Botsford*, 314 F.3d at 396–99.

Plaintiff Doe likewise should have pursued her claims through FEHBA's administrative remedies. Doe alleges that she was unable to find an in-network provider using the Plan directory "with the training or experience necessary to provide adequate care within a reasonable distance of her home." Compl. ¶ 92. As the Supreme Court has recognized, the remedy for such a claim is to obtain treatment and then seek reimbursement through the provided administrative process. *See Aetna Health*, 542 U.S. at 211. And while Doe alleges she was "unable to financially afford out-of-network care" and therefore had to "forgo care," Compl. ¶ 93, Doe could have informed Anthem of her difficulty in finding an in-network provider and requested an accommodation such as a single-case agreement that would have allowed her to see an out-of-network provider at in-network rates. *See Jamie F. v. UnitedHealthCare Ins. Co.*, No. 19-CV-1111-YGR, 2020 WL 6802416, at *1 (N.D. Cal. Nov. 19, 2020) ("A [single-case agreement] is an agreement between a non-network provider and a . . . claims administrator pursuant to which the claims administrator agrees to pay a set rate for . . . treatment for the individual claimant"); *Robert O. v. Harvard Pilgrim Health Care, Inc.*, No. 2:17-CV-1251-TC, 2019 WL 3358706, at *3 (D. Utah July 25, 2019) ("Single case agreements are contracts between the insurer and the out-of-network provider that allow the consumer to see his or her out-of-network provider, usually at a negotiated in-network rate." (*quoting* Miriam Ruttenberg, Esq., Choice and Continuity of Care as Significant Health Issues for Equality in Mental Health Care, 10 J. of Health & Biomedical L. 201, 209 (2014)). Had Anthem refused to provide such an accommodation or otherwise failed to provide Doe with benefits under the Plan, Doe could have pursued her claims through FEHBA's administrative remedy under 5 C.F.R. §§ 890.105 and 890.107.

In short, both Plaintiffs had a straightforward remedy to obtain exactly the coverage they sought through FEHBA's administrative remedy. That Plaintiffs failed to pursue their available remedy does not excuse them from complying with FEHBA's requirements; rather, it bars them from seeking judicial relief on claims for which they failed to exhaust these remedies. 5 C.F.R. § 890.107.

The Second Circuit has held that a failure to exhaust FEHBA's administrative remedy should result in the dismissal of the enrollee's lawsuit. *See Kennedy v. Empire Blue Cross & Blue Shield*, 989 F.2d 588, 594 (2d Cir. 1993); *see also Kobleur v. Grp. Hospitalization & Med. Servs., Inc.*, 954 F.2d 705, 710–11 (11th Cir. 1992). A pre-suit exhaustion requirement "may arise from explicit statutory language or from an administrative scheme providing for agency relief." *Kennedy*, 989 F.2d at 592 (citation omitted). The court in *Kennedy* concluded that the administrative remedy set forth in OPM's regulations satisfies the latter option. *See id*. at 593–94. Accordingly, it affirmed the dismissal of the enrollee's claims for failure to exhaust that remedy. *See id*. at 594, 596.[10] Because Plaintiffs' claims are cognizable under OPM's administrative remedy, they must be dismissed.

IV. PLAINTIFFS CANNOT SUE AS THIRD-PARTY BENEFICIARIES

Plaintiffs' First Cause of Action for breach of the OPM-BCBSA Contract must also be dismissed for the additional reason that Plaintiffs, as non-parties to that contract, are not entitled to sue Anthem to enforce the contract's terms. That was the conclusion correctly reached by the

[10] In *Kennedy*, the court found the exhaustion requirement to exist even though OPM's regulations were, at the time, ambiguous as to whether the administrative remedy was mandatory or optional. *Id*. at 592-93. OPM has since removed any ambiguity and its regulations now make clear that exhaustion is required. *See* 5 C.F.R. § 890.107(d)(1) (a lawsuit "[m]ay not be brought prior to exhaustion of the administrative remedies provided in § 890.105"). Thus, this case presents an even stronger case for dismissal for failure to exhaust than did *Kennedy*.

only case that directly addresses whether Plan enrollees are *intended* third-party beneficiaries of the OPM-BCBSA Contract *with the right to sue* to enforce its terms. *See Fero v. Excellus Health Plan, Inc.*, 236 F. Supp. 3d 735, 763–69 (W.D.N.Y. 2017). And it is the only conclusion consistent with recognized constraints on third party rights to sue, which are heightened where a private party seeks to enforce governmental rights under a government contract.

Third parties can enforce a contract only when they are "intended," rather than "incidental," beneficiaries of the contract. Restatement (Second) of Contracts § 302 (Am. Law Inst. 1981). Although some courts use the terms differently (or use different terms), the Restatement uses "intended beneficiary" to refer to a beneficiary who "acquires a right [to sue] by virtue of a promise" while an "incidental beneficiary" does not. *Id.* at cmt. a. Even under non-government contracts, "[p]roving third-party beneficiary status requires that the contract terms 'clearly evidence[] an intent to permit enforcement by the third party' in question." *Hillside Metro Assocs., LLC v. JPMorgan Chase Bank, N.A.*, 747 F.3d 44, 49 (2d Cir. 2014) (citation omitted); *see also JP Morgan Chase & Co. v. Conegie ex rel. Lee*, 492 F.3d 596, 600 (5th Cir. 2007).

Under federal government contracts, it is even more difficult to show that a third-party was intended to have the right to sue to enforce the contract. *See Rivera v. Bank of Am. Home Loans*, No. 09 CV 2450, 2011 U.S. Dist. LEXIS 43138, at *13 (E.D.N.Y. Apr. 21, 2011) (citing Restatement (Second) of Contracts § 313 cmt. a (Am. Law Inst. 1981)); *see also Cent. Sw. Tex. Dev., L.L.C. v. JPMorgan Chase Bank, N.A.*, 780 F.3d 296, 299–300 (5th Cir. 2015). The Supreme Court has recognized the heightened standard under government contracts: "[t]he distinction between an intention to benefit a third party and an intention that the third party should have the right to enforce that intention is emphasized where the promisee is a governmental entity." *Astra USA, Inc. v. Santa Clara Cnty.*, 563 U.S. 110, 118 (2011) (citation and internal quotations marks

omitted); *see also Caltex Plastics, Inc. v. Lockheed Martin Corp.*, 824 F.3d 1156, 1160 (9th Cir. 2016) (demonstrating status as an intended beneficiary with rights to enforce a government contract is a "'comparatively difficult task'") (citation omitted).

The burden is on a plaintiff to point to specific language in the contract demonstrating an intent to permit a third party to sue to enforce the contract's terms. *See Nguyen v. United States Catholic Conf.*, 719 F.2d 52, 55 (3d Cir. 1983); *Fero*, 236 F. Supp. 3d at 769; *Cade v. BAC Home Loans Servicing, LP*, No. 10-CV-4224, 2011 WL 2470733, at *4 (S.D. Tex. June 20, 2011). "[S]ilence cannot be interpreted to manifest a clear intent to permit enforcement." *Fero*, 236 F. Supp. 3d at 769.

Plaintiffs argue that they are within the class of individual that the OPM-BCBSA Contract was intended to benefit. ECF No. 18 at 3. But more is required. To bring a third-party breach of contract claim, a plaintiff must show that "the contract intended to provide the plaintiff with a legal cause of action, not just [that] the plaintiff falls within a class of individuals that the contract and its underlying policies seek to benefit." *Alpino v. JPMorgan Chase Bank, N.A.*, No. 10-12040, 2011 U.S. Dist. LEXIS 43210, at *9-10 (D. Mass. Apr. 21, 2011); *see also Skillman-Eastridge, Ltd. v. JPMorgan Chase Bank, Nat. Ass'n*, No. 3:09-CV-01988-M, 2011 WL 4528391, at *4 (N.D. Tex. Sept. 29, 2011). For that reason, the court in *Fero* held that even though the OPM-BCBSA Contract's purpose was "to benefit federal employees," those employees could not bring a breach of contract action because "'[p]roving third-party beneficiary status requires that the contract terms clearly evidence an *intent to permit enforcement* by the third party in question.'" 236 F. Supp. 3d at 768 (quoting *Hillside Metro Assocs.*, 747 F.3d at 49).

Here, Plaintiffs cannot point to any contract provisions demonstrating that OPM and BCBSA intended Plan enrollees like Plaintiffs to be able to sue Anthem to enforce the contract's

NSA provisions or any provisions for that matter. To the contrary, the contract indicates they have no such right. The contract does contain provisions allowing Plan enrollees to sue regarding enrollment disputes, benefits disputes, and challenges to OPM regulations, but requires such suits be brought against the government only (either the government employing office or OPM). OPM-BCBSA Contract § 2.8(g); *see also* 2024 Statement of Benefits at 140. The lack of similar provisions for lawsuits against the carrier indicates the contracting parties did not intend there to be such a right. *Cf. Hamdan v. Rumsfeld*, 548 U.S. 557, 578 (2006) (explaining that "a negative inference may be drawn from the exclusion of language from one statutory provision that is included in other provisions of the same statute"); *Russello v. United States*, 464 U.S. 16, 23 (1983).

Further, as discussed above, the OPM-BCBSA Contract (and OPM's regulations) repeatedly places exclusive enforcement responsibility *with OPM* for a wide range of matters, including marketing and other Plan materials and literature and provider networks. *See, e.g.*, OPM-BCBSA Contract §§ 1.9(k), 1.10(a)(4), (b), 1.11, 1.12(a), 1.13(d), 1.14(c), (d). In short, the contract is rife with references to OPM's ability to enforce the contract, including numerous rights for OPM to take action it deems necessary "to protect the interests of" enrollees. *E.g., id*. § 1.10(b), 1.12(a), 1.14(c). But the contract is silent as to any right of enrollees to sue Anthem. Accordingly, enrollees such as Plaintiffs do not have such a right, and thus are not intended third-party beneficiaries of the OPM-BCBSA Contract that may sue to enforce its terms. *Fero*, 236 F. Supp. 3d at 769.

V. PLAINTIFFS CONCEDE THAT BENEFIT-OF-THE BARGAIN DAMAGES ARE UNAVAILABLE TO THEM

Last, Plaintiffs conceded in their response to Anthem's pre-motion letter that "benefit-of-the-bargain" damages are barred in this case by the filed-rate doctrine. ECF No. 18 at 3; *see Fero*,

236 F. Supp. 3d at 780-81. Accordingly, in the event any aspect of the Complaint survives this motion, the Court should enter an order striking benefit-of-the-bargain damages (including portions of Paragraphs 199 and 233 of the Complaint) and precluding Plaintiffs from obtaining, seeking, or referencing benefit-of-the-bargain damages in any future proceeding in this matter.

CONCLUSION

For these reasons, Plaintiffs' Complaint should be dismissed in full with prejudice.

Dated: March 28, 2025

Respectfully Submitted,

By: /s/ Matthew J. Aaronson

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CERTIFICATE OF COMPLIANCE

Pursuant to Rule 2.B of the Court's Individual Rules and Practices in Civil Cases, I HEREBY CERTIFY that this motion complies with the Court's word-count limitations and contains 7,542 words, exclusive of the caption, any index, table of contents, table of authorities, signature blocks, or any required certificates.

/s/ Matthew J. Aaronson
Matthew J. Aaronson

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by CM/ECF to all counsel of record on this 28th day of March 2025.

/s/ Matthew J. Aaronson
Matthew J. Aaronson

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

JANE DOE on behalf of BABY DOE, a minor, and PATRICIA CAVALLARO-KEARINS, on behalf of themselves and all others similarly situated, Plaintiffs, v. ANTHEM HEALTHCHOICE ASSURANCE, INC., d/b/a ANTHEM BLUE CROSS AND BLUE SHIELD, and d/b/a ANTHEM BLUE CROSS, Defendant.	Civil Action No. 1:24-cv-08012

DECLARATION OF BRENDAN G. STUHAN IN SUPPORT OF DEFENDANT'S MOTION TO DISMISS

Pursuant to 28 U.S.C. § 1746, Brendan G. Stuhan, under penalty of perjury under the laws of the United States of America, declares the following to be true and correct:

1. I am over twenty-one years of age, of sound mind, and fully competent to make this declaration. Based on my personal knowledge and experience at the Blue Cross and Blue Shield Association ("BCBSA") and on my review of documents related to the substance of this Declaration as indicated below, the matters below are true and correct.

2. I have personal knowledge of the matters stated in this Declaration and could and would competently testify to them if called as a witness.

3. I am employed as Deputy General Counsel by BCBSA in Washington, D.C. In that role, I am involved and familiar with the Blue Cross and Blue Shield Service Benefit Plan, which is one of the federal government's health benefits plans for federal employees, annuitants, and

their dependents and which is governed by the Federal Employees Health Benefits Act, 5 U.S.C. §§ 8901-8914 ("FEHBA"). "Federal Employee Program" (or "FEP") is a nickname for the Blue Cross and Blue Shield Service Benefit Plan.

4. The Service Benefit Plan is formed by a federal government contract – Contract No. CS 1039 – between the United States Office of Personnel Management ("OPM") and BCBSA. BCBSA is the carrier of the Service Benefit Plan. BCBSA enters into that contract on behalf of and as agent for participating local Blue Cross and/or Blue Shield companies. Local Blue Cross and/or Blue Shield companies are independent licensees of BCBSA. Defendant Anthem HealthChoice Assurance, Inc. ("Anthem") is such a company and administers the Service Benefit Plan in parts of New York state.

5. OPM and BCBSA (on behalf of and as agent for participating local Blue Cross and/or Blue Shield companies such as Anthem) have entered into Contract No. CS 1039 annually for decades. Periodically, the entire contract is restated in what I will refer to as the "OPM-BCBSA Contract." The most recent OPM-BCBSA Contract is the 2025 version, and the 2022 version and 2013 version are the most recent versions before that. With minor redactions in Appendix B thereto, true and correct copies of the 2013 and 2022 OPM-BCBSA Contract are attached hereto as Exhibits A and B, respectively.

6. In other years, OPM and BCBSA (on behalf of and as agent for participating local Blue Cross and/or Blue Shield companies such as Anthem) have entered into annual amendments to the most recent version of the OPM-BCBSA Contract. With minor redactions in Appendix B thereto, true and correct copies of the 2018, 2019, 2020, and 2021 annual amendment to the 2013 OPM-BCBSA Contract are attached hereto as Exhibits C, D, E, and F, respectively. With minor redactions in Appendix B thereto, true and correct copies of the 2023 and 2024 annual amendments

to the 2022 OPM-BCBSA Contract are attached hereto as Exhibits G and H, respectively.

7. Each year, the Service Benefit Plan's Statement of Benefits is incorporated into the applicable OPM-BCBSA Contract or annual contract amendment. True and correct copies of the 2018 through 2024 Statement of Benefits for the Service Benefit Plan are attached hereto as Exhibits I, J, K, L, M, N, and O, respectively. Each annual Statement of Benefits is also available for download on OPM's official government website. For example, the 2024 version can be downloaded at: https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plans/pdf/2024/brochures/71-005.pdf (last visited March 25, 2025). Other versions can be downloaded by changing the year in that web address.

Executed on this the 25th day of March 2025.

Brendan Stuhan

BRENDAN G. STUHAN

EXHIBIT A

2013 Contract No. CS 1039

Between the U.S. Office of Personnel Management and the Blue Cross and Blue Shield Association on Behalf of, and as Agent for, Participating Blue Cross and/or Blue Shield Plans

CONTRACT FOR FEDERAL EMPLOYEES HEALTH BENEFITS

CONTRACT NO: CS 1039
EFFECTIVE: January 1, 1960

FULL CONTRACT
EFFECTIVE: January 1, 2013

BETWEEN: The United States Office of Personnel Management
hereinafter called OPM or the Government

Address: 1900 E Street, NW
Washington, DC 20415-3610

AND

CONTRACTOR: Blue Cross and Blue Shield Association
hereinafter also called the Carrier

Address: 1310 G. Street, NW, Suite 900
Washington, DC 20005

In consideration of payment by OPM of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract, including Appendix A.

FOR THE CARRIER

William A. Breskin
Name of person authorized to execute contract
(type or print)

Vice President, Government Programs
Title

Signature

12/21/12
Date signed

FOR THE GOVERNMENT

Sylvia V. Pulley
Name of Contracting Officer
(type or print)

Chief, Health Insurance I, Federal Employee Insurance Operations
Title

Signature

12/22/12
Date signed

FEDERAL EMPLOYEES

HEALTH BENEFITS PROGRAM

STANDARD CONTRACT

FOR

FEE-FOR-SERVICE CARRIERS

2013

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PART I - GENERAL PROVISIONS

SECTION 1.1
DEFINITIONS OF FEHB TERMS (JAN 2012)

For purpose of this contract, the following definitions apply:

Act: The Federal Employees Health Benefits Act, as amended; chapter 89 of title 5, United States Code.

Benefits: Covered services or payment for covered services set forth in Appendix A, to which Members are entitled to the extent provided by this contract.

Carrier: As defined by chapter 89 of title 5, United States Code, and may be used interchangeably with the term Contractor.

Enrollee: The Federal employee, Tribal Employee, annuitant, former spouse, temporarily-covered former Federal employee or family member enrolled under this contract.

FEHBP: Federal Employees Health Benefits Program.

Letter of Credit: The method by which certain Carriers, and their underwriters if authorized, receive recurring premium payments and contingency reserve payments by drawing against a commitment (certified by a responsible OPM official) which specifies a dollar amount available. For each Carrier participating in the Letter of Credit arrangement for payment under FEHBAR 1632.170(b), the terms "carrier reserves" and "special reserves" include any balance in the Carrier's Letter of Credit account.

Member: The Enrollee and/or an eligible family member for benefit purposes, and sometimes referred to as subscriber.

Regulations: (1) The Federal Employees Health Benefits Regulations; part 890, title 5, Code of Federal Regulations, and (2) Chapters 1 and 16 of title 48, Code of Federal Regulations.

Subcontractor: Any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime contractor, or another subcontractor, except for providers of direct medical services or supplies pursuant to the Carrier's health benefits plan.

Tribal Employee: A full-time or part-time common law employee of a tribal employer.

Tribal Employer: A tribal employer is an Indian tribe or tribal organization, as those terms are defined in 25 U.S.C. Chapter 18, carrying out at least one program under the Indian Self-Determination and Education Assistance Act or an urban Indian organization as that term is defined in 25 U.S.C. Chapter 18 carrying out at least one program under the title V of the Indian Health Care Improvement Act, provided that OPM accepts the tribe, tribal organization, or urban Indian organization's agreement to offer FEHB.

SECTION 1.2
ENTIRE CONTRACT (JAN 2009)

(a) This document as described in the *Table of Contents* constitutes the entire contract between the parties. No oral statement of any person shall modify or otherwise affect the terms, conditions, or specifications stated in this contract. Requests for modifications of this contract must be submitted to the authorized Contracting Officer. Only the Contracting Officer acting within the scope of his or her authority may execute a contract modification on behalf of the government.

(b) All statements concerning coverage or benefits made by OPM, the Carrier or by any individual covered under this contract shall be deemed representations and not warranties. No such statement shall convey or void any coverage, increase or reduce any benefits under this contract or be used in the prosecution of or defense of a claim under this contract unless it is contained in writing and a copy of the instrument containing the statement is or has been furnished to the Member or to the person making the claim.

SECTION 1.3
ORDER OF PRECEDENCE (JAN 1996)

Any inconsistency in this contract shall be resolved by giving precedence in the following descending order: The Act, the regulations in part 890, title 5, Code of Federal Regulations, the regulations in chapters 1 and 16, title 48, Code of Federal Regulations, and this contract.

SECTION 1.4
INCORPORATION OF LAWS AND REGULATIONS (JAN 2002)

(a) The applicable provisions of (1) chapter 89 of title 5, United States Code; (2) OPM's regulations as contained in part 890 of title 5, Code of Federal Regulations; and (3) chapters 1 and 16 of title 48, Code of Federal Regulations constitute a part of this contract as if fully set forth herein, and the other provisions of this contract shall be construed so as to comply therewith.

(b) If the Regulations are changed in a manner which would increase the Carrier's liability under this contract, the Contracting Officer will make an equitable adjustment in accordance with the changes clause, Section 5.38 -- Changes--Negotiated Benefits Contracts.

SECTION 1.5
RECORDS AND INFORMATION TO BE FURNISHED BY OPM (JAN 2012)

(a) OPM shall maintain or cause to be maintained records from which the Carrier may determine the names and social security numbers of all Enrollees. OPM, other agencies of the Federal Government, Tribal Employer, or the FEHB Clearinghouse shall furnish the information to the Carrier at such times and in such form and detail as will enable the Carrier to maintain a currently accurate record of all Enrollees.

(b) The Carrier is entitled to rely on information furnished to it under paragraph (a). OPM agrees that any liabilities incurred under this contract in reliance upon such information

shall be a valid charge against the contract. Errors or delays in keeping or reporting data relating to coverage shall not invalidate coverage that would otherwise be validly in force and shall not continue coverage that would otherwise be terminated. OPM shall make an equitable adjustment of premiums upon discovery of errors or delays under this Section.

(c) Clerical error (whether by OPM, any other agency, Tribal Employer, the FEHB Clearinghouse, or the Carrier) in keeping records pertaining to coverage under this contract, delays in making entries thereon, or failure to make or account for any deduction of enrollment charges, shall not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. OPM shall make an equitable adjustment of premiums when an error, delay, or failure is discovered. If any person finds relevant facts pertaining to a person covered under this contract to be misstated, and if the misstatement affects the existence, amount, or extent of coverage, the actual facts shall determine whether coverage is in force under the terms of this contract and in what amount or to what extent. Any claim payments the Carrier makes before an adjustment or determination shall be a valid charge against this contract.

(d) The OPM shall direct the agencies and Tribal Employers to provide the Carrier or the FEHB Clearinghouse, not less often than quarterly, the names of Enrollees enrolled under the contract by payroll office and the premium paid for those Enrollees for the current pay cycle. The Carrier shall at least quarterly reconcile its enrollment records with those provided by the Government, the Tribal Employer, or the FEHB Clearinghouse.

(e) In instances of erroneous enrollments where benefit payments have been made in error, the Carrier must inform Enrollees within forty-five days of when the Carrier receives notification from the agency or the Tribal Employer that the Carrier will collect for these benefit payments. The Carrier shall provide notice to the Enrollees that they have the right to contest their enrollment change with their agency, Tribal Employer, or their retirement system.

SECTION 1.6
CONFIDENTIALITY OF RECORDS
(JAN 1991) (FEHBAR 1652.224-70)

(a) The Carrier shall use the personal data on employees and annuitants that is provided by agencies and OPM, including social security numbers, for only those routine uses stipulated for the data and published annually in the Federal Register as part of OPM's notice of systems of records.

(b) The Carrier shall also hold all medical records, and information relating thereto, of Federal subscribers confidential except as follows:

(1) As may be reasonably necessary for the administration of this contract;

(2) As authorized by the patient or his or her guardian;

(3) As disclosure is necessary to permit Government officials having authority to investigate and prosecute alleged civil or criminal actions;

(4) As necessary to audit the contract;

(5) As necessary to carry out the coordination of benefit provisions of this contract; and

(6) For bona fide medical research or educational purposes. Release of information for medical research or educational purposes shall be limited to aggregated information of a statistical nature that does not identify any individual by name, social security number, or any other identifier unique to an individual.

(c) If the Carrier uses medical records for the administration of the contract, or for bona fide research or educational purposes, it shall so state in the Plan's brochure.

SECTION 1.7
STATISTICS AND SPECIAL STUDIES (JAN 2009)

(a) The Carrier shall maintain or cause to be maintained statistical records of its operations under the contract and shall furnish OPM, in the form prescribed by the Contracting Officer, the statistical reports reasonably necessary for the OPM to carry out its functions under Chapter 89 of title 5, United States Code.

(b) The Carrier shall furnish such other reasonable statistical data and reports of special studies as the Contracting Officer may from time to time request for the purpose of carrying out its functions under Chapter 89 of title 5, United States Code.

(c) The Carrier shall furnish the routine reports in the required number of copies in a format to be determined by the Contracting Officer as instructed by OPM.

(d) The Carrier shall notify the OPM Contract Representative immediately upon a change in the name or address of the Carrier's contract administrator(s).

SECTION 1.8
NOTICE (JAN 2003)

Where the contract requires that notice be given to the other party, such notice must be given in writing to the address shown on this contract's signature page. To notify OPM, the Carrier must write to the Contracting Officer, unless otherwise specified.

SECTION 1.9
PLAN PERFORMANCE--EXPERIENCE-RATED FFS CONTRACTS (JAN 2013)

(a) Detection of Fraud and Abuse. The Carrier shall conduct a program to assess its vulnerability to fraud and abuse and shall operate a system designed to detect and eliminate fraud and abuse internally by Carrier employees and subcontractors, by providers providing goods or services to FEHB Members, and by individual FEHB Members. The program must specify provisions in place for cost avoidance not just fraud detection, along with criteria for follow-up actions. The Carrier must submit to OPM an annual analysis of the costs and benefits of its fraud and abuse program. The Carrier must submit annual reports to OPM by March 31 addressing the following:

1) Cases opened;
2) Dollars identified as lost and recovered on active cases
3) Actual savings and prevented loss on active cases;
4) Active cases referred to law enforcement (other than the OPM-OIG)
5) Active cases referred to OPM – OIG;
6) Active cases resolved administratively;
7) Percentage of active cases where the FEHB Program is the only or primary line of business affected
8) Number of FEHB providers who are on prepayment review; and
9) Number of arrests and criminal convictions resulting from active cases

The report will also include the industry standards checklist.

(b) Clinical Care Measures. The Carrier shall measure and/or collect data on the quality of the health care services that are provided to its members as requested by OPM. Measurement/data collection efforts may include performance measurement systems such as Healthcare Effectiveness Data and Information Set (HEDIS) or similar measures developed by accrediting organizations such as the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or URAC. Costs incurred by the Carrier for collecting or contracting with a vendor to collect quality measures/data shall be the Carrier's responsibility and are allowable administrative expenses, subject to the administrative cost limitation.

(c) Patient Safety. The Carrier shall implement a patient safety improvement program. At a minimum, the Carrier shall --

(1) Report to OPM on its current patient safety initiatives;

(2) Report to OPM on how it will strengthen its patient safety program for the future;

(3) Assist OPM in providing its members with consumer information and education regarding patient safety; and

(4) Work with its providers, independent accrediting organizations, and others to implement patient safety improvement programs.

(d) Accreditation. To demonstrate its commitment to providing quality, cost-effective health care, the Carrier shall continue to pursue and maintain accreditation according to the steps and timeframes outlined in the carrier's current business plan. The carrier shall submit accreditation changes and business plan updates to its OPM contract representative.

(e) Consumer Assessments of Healthcare Providers and Systems (CAHPS). In addition to any other means of surveying Plan members that the Carrier may develop, the Carrier shall participate in the HEDIS Consumer Assessments of Healthcare Providers and Systems (CAHPS) to provide feedback to Enrollees on Enrollee experience with the various FEHBP plans. The Carrier shall take into account the published results of the survey, or other results as directed by OPM, in identifying areas for improvement as part of the Carrier's quality assurance program. Payment of survey charges will be in accordance with Section 3.11.

(f) Contract Quality Assurance. The Carrier shall develop and apply a quality assurance program specifying procedures for assuring contract quality. At a minimum the carrier shall meet the following standards and submit an annual report to OPM on these standards by July 1 of the following contract period:

(1) *Claims Processing Accuracy* - the number of FEHB claims processed accurately and the total number of FEHB claims processed for the given time period, expressed as a percentage.

REQUIRED STANDARD: An average of 95 percent of FEHB claims must be processed accurately.

(2) *Claims Coding Accuracy* - the number of FEHB claims coded accurately divided by the total number of FEHB claims coded for the given time period, expressed as a percentage.

REQUIRED STANDARD: An average of 98 percent of FEHB claims shall be coded accurately.

(3) *Recovery of Erroneous Payments* - the average number of working days it takes for the Carrier to begin collection action against an FEHB provider or member following identification of an erroneous payment, including overpayments.

REQUIRED STANDARD: The Carrier takes an average of no more than 30 working days from the date it identifies an FEHB erroneous payment to the date it begins the collection action.

(4) *Coordination of Benefits (COB)* - the Carrier must demonstrate that a statistically valid sampling technique is routinely used to identify FEHB claims prior to or after processing that require(d) coordination of benefits (COB) with a third party payer. As an alternative, the Carrier may provide evidence that it pursues all claims for COB.

(5) *Claims Timeliness* - the average number of working days from the date the Carrier receives an FEHB claim to the date it adjudicates it (paid, denied or a request for further information is sent out), for the given time period, expressed as a cumulative percentage.

REQUIRED STANDARD: The Carrier adjudicates 95 percent of claims within 30 working days.

(6) *Processing ID cards on change of plan or option* - the number of calendar days from the date the Carrier receives the enrollment from the Enrollee's agency, Tribal Employer, or retirement system to the date it issues the ID card.

REQUIRED STANDARD: The Carrier issues the ID card within fifteen calendar days after receiving the enrollment from the Enrollee's agency, Tribal Employer, or retirement system except that the Carrier will issue ID cards resulting from an open season election within fifteen calendar days or by December 15, whichever is later.

(7) *Member Inquiries* - the number of working days taken to respond to an FEHB member's written inquiry, expressed as a cumulative percentage, for the given time period.

REQUIRED STANDARD: The Carrier responds to 90 percent of inquiries within 15 working days (including internet inquiries).

(8) *Written Inquiries Accuracy* – the number of FEHB written inquiries handled accurately divided by the total number of FEHB written inquiries handled for the given time period, expressed as a percentage.

REQUIRED STANDARD: A minimum of 97 percent of FEHB written inquiries shall be answered accurately.

(9) *Telephone Inquiries Accuracy* – the number of FEHB telephone inquiries handled accurately divided by the total number of FEHB telephone inquiries handled for the given time period, expressed as a percentage.

REQUIRED STANDARD: A minimum of 97 percent of FEHB telephone inquiries shall be answered accurately.

(10) *Internet Inquiries Accuracy* – the number of FEHB Internet inquiries handled accurately divided by the total number of FEHB Internet inquiries handled for the given time period, expressed as a percentage.

REQUIRED STANDARD: A minimum of 97 percent of FEHB Internet inquiries shall be answered accurately.

(11) *Telephone Access* - the Carrier shall report on the following statistics concerning telephone access to the member services department (or its equivalent) for the given time period. Except that, if the Carrier does not have a computerized phone system, report results of periodic surveys on telephone access.

(i) Call Answer Timeliness - the average number of seconds elapsing before the Carrier connects a member's telephone call to its service representative.

REQUIRED STANDARD: On average, no more than 30 seconds elapse before the Carrier connects a member's telephone call to its service representative.

(ii) Telephone Blockage Rate - the percentage of time that callers receive a busy signal when calling the Carrier.

REQUIRED STANDARD: No more than 5% of callers receive a busy signal.

(iii) Telephone Abandonment Rate - the number of calls attempted but not completed (presumably because callers tired of waiting to be connected to a Carrier representative) divided by the total number of calls attempted (both completed and not completed), expressed as a percentage.

REQUIRED STANDARD: On average, Enrollees abandon the effort no more than 5 percent of the time.

(iv) *Initial Call Resolution* – the percentage of issues resolved during the initial call.

REQUIRED STANDARD: On average, caller's issues must be resolved during the initial call at least 60% of the time.

(12) *Responsiveness to FEHB Member Requests for Reconsideration*:

REQUIRED STANDARD: For 100 percent of written FEHB disputed claim requests received for the given time period, within 30 days after receipt by the Carrier, the Carrier shall affirm the denial in writing to the FEHB member, pay the claim, provide or authorize coverage of the service, or request additional information reasonably necessary to make a determination.

(g) Quality Assurance Plan. The Carrier must demonstrate that a statistically valid sampling technique is routinely used prior to or after processing to randomly sample FEHB claims against Carrier quality assurance/fraud and abuse prevention standards.

(h) Reporting Compliance. The Carrier shall keep complete records of its quality assurance procedures and fraud prevention program and the results of their implementation and make them available to the Government as determined by OPM.

(i) FEHB Clearinghouse (CLER). The Carrier shall not have any CLER records with a 160 error code and a fail count of four or higher, except for OPM annuitants. A '160' error is when a Carrier reports an enrollment but no agency or Tribal Employer reports that enrollment.

(j) Correction of Deficiencies. The Contracting Officer may order the correction of a deficiency in the Carrier's quality assurance program or fraud prevention program. The Carrier shall take the necessary action promptly to implement the Contracting Officer's order. If the Contracting Officer orders a modification of the Carrier's quality assurance program or fraud prevention program pursuant to this paragraph (j) after the contract year has begun, the costs incurred to correct the deficiency may be excluded from the administrative expenses -- for the contract year -- that are subject to the administrative expenses limitation specified at Appendix B; provided the Carrier demonstrates that the correction of the deficiency significantly increases the Carrier's liability under this contract.

(k) In order to allow sufficient implementation time, the Contracting Officer will notify the Carrier reasonably in advance of any new requirement(s) under paragraphs (a) through (j).

SECTION 1.10
NOTICE OF SIGNIFICANT EVENTS (JUL 2005) (FEHBAR 1652.222-70)

(a) The Carrier agrees to notify the Contracting Officer of any Significant Event within ten (10) working days after the Carrier becomes aware of it. As used in this section, a Significant Event is any occurrence or anticipated occurrence that might reasonably be expected

to have a material effect upon the Carrier's ability to meet its obligations under this contract, including, but not limited to, any of the following:

(1) Disposal of major assets;

(2) Loss of 15% or more of the Carrier's overall membership;

(3) Termination or modification of any contract or subcontract if such termination or modification might have a material effect on the Carrier's obligations under this contract;

(4) Addition or termination of provider agreements;

(5) Any changes in underwriters, reinsurers or participating plans;

(6) The imposition of, or notice of the intent to impose, a receivership, conservatorship, or special regulatory monitoring;

(7) The withdrawal of, or notice of intent to withdraw State licensing, HHS qualification, or any other status under Federal or State law;

(8) Default on a loan or other financial obligation;

(9) Any actual or potential labor dispute that delays or threatens to delay timely performance or substantially impairs the functioning of the Carrier's facilities or facilities used by the Carrier in the performance of the contract;

(10) Any change in its charter, constitution, or by-laws which affects any provision of this contract or the Carrier's participation in the Federal Employees Health Benefits Program;

(11) Any significant changes in policies and procedures or interpretations of the contract or brochure which would affect the benefits available under the contract or the costs charged to the contract;

(12) Any fraud, embezzlement or misappropriation of FEHB funds; or

(13) Any written exceptions, reservations or qualifications expressed by the independent accounting firm (which ascribes to the standards of the American Institute of Certified Public Accountants) contracted with by the Carrier to provide an opinion on its annual financial statements.

(b) Upon learning of a Significant Event OPM may institute action, in proportion to the seriousness of the event, to protect the interest of Members, including, but not limited to--

(1) Directing the Carrier to take corrective action;

(2) Suspending new enrollments under this contract;

(3) Advising Enrollees of the Significant Event and providing them an opportunity to transfer to another plan;

(4) Withholding payment of subscription income or restricting access to the Carrier's Letter of Credit account;

(5) Terminating the enrollment of those Enrollees who, in the judgment of OPM, would be adversely affected by the Significant Event; or

(6) Terminating this contract pursuant to Section 1.15, Renewal and Withdrawal of Approval.

(c) Prior to taking action as described in paragraph (b) of this clause, the OPM will notify the Carrier and offer an opportunity to respond.

(d) The carrier will insert this clause in any subcontract or subcontract modification if the amount of the subcontract or modification charged to the FEHB Program (or in the case of a community-rated carrier, applicable to the FEHB Program) equals or exceeds $550,000 and is at least 25 percent of the total subcontract cost. The amount of the dollar charge to the FEHB Program shall be adjusted by the same amount and at the same time as any change to the threshold for application of the Truth in Negotiations Act pursuant to 41 U.S.C. 254b(a)(7).

SECTION 1.11
FEHB INSPECTION (JUL 2005) (FEHBAR 1652.246-70)

(a) The Contracting Officer, or an authorized representative of the Contracting Officer, has the right to inspect or evaluate the work performed or being performed under the contract, and the premises where the work is being performed, at all reasonable times and in a manner that will not unreasonably delay the work.

(b) The Contractor shall maintain and the Contracting Officer, or an authorized representative of the Contracting Officer, shall have the right to examine and audit all books and records relating to the contract for purposes of the Contracting Officer's determination of the Carrier's subcontractor or Large Provider's compliance with the terms of the contract, including its payment (including rebate and other financial arrangements) and performance provisions. The Contractor shall make available at its office at all reasonable times those books and records for examination and audit for the record retention period specified in the Federal Employees Health Benefits Acquisition Regulation (FEHBAR), 48 CFR 1652.204-70. This subsection is applicable to subcontract and Large Provider Agreements with the exception of those that are subject to the "Audits and Records – Negotiation" clause, 48 CFR 52.215-2.

(c) If the Contracting Officer, or an authorized representative of the Contracting Officer, performs inspection, audit or evaluation on the premises of the Carrier, the subcontractor, or the Large Provider, the Carrier shall furnish or require the subcontractor or Large Provider to furnish all reasonable facilities for the safe and convenient performance of these duties.

(d) The Carrier shall insert this clause, including this subsection (d), in all subcontracts for underwriting and claim payments and administrative services and in all Large Provider Agreements and shall substitute "contractor", "Large Provider," or other appropriate reference for the term "carrier."

SECTION 1.12
CORRECTION OF DEFICIENCIES (JAN 1997)

(a) The Carrier shall maintain sufficient financial resources, facilities, providers, staff and other necessary resources to meet its obligations under this contract. If the OPM determines that the Carrier does not demonstrate the ability to meet its obligations under this contract, the OPM shall notify the Carrier of the asserted deficiencies. The Carrier agrees that, within ten (10) working days following notification, it shall present detailed plans for correcting the deficiencies. These plans shall be presented in a form prescribed by the OPM. Pending submission or implementation of plans required under this Section, the OPM may institute action as it deems necessary to protect the interests of Members, including, but not limited to:

(1) Suspending new enrollments under this contract;

(2) Advising Enrollees of the asserted deficiencies and providing them an opportunity to transfer to another plan;

(3) Withholding payment of subscription income or restricting access to the Carrier's Letter of Credit account; or

(4) Terminating the enrollment of those Enrollees who, in the judgment of OPM, would be adversely affected by the deficiency.

(b) The Carrier agrees that failure to submit or to diligently implement plans which are required under this Section shall constitute sufficient grounds for termination of this contract pursuant to Section 1.15, *Renewal and Withdrawal of Approval.*

(c) Prior to taking action as described in paragraph (a) the OPM shall notify the Carrier and offer an opportunity to respond.

(d) The Carrier shall include the substance of this clause in the contract with its underwriter and substitute an appropriate term for "Carrier."

SECTION 1.13
INFORMATION AND MARKETING MATERIALS (JAN 2013)

(a) OPM and the Carrier shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The Carrier bears full responsibility for the accuracy of its FEHB brochure. OPM in its sole discretion, may order the Carrier to produce and distribute the agreed upon brochure text in a format and quantity approved by OPM, including an electronic 508 compliant brochure version. Section 508 of the Rehabilitation Act of 1973, as amended 29 U.S.C. § 794d, for OPM's web site. This formatted document is referred to as the FEHB brochure. The Carrier shall distribute the FEHB brochure on a timely basis to new Enrollees and to other Enrollees upon their request. The Carrier shall also distribute the document(s) to Federal agencies and Tribal Employers to be made available to such individuals who are eligible to enroll under this contract. At the direction of OPM, the Carrier shall produce and distribute an audio cassette version, CD, or other electronic media of the approved language. The Carrier may print additional FEHB brochures for distribution for its own use, but only in the approved format and at its own expense.

(b) Supplemental material. Only marketing materials or other supplemental literature prepared in accordance with FEHBAR 1652.203-70 (Section 1.14 of this contract) may be distributed or displayed at or through Federal facilities.

(c) The Carrier shall reflect the statement of benefits in the agreed upon brochure text included at Appendix A of this contract, verbatim, in the FEHB brochure.

(d) OPM may order the Carrier to prepare an addendum or reissue the FEHB brochure or any piece(s) of supplemental marketing material at no expense to the Government if it is found to not conform to the agreed upon brochure text and/or supplemental marketing materials preparations described in paragraphs (a), (b) and (c) of this section.

(e) The Carrier shall produce and distribute an FEHB Summary of Benefits and Coverage (SBC).

SECTION 1.14
MISLEADING, DECEPTIVE OR UNFAIR ADVERTISING (JAN 1991) (FEHBAR 1652.203-70)

(a) The Carrier agrees that any advertising material, including that labeled promotional material, marketing material, or supplemental literature, shall be truthful and not misleading.

(b) Criteria to assess compliance with paragraph (a) of this clause are available in the *FEHB Supplemental Literature Guidelines* which are developed by OPM and should be used, along with the additional guidelines set forth in FEHBAR 1603.7002, as the primary guide in preparing material; further guidance is provided in the NAIC *Advertisements of Accident and Sickness*

Insurance Model Regulation. The guidelines are periodically updated and provided to the Carrier by OPM.

(c) Failure to conform to paragraph (a) of this clause may result in a reduction in the service charge, if appropriate, and corrective action to protect the interest of Federal Members. Corrective action will be appropriate to the circumstances and may include, but is not limited to the following actions by OPM:

(1) Directing the Carrier to cease and desist distribution, publication, or broadcast of the material;

(2) Directing the Carrier to issue corrections at the Carrier's expense and in the same manner and media as the original material was made; and

(3) Directing the Carrier to provide, at the Carrier's expense, the correction in writing by certified mail to all Enrollees of the Plan(s) that had been the subject of the original material.

(d) Egregious or repeated offenses may result in the following action by OPM:

(1) Suspending new enrollments in the Carrier's Plan(s);

(2) Providing Enrollees an opportunity to transfer to another plan: and

(3) Terminating the contract in accordance with Section 1.15. *Renewal and Withdrawal of Approval.*

(e) Prior to taking action as described in paragraphs (c) and (d) of this clause, the OPM will notify the Carrier and offer an opportunity to respond.

(f) The Carrier shall incorporate this clause in subcontracts with its underwriter, if any, and other subcontractors directly involved in the preparation or distribution of such advertising material and shall substitute "Contractor" or other appropriate reference for the term "Carrier."

SECTION 1.15
RENEWAL AND WITHDRAWAL OF APPROVAL (JAN 1991) (FEHBAR 1652.249-70)

(a) The contract renews automatically for a term of one (1) year each January first, unless written notice of non-renewal is given either by OPM or the Carrier not less than 60 calendar days before the renewal date, or unless modified by mutual agreement.

(b) This contract also may be terminated at other times by order of OPM pursuant to 5 U.S.C. 8902(e). After OPM notifies the Carrier of its intent to terminate the contract, OPM may take action as it deems necessary to protect the interests of Members, including but not limited to--

(1) Suspending new enrollments under the contract;

(2) Advising Enrollees of the asserted deficiencies; and

(3) Providing Enrollees an opportunity to transfer to another plan.

(c) OPM may, after proper notice, terminate the contract at the end of the contract term if it finds that the Carrier did not have at least 300 Enrollees enrolled in its Plan at any time during the two preceding contract terms.

SECTION 1.16
SUBCONTRACTS (JUL 2005) (FEHBAR 1652.244-70)

(a) The Carrier will notify the Contracting Officer in writing at least 30 days in advance of entering into any subcontract or subcontract modification, or as otherwise specified by this contract, if the amount of the subcontract or modification charged to the FEHB Program equals or

exceeds $550,000 and is at least 25 percent of the total subcontract cost. The amount of the dollar charge to the FEHB Program shall be adjusted by the same amount and at the same time as any change to the threshold for application of the Truth in Negotiations Act pursuant to 41 U.S.C. 254b(a)(7). Failure to provide advance notice may result in a Contracting Officer's disallowance of subcontract costs or a penalty in the performance aspect of the Carrier's service charge. In determining whether the amount chargeable to the FEHB Program contract for a given subcontract or modification equals or exceeds the $550,000 threshold, the following rules apply:

(1) For initial advance notification, the Carrier shall add the total cost/price for the base year and all options, including quantity or service options and option periods.

(2) For contract modifications, options and/or renewals (e.g. evergreen contracts) not accounted for in paragraph (a)(1) of this clause, the carrier shall provide advance notification if they cause the total price to equal or exceed the threshold. OPM's review will be of the modification(s), itself, but documentation for the original subcontract will be required to perform the review. The $550,000 threshold will be adjusted by the same amount and at the same time as any change to the threshold for application of the Truth in Negotiations Act. All subcontracts or subcontract modifications that equal or exceed the threshold are subject to audit under FAR 52.215-2 "Audit and Records-Negotiations" if based on cost analysis or 48 CFR 1646.301 and 1652.246-70 "FEHB Inspection" if based on price analysis.

(b) The advance notification required by paragraph (a) of this clause shall include the information specified below:

(1) A description of the supplies or services to be subcontracted;

(2) Identification of the type of subcontract to be used;

(3) Identification of the proposed subcontractor and an explanation of why and how the proposed subcontractor was selected, including the competition obtained;

(4) The proposed subcontract price and the Carrier's cost or price analysis;

(5) The subcontractor's current, complete, and accurate cost or pricing data and Certificate of Current Cost or Pricing Data, must be submitted to the Contracting Officer if required by law, regulation, or other contract provisions.

(6) (Reserved)

(7) A negotiation memorandum reflecting--

(i) The principal elements of the subcontract price negotiations;

(ii) The most significant consideration controlling establishment of initial or revised prices;

(iii) An explanation of the reason cost or pricing data are not required, if the Carrier believes that cost or pricing data are not required.

(iv) The extent, if any, to which the Carrier did not rely on the subcontractor's cost or pricing data in determining the price objective and in negotiating the final price;

(v) The extent, if any, to which it was recognized in the negotiation that the subcontractor's cost or pricing data were not accurate, complete, or current; the action taken by the Carrier and the subcontractor; and the effect of any such defective data on the total price negotiated;

(vi)The reasons for any significant difference between the Carrier's price objective and the price negotiated; and

(vii) A complete explanation of the incentive fee or profit plan when incentives are used. The explanation will identify each critical performance element, management decisions used to

quantify each incentive element, reasons for the incentives, and a summary of all trade-off possibilities considered.

(c) The Carrier will obtain the Contracting Officer's written consent before placing any subcontract for which advance notification is required under paragraph (a) of this clause. However, the Contracting Officer may ratify in writing any such subcontract for which written consent was not obtained. Ratification will constitute the consent of the Contracting Officer.

(d) The Contracting Officer may waive the requirement for advance notification and consent required by paragraphs (a), (b) and (c) of this clause where the Carrier and subcontractor submit an application or renewal as a contractor team arrangement as defined in FAR Subpart 9.6 and--

(1) The Contracting Officer evaluated the arrangement during negotiation of the contract or contract renewal; and

(2) The subcontractor's price and/or costs were included in the Plan's rates that were reviewed and approved by the Contracting Officer during negotiation of the contract or contract renewal.

(e) If the carrier follows the notification and consent requirements of paragraphs (a), (b) and (c) of this clause and subsequently obtains the Contracting Officer's consent or ratification, then the reasonableness of the subcontract's costs will be inferred as provided for in 1631.205-81. However, consent or ratification by the Contracting Officer will not constitute a determination:

(1) Of the acceptability of any subcontract terms or conditions;

(2) Of the allowability of any cost under this contract; or

(3) That the Carrier should be relieved of any responsibility for performing this contract.

(f) No subcontract placed under this contract will provide for payment on a cost-plus-a-percentage-of-cost basis. Any fee payable under cost reimbursement type subcontracts will not exceed the fee limitations in FAR 15.404-4(c)(4)(i). Any profit or fee payable under a subcontract will be in accordance with the provision of Section 3.7, *Service Charge*.

(g) The Carrier will give the Contracting Officer immediate written notice of any action or suit filed and prompt notice of any claim made against the Carrier by any subcontractor or vendor that, in the opinion of the Carrier, may result in litigation related in any way to this contract with respect to which the Carrier may be entitled to reimbursement from the Government.

SECTION 1.17
NOVATION AGREEMENT (JAN 1996)

The agreement at FEHBAR 1642.1204 shall be submitted for approval to OPM when the Carrier's assets or the entire portion of the assets pertinent to the performance of this contract, as determined by the Government, are transferred.

SECTION 1.18
AGREEMENT TO RECOGNIZE CARRIER'S CHANGE OF NAME (JAN 1996)

The agreement at FEHBAR 1642.1205 shall be submitted for approval to OPM when the carrier changes its name and the Government's and Contractor's rights and obligations remain unaffected.

SECTION 1.19
UNDERWRITER (JAN 2009)

(a) If this Plan is underwritten, the Carrier shall not modify (except as allowed in Section 2.3, *Payment of Benefits and Provision of Services and Supplies*) or terminate the policy issued by the Underwriter of the Plan or give notice of termination or intent not to renew the policy without prior express approval of the Contracting Officer. The Carrier shall notify the Contracting Officer in writing of its decision to change Underwriters as soon as is reasonable after the decision is made but no later than at the time the Carrier submits its benefit and rate proposal to OPM for the succeeding contract term.

(b) In the event of any inconsistency between the terms of this contract between OPM and the Carrier and the terms of the policy issued by the Underwriter to the Carrier, the terms of this contract shall prevail.

(c) If this Plan is underwritten, the policy issued to the Carrier by its Underwriter is a part of this contract and is incorporated therein by reference. The Carrier shall include paragraph (b) in the contract with its Underwriter.

SECTION 1.20
CERTIFICATION UNDER P.L. 104-191 (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996) (JAN 1998)

The Carrier will issue a certification of coverage for members in accordance with the regulations issued by the Department of Health and Human Services.

SECTION 1.21
PATIENTS' BILL OF RIGHTS (JAN 1999)

(a) The Carrier shall implement the recommendations in the Health Care Consumer Bill of Rights and Responsibilities ("Patients' Bill of Rights") in accordance with OPM guidance.

(b) During the Carrier's provider contract renewal process, the Carrier shall make any necessary modifications to such provider contracts to comply with the recommendations of the Patients' Bill of Rights in accordance with OPM guidance. All new provider contracts with the Carrier shall comply with the recommendations of the Patients' Bill of Rights in accordance with OPM guidance.

SECTION 1.22
ADMINISTRATIVE SIMPLIFICATION-HIPAA (JAN 2008)

(a) The Carrier shall implement and be in compliance with the Department of Health and Human Services (DHHS) regulations regarding the standards for electronic transactions, code sets and unique identifiers on the date DHHS specifies. Subject to paragraph (c) of this section, the regulations at 45 CFR parts 160 and 162 are incorporated by reference in this contract.

(b) The Carrier shall implement and be in compliance with the DHHS regulations regarding the standards for privacy and security of individually identifiable health information on

the date DHHS specifies. Subject to paragraph (c) of this section, the regulations at 45 CFR parts 160 and 164 are incorporated by reference in this contract.

(c) Because OPM has determined that the DHHS administrative simplification regulations should serve as a uniform nationwide standard for the FEHB Program, and because of the preemption provision at 5 U.S.C. 8902(m)(1), the provisions of 45 CFR part 160, subpart B are inapplicable to the Carrier with respect to the Plan.

(d) If the Carrier is an employee organization that retains an underwriter, then these requirements also apply to the underwriter with respect to the Plan. If the Carrier for the plan authorized under 5 U.S.C. 8903(1), qualifies for limited application of the HHS Privacy Rule as a business associate, then the HHS Privacy Rule requirements apply to the underwriting participating affiliates.

SECTION 1.23
HIPAA COMPLIANCE (JAN 1998)

(a) The Carrier shall comply with and shall take all steps reasonably necessary to ensure that its affiliates, subcontractors, and agents comply with the guaranteed availability provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations. "Guaranteed availability" means the Carrier, affiliates, subcontractors, and agents do not engage in practices that: 1) decline to offer health insurance coverage (as defined in section 2791(b)(1) of the Public Health Service Act "the Act") to, or deny enrollment of an eligible individual (as defined in section 2741(b) of the Act); or, 2) impose any preexisting condition exclusion (as defined in section 2701(b)(1)(A) of the Act), with respect to such coverage.

(b) A State or Federal enforcement action as the result of noncompliance with the requirements of HIPAA is a significant event under Section 1.10 of this contract, Notice of Significant Events. If the Carrier, or any affiliate, subcontractor, or agent, is notified of any enforcement action by any Federal or State authority with regard to HIPAA compliance, the Carrier must notify OPM within ten working days of learning of the action.

SECTION 1.24
NOTICE ON TERMINATION OF FEHBP OR PROVIDER CONTRACT (JAN 2003)

(a) Members who are undergoing treatment for a chronic or disabling condition or who are in the second or third trimester of pregnancy at the time a carrier terminates (1) its FEHBP contract, (2) the members' specialty provider contract, or (3) a Preferred Provider Organization (PPO) or Point of Service (POS) network contract, for reasons other than cause, may be able to continue to see their specialty provider for up to 90 days or through their postpartum care.

(b) The Carrier shall notify its members in writing of its intent to terminate its FEHBP contract, the members' specialty provider contract, or a PPO or POS network contract, for reasons other than cause, in order to allow sufficient time for the members to arrange for continued care after the 90-day period or their postpartum care, whichever applies. The Carrier shall send the required notice to the member if the Carrier has in its records an address for the member different from the Enrollee's address; otherwise, the Carrier may send the notice to the Enrollee. The Carrier shall send the notice in time to ensure it is received by the members no less than 90 days prior to the date it terminates the contract, unless the Carrier demonstrates it was prevented from doing so for

reasons beyond its control. The Carrier's prompt notice will ensure that the notification period and the transitional care period run concurrently.

SECTION 1.25
TRANSITIONAL CARE (JAN 2003)

(a) "Transitional care" is specialized care provided for up to 90 days or through the postpartum period, whichever is later, to a member who is undergoing treatment for a chronic or disabling condition or who is in the second or third trimester of pregnancy when the Carrier terminates (1) its FEHBP contract, (2) the member's specialty provider contract, or (3) a Preferred Provider Organization (PPO) or Point of Service (POS) network contract for reasons other than cause. The 90-day period begins the earlier of the date the member receives the notice required under Section 1.24, Notice on Termination of FEHBP or Provider Contract, or the date the Carrier's or the provider's contract ends.

(b) The Carrier shall ensure the following:

(1) If it terminates a specialty provider contract or a PPO or POS network contract other than for cause, it allows members who are undergoing treatment for a chronic or disabling condition or who are in the second or third trimester of pregnancy to continue treatment under the specialty provider for up to 90 days, or through their postpartum period, whichever is later, under the same terms and conditions that existed at the beginning of the transitional care period; and

(2) If it enrolls a new member who voluntarily changed carriers because the member's former carrier was no longer available in the FEHB Program, it provides transitional care for the member if he or she is undergoing treatment for a chronic or disabling condition or is in the second or third trimester of pregnancy for up to 90 days, or through the postpartum period, whichever is later, under the same terms and conditions the member had under the prior carrier.

(c) In addition, the Carrier shall (1) pay for or provide the transitional care required under this clause at no additional cost to members;

(2) require the specialty provider or network to promptly transfer all medical records to the designated new provider during or upon completion of the transition period, as authorized by the patient; and,

(3) require the specialty provider or network to give all necessary information to the Carrier for quality assurance purposes.

SECTION 1.26
STANDARDS FOR PHARMACY BENEFIT MANAGEMENT COMPANY (PBM) ARRANGEMENTS (JAN 2012)

The Carrier will ensure and report that the following standards are included in new, renewing or amended contracts with vendors providing a retail pharmacy network and/or a mail order pharmacy and/or a specialty pharmacy to Enrollees and Family Members (hereafter "PBM") effective on or after January 1, 2011. Notwithstanding the foregoing, the revisions to Section 1.26(a) in the January 2011 clause shall not take effect before the expiration of the Carrier's current contract (including the exercise of an existing option to extend the term by not more than one year at a time) but not later than January 2013. The PBM includes all entities that have a

majority ownership interest in or majority control over the PBM. The PBM also includes any other subsidiary of the entity that has majority ownership or control over the PBM.

This section does not apply to carrier-owned PBMs, which are already expected to adhere to the FAR and FEHBAR standards and requirements, and the remaining provisions of this contract.

(a) Transparency Standards

(1) The PBM is not majority-owned or majority-controlled by a pharmaceutical manufacturing company. The PBM must disclose to the Carrier and OPM the name of any entity that has a majority ownership interest in or majority control over the PBM.

(2) The PBM agrees to provide pass-through transparent pricing based on the PBM's cost for drugs (as described below) in which the Carrier receives the value of the PBM's negotiated discounts, rebates, credits or other financial benefits.

(i) The PBM shall charge the Carrier no more than the amount it pays the pharmacies in its retail network for brand and generic drugs plus a dispensing fee.

(ii) The PBM shall charge the Carrier the cost of drugs at mail order pharmacies based on the actual cost, plus a dispensing fee. Costs shall not be based on industry benchmarks; for example, Average Acquisition Cost (AAC) or Wholesale Acquisition Cost (WAC).

(iii) The PBM, or any other entity that negotiates and collects Manufacturer Payments allocable to the Carrier, agrees to credit to the Carrier either as a price reduction or by cash refund the value of all Manufacturer Payments properly allocated to the Carrier. Manufacturer Payments are any and all compensation, financial benefits, or remuneration the PBM receives from a pharmaceutical manufacturer, including but not limited to, discounts; credits; rebates, regardless of how categorized; market share incentives, chargebacks, commissions, and administrative or management fees. Manufacturer payments also include any fees received for sales of utilization data to a pharmaceutical manufacturer.

(3) The PBM must identify sources of profit to the Carrier and OPM as it relates to the FEHB contract.

(4) The PBM's administrative fees, such as dispensing fees, must be clearly identified to retail claims, mail claims and clinical programs, if applicable. The PBM must agree to disclose sources of each administrative fee to the Carrier and OPM.

(5) The PBM, or any other entity that negotiates and collects Manufacturer Payments allocable to the Plan, will provide the Carrier with quarterly and annual Manufacturer Payment Reports identifying the following information. This information shall be presented for both the total of all prescription drugs dispensed through the PBM, acting as a mail order pharmacy, and its retail network and in the aggregate for the 25 brand name drugs that represent the greatest cost to the Carrier or such number of brand name drugs that together represent 75% of the total cost to the Carrier, whichever is the greater number:

(i) the dollar amount of Total Product Revenue for the reporting period, with respect to the PBM's entire client base. Total Product Revenue is the PBM's net revenue which consists of sales of prescription drugs to clients, either through retail networks or PBM-owned or controlled mail order pharmacies. Net revenue is recognized at the prescription price negotiated with clients and associated administrative fees;

(ii) the dollar amount of total drug expenditures for the Plan:
(iii)the dollar amount of all Manufacturer Payments earned by the PBM for the reporting period;
(iv) the Manufacturer Payments that have been (1) earned but not billed (2) billed and (3) paid to the PBM based on the drugs dispensed to the Plan members during the past year.
(v) the percentage of all Manufacturer Payments earned by the PBM for the reporting period that were Manufacturer Formulary Payments, which are payments the PBM receives from a manufacturer in return for formulary placement and/or access, or payments that are characterized as "formulary" or "base" rebates or payments pursuant to the PBM's agreements with pharmaceutical manufacturers:
(vi)the percentage of all Manufacturer Payments received by the PBM during the reporting period that were Manufacturer Additional Payments, which are all Manufacturer Payments other than Manufacturer Formulary Payments.

(6) The PBM agrees to provide the Carrier, at least annually, with all financial and utilization information requested by the Carrier relating to the provision of benefits to eligible Enrollees through the PBM and all financial and utilization information relating to services provided to the Carrier.

(7) The Carrier shall provide any information it receives from the PBM, including a copy of its contract with the PBM to OPM. A PBM providing information to a Carrier under this subsection may designate that information as confidential commercial information. The Carrier in its contract with the PBM shall effectuate the PBM's consent to the disclosure of this information to OPM. OPM shall treat such designated information as confidential under 5 C.F.R. § 294.112.

(8) If the Carrier's PBM arrangement is with an Underwriter rather than with the Carrier, then all references to the Carrier and Plan appearing in this Section 1.26 shall be deemed to be references to the Underwriter.

(9) The Carrier will require that its PBM contractors:

(i) Provide information to physicians, pharmacists, other health care professionals, consumers, and payers about the factors that affect formulary system decisions, including: cost containment measures; the procedures for obtaining non-formulary drugs; and the importance of formulary compliance to improving quality of care and restraining health care costs;

(ii) Provide consumer education that explains how formulary decisions are made and the roles and responsibilities of the consumer; and

(iii) Disclose the existence of formularies and have copies of the current formulary readily available and publicly accessible.

(10) In accordance with FEHBAR 1652.204-74, FAR 52.215-2 and FEHBAR 1652.246-70, all contracts and other documentation that support amounts charged to the Carrier contract are fully disclosed to and auditable by the OPM Office of Inspector General (OPM OIG). The PBM must provide the OPM OIG upon request all PBM records including, but not limited to:

(i) All PBM contracts with Participating Pharmacies;
(ii) All PBM contracts with Pharmaceutical Manufacturers;
(iii)All PBM contracts with third parties purchasing or using claims data;
(iv) All PBM transmittals in connection with sales of claims data to third parties; and

(v) All PBM Maximum Allowable Cost (MAC) price lists.

(b) Integrity Standard

The Carrier will require that its PBM contractors agree to adopt and adhere to a code of ethics promulgated by a national professional association, such as the Code of Ethics of the American Pharmacists Association (dated October 27, 1994), for their employed pharmacists.

(c) Performance Standards

The Carrier will require that its PBM contractors develop and apply a quality assurance program specifying procedures for ensuring contract quality on the following standards at a minimum and submit reports to the Carrier on their performance. PBMs must meet, at minimum, the member inquiry, telephone customer service, paper claims processing, and other applicable standards set for Carriers at Section 1.9(f)(1), (2), (5), (7), and (11). All other standards discussed below will have specific target goals the PBM is expected to achieve. Carriers may permit PBMs to measure compliance using statistically valid samples for the PBMs book of business. Agreed to standards shall be provided to OPM for its review and comment. If OPM has concerns about a particular standard, the Carrier agrees to present OPM's concerns to the PBM and either revise the standard as requested by OPM or revise the standard to the extent feasible and present to OPM information demonstrating the problems associated with making the requested revisions in full.

(1) Retail Pharmacy Standards

(i) Point of Service (POS) system response time. The PBM's network electronic transaction system provides rapid response to network pharmacies.

(ii) POS system availability. The PBM's network electronic transaction system generally is available to, and accessible by, network pharmacies.

(iii) Licensing – The PBM verifies the appropriate licensing of its network pharmacies.

(2) Mail Service Pharmacy Standards

(i) Dispensing accuracy – The PBM dispenses its prescriptions to the correct patient and for the correct drug, drug strength and dosage in accordance with the physician's prescription not less than 99.9% of the time.

(ii) Turnaround time – The PBM promptly dispenses and ships at least 98% on average of all prescriptions not requiring intervention or clarification within 3 business days or meets an equivalent measure approved by OPM.

(3) Prior Approval – if applicable – The PBM promptly reviews and responds to requests for prior approval for specific drugs following receipt of all required information.

(4) Quality of Drug Therapy - The quality assurance program implemented by a Carrier's PBM contractor must include a process to measure the quality of its drug therapy provided to Enrollees. Specific areas to be addressed include achievement of quality targets measured by both internal and external metrics; identification and appropriate use of best practices; and

application of evidence-based medicine, as appropriate.

(d) Alternative Drug Options
The Carrier will require that its PBM contractors, at a minimum, utilize the following protocols for PBM initiated drug interchanges (any change from the original prescription) other than generic substitutions:

(i) The PBM must treat the prescribing physician, and not itself, as the ultimate decision-maker. Furthermore, to the extent appropriate under the circumstances, the PBM must allow the patient input into that decision-making process. At a minimum, the PBM must provide the patient with a written notice in the package sent to the patient that the drug interchange has occurred with the approval of the Prescriber.

(ii) The PBM will obtain authorization for a drug interchange only with the express, verifiable authorization from the Prescriber as communicated directly by the Prescriber, in writing or verbally, or by a licensed medical professional or other physician's office staff member as authorized by the Prescriber.

(iii) The PBM must memorialize in appropriate detail all conversations with patients and physicians in connection with drug interchanging requests, including the identity of the contact person at the physician's office and the basis for his or her authority.

(iv) The PBM will only interchange a patient's drug from a lower priced drug to a higher priced drug to patient or Plan when authorized by the Carrier or the Plan.

(v) The PBM will permit pharmacists to express their professional judgment to both the PBM and physicians on the impact of drug interchanges and to answer physicians' questions about dosing. PBMs will not require pharmacists to, and will not penalize pharmacists for refusing to, initiate calls to physicians for drug interchanges that in their professional judgment should not be made.

(vi) The PBM will offer to disclose, and if requested, will disclose to physicians, the Carrier, and patients (i) the reason(s) why it is suggesting a drug interchange and (ii) how the interchange will affect the PBM, the Plan, and the patients financially.

(e) Patient Safety Standard - The Carrier will require that its PBM contractors establish drug utilization management, formulary process and procedures that have distinct systems for identifying and rectifying consumer safety issues including:

(i) A system for identifying and communicating drug and consumer safety issues at point-of-service; and

(ii) A system of drug utilization management tools, such as prospective and concurrent drug utilization management that identifies situations which may compromise the safety of the consumer.

(f) Safety and Accessibility for Consumers - The Carrier will require that its PBM contractors meet the following standards related to pharmacy network management and consumer access to medications.

(1) The Carrier will require that its PBM contractor define the scope of its services with respect to:

(i) The distribution channels offered (e.g. pharmacy network, mail order pharmacies, or specialty pharmacies);
(ii) The types of pharmacy services offered within each distribution channel; and
(iii) The geographic area served by each distribution channel.

(2) The Carrier will require that for each distribution channel provided by its PBM contractor. the PBM contractor:

(i) Establishes criteria and measures actual performance in comparison to those criteria: and
(ii) Makes improvements where necessary to maintain the pharmacy network and meet contractual requirements.

(3) The Carrier will require that its PBM contractor establish a quality and safety mechanism for each distribution channel in order to identify and address concerns related to:

(i) Quality and safety of drug distribution; and
(ii) Quality of service

(g) Contract Terms - The contract between the PBM and the Carrier must not exceed 3 years without re-competition unless the Contracting Officer approves an exception. The Carrier's PBM contract must allow for termination based on a material breach of any terms and conditions stated in the Carrier's PBM contract. The Carrier must provide sufficient written notice of the material breach to the PBM and the PBM must be given adequate time to respond and cure the material breach.

SECTION 1.27
DISCLOSURE NOTICE UNDER P.L. 108-173 (MEDICARE MODERNIZATION ACT OF 2003) (JAN 2006)

The Carrier will issue, as part of its FEHB benefits brochure, a disclosure notice concerning creditable prescription drug coverage in accordance with the regulation at 42 CFR §423.56 issued by the Department of Health and Human Services.

SECTION 1.28
CARRIER DISASTER RECOVERY PLAN (JAN 2007)

The Carrier must implement a disaster recovery plan that addresses flexibility for the following:

(a) Medical and pharmacy procedures and requirements
(b) Barriers to accessing needed health care;
(c) Requests for out-of-network medical services;
(d) Alternatives for medical pre-certification, referrals, medical necessity review and notification of hospital admissions;
(e) Accessing other PCPs or specialists;

(f) Pharmacy restrictions, refills, additional supplies of medications as backup;
(g) Mail-order pharmacy;
(h) Adhering to recommendations for vaccinations from the Center for Disease Control;
(i) Claims payments;
(j) Crisis toll free hotline;
(k) Ability to identify current members;
(l) Recovery procedures for critical business functions (i.e., system, network, communication, work area recovery); and
(m) Secure backup site (hot/cold). A "hot work site" is a designated location to be used in the event of a disaster that is fully prepared for continuation of work to which the employees can go. A "cold work site" is a designated location to use in the event of a disaster that is not fully prepared for continuation of work to which the employees can go.

The Carrier must provide OPM with the following information:
(a) description of its disaster recovery plan;
(b) the carrier's current state of readiness and the frequency of evaluations;
(c) the carrier's work with its subcontractor on this issue;
(d) a timeline; and
(e) any potential problem areas.

The Carrier may implement its own additional measures.

Carriers must submit this information by January 1, 2007. Carriers who enter the FEHBP subsequent to 2007, must submit this information by January 1st of their first FEHBP contract year. Any material changes to the disaster recovery plan, such as a prime disaster recovery subcontract change or a hot site change, should be reported to OPM.

SECTION 1.29
HEALTH INFORMATION TECHNOLOGY REQUIREMENTS (JAN 2011)

(a) The Carrier agrees that as it implements, acquires, or upgrades health information technology systems, it shall utilize, where available, certified health information technology systems and products that meet interoperability standards recognized by the Secretary of Health and Human Services, as existing on the date of the implementation, acquisition, or upgrade of health information technology systems ("Interoperability Standards"). Interoperability standards include those standards adopted by the Secretary to promote meaningful use of health information technology in accordance with Public Law 111-5, The Health Information Technology for Economic and Clinical Health Act (HITECH Act).

(b) The Carrier agrees that such health information technology systems will have already been pilot tested in a variety of live settings and refined, if needed, before the Carrier will consider them for implementation.

(c) The Carrier agrees that as its provider agreements are established or renewed, it will encourage contracted providers to comply with applicable Interoperability Standards and to demonstrate meaningful use of health information technology in accordance with the HITECH ACT.

SECTION 1.30
HEALTH INFORMATION TECHNOLOGY PRIVACY AND SECURITY (JAN 2012)

(a) Any Carrier subcontractor, large provider, or vendor, that administers a personal health record or quality and cost or price transparency software applications for Members that collect, create, receive, store or transmit individually identifiable protected health information of Members that does not qualify as a covered entity or business associate under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or regulations will be required by the Carrier to, at a minimum, comply with equivalent privacy and security policies as are required of a "covered entity" under the HIPAA Privacy and Security regulations.

(b) The Carrier will provide for consumer transparency including, but not limited to, the posting of the subcontractor's, large provider's, or vendor's notice of privacy practices prominently at the point where the Member enters the subcontractor's, large provider's, vendor's or other entity's website or web portal.

(c) Notices of privacy practices disclosures must describe the uses of individually identifiable protected health information and any potential disclosure to other entities as described in the HIPAA Privacy Rule.

SECTION 1.31
DEFINITION AND SCOPE OF INFORMATION SECURITY (JAN 2012)

(a) As indicated in FAR Subpart 2.1, information security means protecting OPM information and information systems from unauthorized access, use, disclosure, disruption, modification, or destruction in order to provide —

1. Integrity, which means guarding against improper information modification or destruction, and includes ensuring information nonrepudiation and authenticity; or destruction.

2. Confidentiality, which means preserving authorized restrictions on access and disclosure, including means for protecting personal privacy and proprietary information; and

3. Availability, which means ensuring timely and reliable access to, and use of, information.

(b) This Contract grants the Carrier access to OPM's Letter of Credit (LOC) System. The Carrier recognizes its responsibility to help maintain the information security of OPM's LOC System. Section 1.31 through 1.35 inclusive and Section 5.67 and 5.68 pertain exclusively to such limited access to OPM's LOC System.

SECTION 1.32
CARRIER PERSONNEL ACCESS DETERMINATION REQUIREMENTS (JAN 2012)

(a) Carrier personnel who receive a user identification and password to access OPM's LOC System shall comply with the U.S. Office of Management and Budget (OMB) Memorandum M-05-24, referenced in paragraph (a) of FAR 52.204-9, Personal Identity Verification of Contractor Personnel, which is available on-line at http://www.whitehouse.gov/omb/memoranda/fy2005/m05-24.pdf.

(b) Homeland Security Presidential Directive (HSPD) 12 requires the Government to institute standards for secure and reliable identification of employees and contractors accessing

Federal facilities. OPM has determined that a National Agency Check with Written Inquiries (NACI) is required for Carrier employees with access to OPM's LOC System. The Carrier must obtain these access determinations for its employees with access to OPM's LOC System using the e-QIP system. The NACI will be requested on a Standard Form (SF) 85, "Questionnaire for Non-Sensitive Positions." OPM will not allow Carrier employees who have not completed the NACI process in any of its facilities, pursuant to applicable security policies.

(c) Carriers must meet facility and access clearance requirements.

(d) Carriers are responsible for the security, integrity and appropriate authorized use of their systems interfacing with OPM's LOC System. OPM, through its Contracting Officer, may require the use or modification of security and/or secure communications technologies related to Government systems access and use.

(e) OPM, at its discretion, may suspend or terminate the Carrier's access to and/or use of OPM's LOC System when a security or other electronic access, use or misuse issue gives cause for such action. The suspension or termination may last until such time as the Government determines that the situation has been corrected or no longer exists.

SECTION 1.33
INFORMATION TECHNOLOGY SYSTEMS SECURITY (JULY 2011)

Carriers must comply with OPM IT Security and Privacy, NIST and OMB requirements for system users. System users are Carrier employees with a user identification and password to access OPM's LOCS. Based upon the Federal Information Processing Standards Publication 199 (FIPS PUB 199), the Government has determined that a minimum level, applies to the sensitivity of the data contained in OPM's LOC System and a minimum level, applies to the operational criticality of the data processing capabilities of OPM's LOC System. (Note: FIPS PUB 199 is accessible on line at: http://csrc.nist.gov/publications/fips/fips199/FIPS-PUB-199-final.pdf.)

In order to access the OPM LOC System, the Carriers must demonstrate that they comply with the end-user security requirements in the Federal Information Security Management Act of 2002 (FISMA, Public Law 107-347, 44 U.S.C. 3531-3536); Office of Management and Budget (OMB) Circular A-130, Appendix III, "Security of Federal Automated Information Systems" and an acknowledgement of their understanding of the security requirements in the contract. (Note: OMB Circular A-130, Appendix III is accessible on line at: http://www.whitehouse.gov/omb/circulars/a130/appendix_iii.pdf.)

SECTION 1.34
CARRIER ACCESS TO OPM IT SYSTEMS (JAN 2011)

Each Carrier employee is required to utilize individual identification and authorization to access the OPM LOC System. Using shared accounts to access the OPM LOC System is strictly prohibited. OPM will disable accounts and access to the OPM LOC System will be revoked and denied if carriers share accounts. Users of the OPM LOC System will be subject to periodic auditing to ensure compliance to OPM Security and Privacy Policy. In addition, Carriers are required to comply with the following NIST 800-53 security controls to include at a minimum: Access Control (AC) - Controls falling under the AC category ensure that proper restrictions are in place to limit access to authorized users with a need to know.

(1) Provide to the OPM Letter of Credit (LOC) System Security Officer listed in OPM's "Letter of Credit Drawdown System User Manual For Experience Rated Carriers" - Contacts for Questions and Problem Resolution, an initial and complete list of employees' names that require access to OPM's LOC System;

(2) By the fifth day of each month thereafter, send a staffing change report to the Contracting Officer's Representative, contract administrator and LOC Security Officer. The report must contain the listing of all staff members with an LOC System user identification and password who left employment or were hired under this contract in the past 60 days. This form must be submitted even if no separation has occurred during this period. Failure to submit a 'Contractor Staffing Change Report' each month will result in the suspensions of all user IDs associated with this contract; and

(3) Anyone who accesses the OPM LOC System must complete OPM's IT Security and Privacy Awareness Training (ITPSA) annually and upon the initial access. This requirement applies to all Carriers.

SECTION I.35
PROCEDURES FOR REPORTING A LETTER OF CREDIT SYSTEM SECURITY BREACH (JAN 2013)

(a) A breach of data, system access, etc. includes loss of control, compromise, unauthorized disclosure, unauthorized acquisition, or unauthorized access of information whether physical or electronic. As an agency, OPM is required to immediately report all potential security and data breaches -- whether they involve paper documents or electronic information. In order to meet this responsibility, OPM has established a new internal procedure for reporting the loss or possible compromise of any data, and this clause conforms to that procedure.

(b) OPM Carriers must report any breach or potential breach to the OPM Situation Room and the Contracting Officer within 30 minutes of becoming aware of the risk – regardless of the time or day of the week. Breaches should be reported, even if it is believed the breach is limited, small, or insignificant. OPM's IT security experts, who will determine when a breach needs additional focus and attention. The OPM Situation Room is available 24 hours per day, 365 days per year. Report the breach to the OPM Situation Room and the Contracting Officer either by phone or by e-mail; however, be sure NOT to include PII in the e-mail.

(1) OPM Carriers must report a breach or potential security breach to the OPM Situation Room at: sitroom@opm.gov, (202) 418-0111, Fax (202) 606-0624.

(2) When notifying the Situation Room, please copy the Contracting Officer.

(3) To get help with WinZip, please contact the OPM Help Desk at: helpdesk@opm.gov, (202) 606-4927, TTY (202) 606-1295.

(4) If you have questions regarding these procedures, contact the Contracting Officer.

PART II – BENEFITS

SECTION 2.1
ENROLLMENT ELIGIBILITY AND EVIDENCE OF ENROLLMENT (JAN 2012)

(a) Enrollment.

(1) Each eligible individual who wishes to be enrolled in the plan offered by this Carrier shall, as a prerequisite to such enrollment, complete a Health Benefits Election Form, or use an electronic or telephonic method approved by OPM, within the time and under the conditions specified in 5 CFR Part 890. The personnel office having cognizance over the Enrollee shall promptly furnish notification of such election to the Carrier.

(2) A person's eligibility for coverage, effective date of enrollment, the level of benefits (option), the effective date of termination or cancellation of a person's coverage, the date any extension of a person's coverage ceases, and any continuance of benefits beyond a period of enrollment and the date any such continuance ceases, shall all be determined in accordance with regulations or directions of OPM given pursuant to chapter 89, title 5, United States Code.

(b) Special Limitations With Regard To Employee Organizations.

(1) A plan sponsored by an employee organization as defined by the Act, is available only to eligible employees, Tribal Employees, annuitants, former spouses, and former employees and eligible members of their families who must be or must become members of the sponsoring organization to enroll in the Plan.

(2) Employees or Tribal Employees with membership status in an employee organization at the time they become annuitants may retain their membership in the organization and, if eligible, continue their enrollment in the Plan. Survivor annuitants of Enrollees in the Plan may continue their enrollment in the Plan without becoming members of the sponsoring employee organization.

(c) The Carrier shall issue evidence of the Enrollee's coverage and furnish to the Enrollee copies of any forms necessary to make claim for benefits.

SECTION 2.2
BENEFITS PROVIDED (JAN 2009)

(a) The Carrier shall provide the benefits as described in the agreed upon brochure text found in Appendix A.

(b) In addition to providing benefits in accordance with (a) above, the Carrier shall be authorized to modify them as follows:

(1) To permit methods of treatment not expressly provided for, but not prohibited by law, rule or Federal policy, if otherwise contractually appropriate, and if such treatment is medically necessary and is as cost effective as providing benefits to which the Member may otherwise be entitled.

(2) To pay for or provide a health service or supply in an individual case which does not come within the specific benefit provisions of the contract, if the Carrier determines the benefit is within the intent of the contract, and the Carrier determines that the provision of such benefit is in the best interests of the Federal Employees Health Benefits Program.

(3) To offer in individual cases, after consultation with and concurrence by the Member and provider(s), a benefit alternative not ordinarily covered under this contract which will result in equally effective medical treatment at no greater benefit cost. An alternative benefit will be made available for a limited time period and is subject to the Carrier's ongoing review. Members must cooperate with the Carrier's review process.

(c)The decision to offer, deny, or withdraw coverage for a modified benefit provided in accordance with (b) above is solely within the Carrier's discretion (unless the Carrier and Member have entered into an alternative benefits agreement that expressly modifies this authority), and is not subject to OPM review under the disputed claims process.

(d) In each case when the Carrier provides a non-covered benefit in accordance with the authority of (b) above, the Carrier shall document in writing prior to the provision of such benefit the reasons and justification for its determination. The writing may be in the form of an alternative benefit agreement with the Member. Such payment or provision of services or supplies while a valid charge under the contract shall not be considered to be a precedent in the disposition of similar cases or extensions in the same case beyond the approved period.

(e) Except as provided for in (b) above, the Carrier shall provide benefits for services or supplies in accordance with Appendix A.

(f) The Carrier, subject to (g) below, shall determine whether in its judgment a service or supply is medically necessary or payable under this contract.

(g) The Carrier agrees to pay for or provide a health service or supply in an individual case if OPM finds that the Member is entitled thereto under the terms of the contract.

(h) (1) Notwithstanding (b) and (e) above, in accordance with Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, and 5 C.F.R. § 723.130(d), in the case of a Member who is a qualified individual with a handicap, the Carrier shall pay for or provide a covered health service or supply in the most integrated setting appropriate to the Member's needs, when required by OPM following OPM consultation with the Carrier, pursuant to paragraph 2.2(g), above.

(2) An OPM requirement under (h)(1) is subject to ongoing review by OPM and the Carrier. Members must cooperate with the review process. If, in the Carrier's judgment, the conditions for the OPM requirement are no longer satisfied, the Carrier may request that OPM modify or terminate the requirement. OPM's decision to modify or terminate a requirement shall be subject to judicial review.

SECTION 2.3
PAYMENT OF BENEFITS AND PROVISION OF SERVICES AND SUPPLIES (JAN 2013)

(a) By enrolling or accepting services under this contract, Members are obligated to all terms, conditions, and provisions of this contract. The Carrier may request Members to complete reasonable forms or provide information which the Carrier may reasonably request, provided, however, that the Carrier shall not require Members to complete any form as a precondition of receiving benefits unless the form has first been approved for use by OPM. Notwithstanding Section 2.9, *Claims Processing*, forms requiring specific approval do not include claim forms and other forms necessary to receive payment of individual claims.

(b) All benefits shall be paid (with appropriate documentation of payment) within a reasonable time after receipt of reasonable proof covering the occurrence, character, and extent of the event for which the claim is made. The claimant shall furnish satisfactory evidence that all

services or supplies for which expenses are claimed are covered services or supplies within the meaning of the contract.

(c) The procedures and time period for filing claims shall be as specified in the agreed upon brochure text (*Appendix A*). However, failure to file a claim within the time required shall not in itself invalidate or reduce any claim where timely filing was prevented by administrative operations of Government or legal incapacitation, provided the claim was submitted as soon as reasonably possible.

(d) The Carrier may request a Member to submit to one or more medical examinations to determine whether benefits applied for are for services and supplies necessary for the diagnosis or treatment of an illness or injury or covered condition of the Member and may withhold payment of such benefits pending completion of the examinations. The examinations shall be made at the expense of the Carrier by a physician selected by the Member from a panel of at least three physicians whose names are furnished by the Carrier, and the results of the examinations shall be made available to the Carrier and the Member.

(e) As a condition precedent to the provision of benefits hereunder, the Carrier, to the extent reasonable and necessary and consistent with Federal law, shall be entitled to obtain from any person, Tribal Employer, organization or agency, including the Office of Personnel Management, all information and records relating to visits or examination of, or treatment rendered or supplies furnished to, a Member as the Carrier requires in the administration of such benefits. The Carrier may obtain from any insurance company or other organization or person any information, with respect to any Member, which it has determined is reasonably necessary to:

(1) identify enrollment in a plan,

(2) verify eligibility for payment of a claim for health benefits, and

(3) carry out the provisions of the contract, such as subrogation, recovery of payments made in error, workers compensation, and coordination of benefits.

(f) Benefits are payable to the Enrollee in the Plan or his or her assignees. However, under the following circumstances different payment arrangements are allowed:

(1) Reimbursement Payments for the Enrollee. If benefits become payable to the estate of an Enrollee or an Enrollee is a minor, or an Enrollee is physically or mentally not competent to give a valid release, the Carrier may either pay such benefits directly to a hospital or other provider of services or pay such benefits to any relative by blood or connection by marriage of the Enrollee determined by the Carrier to be equitably entitled thereto.

(2) Reimbursement Payments for a minor child. If a child is covered as a Family Member under the Enrollee's self and family enrollment and is in the custody of a person other than the Enrollee, and if that other person certifies to the Carrier that he or she has custody of and financial responsibility for the child, then the Carrier may issue an identification card for the child(ren) to that person and may reimburse that person for any covered medical service or supply.

(3) Reimbursement Payments to family members covered under the Enrollee's self and family enrollment. If a covered child is legally responsible, or if a covered spouse is legally separated, and if the covered person does not reside with the Enrollee and certifies such conditions to the Carrier, then the Carrier may issue an identification card to the person and may reimburse that person for any covered medical service or supply. In the case of a legally separated spouse, the Carrier may also furnish the explanation of benefits to the spouse when determined by the Carrier to be required.

(4) Reimbursement payments to Government programs, such as Medicaid. If Federal law provides that reimbursement is payable to a Government program under coordination of benefits or similar rules, in lieu of being payable to the Enrollee or other covered person, the Carrier may reimburse the other Government program for any covered medical service or supply. To the degree that the Carrier is able to identify Medicaid beneficiaries, the Carrier will process claims directly to the provider of service or reimburse the Medicaid agency if the Medicaid agency has already paid the provider and is seeking reimbursement. When this situation is identified, the Carrier will update the member's records to ensure proper adjudication of claims.

(5) Compliance with the HIPAA Privacy Rule. The Carrier may pay benefits to a covered person other than the Enrollee when in the exercise of its discretion the Carrier decides that such action is necessary to comply with the HIPAA Privacy Rule, 45 C.F.R. §164.500 et seq.

(6) Any payments made in good faith in accordance with paragraphs (f)(1) through (f)(5) shall fully discharge the Carrier to the extent of such payment.

(g) *Erroneous Payments.* It is the Carrier's responsibility to proactively identify overpayments through comprehensive, statistically valid reviews and a robust internal control program. If the Carrier determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider. The recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment under 48 C.F.R. §1631.201-70(h) regardless of any time period limitations in the written agreement with the provider. The Carrier shall follow general business practices and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall--

(1) Send a written notice of erroneous payment to the member or provider that provides: (A) an explanation of when and how the erroneous payment occurred, (B) when applicable, cite the appropriate contractual benefit provision, (C) the exact identifying information (i.e., dollar amount paid erroneously, date paid, check number, date of service and provider name), (D) a request for payment of the debt in full, and (E) an explanation of what may occur should the debt not be paid, including possible offset to future benefits. The notice may also offer an installment option. In addition, the Carrier shall provide the debtor with an opportunity to dispute the existence and amount of the debt before proceeding with collection activities;

(2) After confirming that the debt does exist and in the appropriate amount, send follow-up notices to the member or the provider at 30, 60 and 90 day intervals, if the debt remains unpaid and undisputed;

(3) The Carrier may off-set future benefits payable to the member or to a provider on behalf of the member to satisfy a debt due under the FEHBP if the debt remains unpaid and undisputed for 120 days after the first notice;

(4) After applying the first three steps, refer cases when it is cost effective to do so to a collection attorney or a collection agency if the debt is not recovered; provided, however, that the carrier may not commence an overpayment recovery lawsuit later than December 31 of the third year after the year in which the overpayment was discovered by the carrier (except in cases where the False Claims Act, 31 U.S.C § 3729, or another federal limitations period applies);

(5) Make prompt and diligent effort to recover erroneous payments until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost effective to

pursue further collection efforts or it would be against equity and good conscience to continue collection efforts;

(6) Additional prompt and diligent effort is required for significant claim overpayments that exceed $10,000 per each claim. Examples of such efforts include copies of dated notices, offset attempt(s) made, certified letter communication(s), and third party collection efforts to the extent required under (g)(4) above. The Carrier should maintain and provide to OPM upon request, documentation of those efforts.

(7) Suspend recovery efforts for a debt which is based upon a retroactive disenrollment that has been appealed under 5 C.F.R. § 890.104 or a claim that has been appealed as a disputed claim under Section 2.8, until the appeal has been resolved;

(8)(i) The Carrier may charge the contract for benefit payments made erroneously but in good faith provided that it can document that it made a prompt and diligent effort to recover erroneous payments as described above.

(ii) Notwithstanding (g)(8)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that caused erroneous benefit payments) when the errors are egregious or repeated. These costs are deemed to be unreasonable and unallowable under section 3.2(b)(2)(ii);

(9) Maintain records that document individual unrecovered erroneous payment collection activities for audit or future reference.

(10) If OPM determines that a Member's claim has been paid in error for any reason (except fraud and abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider as specified in (g)(1) through (9).

(11) At the request of OPM, the Carrier shall provide evidence that it has taken the steps enumerated above in this subsection to promptly recover erroneous payments, including but not limited to overpayments related to Medicare coordination of benefits. OPM will review the Carrier's claims payments and procedures to validate the Carrier's prompt and diligent effort. The Contracting Officer may require the Carrier to establish and submit to the Contracting Officer a written corrective action plan.

(12) In compliance with the provisions of the Contract Disputes Act, the Carrier shall return to the Program an amount equal to the uncollected erroneous payment where the Contracting Officer determines that (a) the Carrier's failure to appropriately apply its operating procedure caused the erroneous payment and (b) that the Carrier failed to make a prompt and diligent effort to recover an erroneous payment.

(h) Erroneous payment recoveries may be reduced by any legal or collection agency fees expended to obtain the recoveries and which are not otherwise payable under this experience-rated contract. The amount credited to the contract shall be the net amount remaining after deducting the related legal or collection agency fees.

(i) All health benefit refunds and recoveries, including erroneous payment recoveries, must be deposited into the working capital or investment account within 30 days and returned to or accounted for in the FEHBP letter of credit account within 60 days after receipt by the Carrier.

(j) Notwithstanding subsection (f), the Carrier reserves the right to pay the Member directly for all covered services described in the agreed upon brochure text attached as Appendix A.

(a) A Member's coverage is terminated as specified in regulations issued by the OPM. Benefits after termination of coverage are as specified in the regulations.

(b) A Member is entitled to a temporary continuation of coverage or an extension of coverage under the conditions and to the extent specified in the regulations.

(c) A Member whose coverage hereunder has terminated is entitled, upon application within the times and under the conditions specified in regulations, to a non-group contract regularly offered for the purpose of conversion from the contract or similar contracts. The conversion contract shall be in compliance with 5 U.S.C., chapter 89, and regulations issued thereunder.

(d) Costs associated with writing or providing benefits under conversion contracts shall not be an allowable cost of this contract.

(e) The Carrier shall maintain on file with OPM copies of the conversion policies offered to persons whose coverage under this contract terminates and advise OPM promptly of any changes in the policies. The Contracting Officer may waive this requirement where because of the large number of different conversion policies offered by the Carrier it would be impractical to maintain a complete up-to-date file of all policies. In this case the Carrier shall submit a representative sample of the general types of policies offered and provide copies of specific policies on demand.

SECTION 2.5
SUBROGATION (JAN 2006)

(a) The Carrier's subrogation rights, procedures and policies, including recovery rights, for payments with respect to benefits shall be in accordance with the provisions of the agreed upon brochure text, which is incorporated in this Contract in Appendix A. As the member is obligated by Section 2.3(a) to comply with the terms of this Contract, the Carrier, in its discretion, shall have the right to file suit in federal court in order to enforce those rights.

(b) Subrogation recoveries may be reduced by any legal fees expended to obtain the recoveries and which are not otherwise payable under this experience-rated contract. The amount credited to the contract shall be the net amount remaining after deducting the related legal fees.

SECTION 2.6
COORDINATION OF BENEFITS (JAN 2001) (FEHBAR 1652.204-71)

(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare, other group health benefits coverages, and the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault.

(b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier or unless permitted to do so by the Contracting Officer.

(c) In coordinating benefits between plans, the Carrier shall follow the order of precedence established by the NAIC Group Coordination of Benefits Model Regulation, Rules for Coordination of Benefits, as specified by OPM.

(d) Where (1) the Carrier makes payments under this contract which are subject to COB provisions; (2) the payments are erroneous, not in accordance with the terms of the contract, or in

excess of the limitations applicable under this contract; and (3) the Carrier is unable to recover such COB overpayments from the Member or the providers of services or supplies, the Contracting Officer may allow such amounts to be charged to the contract; the Carrier must be prepared to demonstrate that it has made a diligent effort to recover such COB overpayments.

(e) COB savings shall be reported by experience-rated carriers each year along with the Carrier's annual accounting statement in a form specified by OPM.

(f) Changes in the order of precedence established by the NAIC Group Coordination of Benefits Model Regulation, Rules for Coordination of Benefits, implemented after January 1 of any given year shall be required no earlier than the beginning of the following contract term.

[NOTE: In the event that benefits are payable to the Member under no-fault automobile insurance, the no-fault automobile insurer shall be the Primary Carrier if it is obligated legally to pay benefits for health care expenses without regard to other health benefits coverage that the Member may have. The term "no-fault automobile insurance" includes any automobile insurance policy under which the insurer pays benefits for health care expenses resulting from the accident without regard to whether the insured's conduct contributed to the accident.]

SECTION 2.7
DEBARMENT AND OTHER SANCTIONS (JAN 1999)

(a) Notwithstanding 5 U.S.C. 8902(j) or any other provision of the law and regulations, if, under 5 U.S.C. 8902a, 5 CFR 970, or Public Law 103-123 (or other applicable appropriations law), a provider is barred from participating in the Program under 5 U.S.C. or the provider's services under 5 U.S.C. are excluded, the Carrier agrees that no payment shall be made by the Carrier pursuant to any contract under 5 U.S.C. (either to such provider or by reimbursement) for any service or supply furnished by such provider during the period of the debarment, except as provided in 5 CFR 970.200(b).

(b) The OPM shall notify the Carrier when a provider is barred from the FEHBP.

SECTION 2.8
FILING HEALTH BENEFIT CLAIMS/COURT REVIEW OF DISPUTED CLAIMS (MAR 1995) (FEHBAR 1652.204-72)

(a) General. (1) The Carrier resolves claims filed under the Plan. All health benefit claims must be submitted initially to the Carrier. If the Carrier denies a claim (or a portion of a claim), the covered individual may ask the Carrier to reconsider its denial. If the Carrier affirms its denial or fails to respond as required by paragraph (b) of this clause, the covered individual may ask OPM to review the claim. A covered individual must exhaust both the Carrier and OPM review processes specified in this clause before seeking judicial review of the denied claim.

(2) This clause applies to covered individuals and to other individuals or entities who are acting on the behalf of a covered individual and who have the covered individual's specific written consent to pursue payment of the disputed claim.

(b) Time limits for reconsidering a claim. (1) The covered individual has 6 months from the date of the notice to the covered individual that a claim (or a portion of a claim) was denied by the Carrier in which to submit a written request for reconsideration to the Carrier. The time limit for requesting reconsideration may be extended when the covered individual shows that he

or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(2) The Carrier has 30 days after the date of receipt of a timely-filed request for reconsideration to:

(i) Affirm the denial in writing to the covered individual;

(ii) Pay the bill or provide the service; or

(iii) Request from the covered individual or provider additional information needed to make a decision on the claim. The Carrier must simultaneously notify the covered individual of the information requested if it requests additional information from a provider. The Carrier has 30 days after the date the information is received to affirm the denial in writing to the covered individual or pay the bill or provide the service. The Carrier must make its decision based on the evidence it has if the covered individual or provider does not respond within 60 days after the date of the Carrier's notice requesting additional information. The Carrier must then send written notice to the covered individual of its decision on the claim. The covered individual may request OPM review as provided in paragraph (b)(3) of this clause if the Carrier fails to act within the time limit set forth in this paragraph.

(3) The covered individual may write to OPM and request that OPM review the Carrier's decision if the Carrier either affirms its denial of a claim or fails to respond to a covered individual's written request for reconsideration within the time limit set forth in paragraph (b)(2) of this clause. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this clause.

(4) The Carrier may extend the time limit for a covered individual's submission of additional information to the Carrier when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the additional information.

(c) Information required to process requests for reconsideration. (1) The covered individual must put the request to the Carrier to reconsider a claim in writing and give the reasons, in terms of applicable brochure provisions, that the denied claim should have been approved.

(2) If the Carrier needs additional information from the covered individual to make a decision, it must:

(i) Specifically identify the information needed;

(ii) State the reason the information is required to make a decision on the claim;

(iii) Specify the time limit (60 days after the date of the Carrier's request) for submitting the information; and

(iv) State the consequences of failure to respond within the time limit specified, as set out in paragraph (b)(2) of this section.

(d) Carrier determinations. The Carrier must provide written notice to the covered individual of its determination. If the Carrier affirms the initial denial, the notice must inform the covered individual of:

(1) The specific and detailed reasons for the denial;

(2) The covered individual's right to request a review by OPM; and

(3) The requirement that requests for OPM review must be received within 90 days after the date of the Carrier's denial notice and include a copy of the denial notice as well as documents to support the covered individual's position.

(e) OPM review. (1) If the covered individual seeks further review of the denied claim, the covered individual must make a request to OPM to review the Carrier's decision. Such a request to OPM must be made:

(i) Within 90 days after the date of the Carrier's notice to the covered individual that the denial was affirmed; or

(ii) If the Carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this clause, within 120 days after the date of the covered individual's timely request for reconsideration by the Carrier; or

(iii) Within 120 days after the date the Carrier requests additional information from the covered individual, or the date the covered individual is notified that the Carrier is requesting additional information from a provider. OPM may extend the time limit for a covered individual's request for OPM review when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by the Carrier, OPM may

(i) Request that the covered individual submit additional information;

(ii) Obtain an advisory opinion from an independent physician;

(iii) Obtain any other information as may in its judgment be required to make a determination; or

(iv) Make its decision based solely on the information the covered individual provided with his or her request for review.

(3) When OPM requests information from the Carrier, the Carrier must release the information within 30 days after the date of OPM's written request unless a different time limit is specified by OPM in its request.

(4) Within 90 days after receipt of the request for review, OPM will either:

(i) Give a written notice of its decision to the covered individual and the Carrier; or

(ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph (e)(3) of this clause, OPM may make its decision based solely on information available to it at that time and give a written notice of its decision to the covered individual and to the Carrier.

(f) OPM, upon its own motion, may reopen its review if it receives evidence that was unavailable at the time of its original decision.

(g) Court review. (1) A suit to compel enrollment under § 890.102 of Title 5, Code of Federal Regulations, must be brought against the employing office that made the enrollment decision.

(2) A suit to review the legality of OPM's regulations under this part must be brought against the Office of Personnel Management.

(3) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of Federal statute (chapter 89, title 5, United States Code). A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the Carrier or the Carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the Carrier to pay the amount of benefits in dispute.

(4) An action under paragraph (3) of this clause to recover on a claim for health benefits:

(i) May not be brought prior to exhaustion of the administrative remedies provided in paragraphs (a) through (f) of this clause;

(ii) May not be brought later than December 31 of the 3rd year after the year in which the care or service was provided; and

(iii) Will be limited to the record that was before OPM when it rendered its decision affirming the Carrier's denial of benefits.

SECTION 2.9
CLAIMS PROCESSING (JAN 2011)

A standardized claims filing process shall be used by all FEHB carriers. The Carrier shall apply procedures for using the standard claims process. At a minimum the Carrier's program must achieve the following objectives:

(1) The majority of provider claims should be submitted electronically;

(2) All providers shall be notified that future claims must be submitted electronically, or on the Centers for Medicare and Medicaid Services 1500 form or the UB-04 form;

(3) The Carrier shall not use any unique provider claim form(s) for such FEHB member claims;

(4) The Carrier should reject all such claims submitted on forms other than the CMS 1500 form or the UB-04 form and shall explain the reason on the Explanation of Benefits form; and

(5) The Carrier shall advise OPM of its progress in implementing this policy as directed by the Contracting Officer.

SECTION 2.10
CALCULATION OF COST SHARING PROVISIONS (JAN 1996)

When the Member is required to pay a specified percentage of the cost of covered services, the Member's obligation for covered services shall be based on the amount the provider has agreed to accept as full payment, including future discounts that are known and that can be accurately calculated at the time the claim is processed. This includes for example, prompt pay discounts as well as other discounts granted for various business reasons. Any discount not determined at the time of the actual adjudication shall be placed in the Special Reserve upon its determination.

SECTION 2.11
BENEFITS PAYMENTS WHEN MEDICARE IS PRIMARY (JAN 2007)

When a Member who is covered by Medicare Part A, Part B, or Parts A and B on a fee-for-service basis (a) receives services that generally are eligible for coverage by Medicare (regardless of whether or not benefits are paid by Medicare) and are covered by the Carrier, and (b) Medicare is the primary payer and the Carrier is the secondary payer for the Member under the order of benefit determination rules stated in Appendix A and Appendix D of this contract, then the Carrier shall limit its payment to an amount that supplements the benefits payable by Medicare (regardless of whether or not Medicare benefits are paid). For Medicare Part B prescription drugs, the Carrier will coordinate benefits except when prescription drugs are purchased from retail or mail order. When emergency services have been provided by a Medicare nonparticipating institutional provider and the provider is not reimbursed by Medicare, the Carrier shall pay its primary benefits. Payments that supplement Medicare include amounts necessary to reimburse the Member for Medicare deductibles, coinsurance, copayments, and the

balance between the Medicare approved amount and the Medicare limiting charge made by non-participating providers.

Carriers may use the Department of Veterans Affairs (VA) Medicare-equivalent remittance advice (MRA) when the form is submitted to determine the Plan's benefits payment for covered services provided to members who have Medicare as their primary payer, when Medicare does not pay the VA facility.

SECTION 2.12
CONTINUING REQUIREMENTS AFTER TERMINATION OF THE CARRIER
(JAN 2004)

(a) The Carrier shall fulfill all of the requirements agreed to under the contract that continue after termination. The order of precedence for the applicable laws, regulations, and the contract are listed in Section 1.3.

(b) Contract requirements extend beyond the date of the Carrier's termination until the effective date of the new enrollment including processing and paying claims incurred prior to the effective date of the new enrollment.

(c) When the prior carrier is discontinued in whole or in part, the gaining carrier assumes full coverage on the effective date of the new enrollment.

SECTION 2.13
LARGE PROVIDER AGREEMENTS (OCT 2005) (FEHBAR 1652.204-74)

(a) Notification and Information Requirements. (1) The experience-rated Carrier must provide notice to the Contracting Officer of its intent to enter into or to make a significant modification of a Large Provider Agreement:

(i) Not less than 60 days before entering into any Large Provider Agreement; and

(ii) Not less than 60 days before exercising a renewal or other option, or significant modification to a Large Provider Agreement, when such action would result in total costs to the FEHB Program of an additional 20 percent or more above the existing contract. However, if a Carrier is exercising a simple renewal or other option contemplated by a Large Provider Agreement that OPM previously reviewed, and there are no significant changes, then a statement to the effect that the renewal or other option is being exercised along with the dollar amount is sufficient notice.

(2) The Carrier's notification to the Contracting Officer must be in writing and must, at a minimum:

(i) Describe the supplies and/or services the proposed provider agreement will require;

(ii) Identify the proposed basis for reimbursement;

(iii) Identify the proposed provider agreement, explain why the Carrier selected the proposed provider, and what contracting method it used, where applicable, including the kind of competition obtained;

(iv) Describe the methodology the Carrier used to compute the provider's profit; and,

(v) Describe provider risk provisions.

(3) The Contracting Officer may request from the Carrier any additional information on a proposed provider agreement and its terms and conditions prior to a provider award and during the performance of the agreement.

(4) Within 30 days of receiving the Carrier's notification, the Contracting Officer will give the Carrier either written comments or written notice that there will be no comments. If the Contracting Officer comments, the Carrier must respond in writing within 10 calendar days, and explain how it intends to address any concerns.

(5) When computing the Carrier's service charge, the Contracting Officer will consider how well the Carrier complies with the provisions of this section, including the advance notification requirements, as an aspect of the Carrier's performance factor.

(6) The Contracting Officer's review of any Large Provider Agreement, option, renewal, or modification will not constitute a determination of the acceptability of the terms and conditions of any provider agreement or of the allowability of any costs under the Carrier's contract, nor will it relieve the Carrier of any responsibility for performing the contract.

(b) Records and Inspection. The Carrier must insert in all Large Provider Agreements the requirement that the provider will retain and make available to the Government all records relating to the agreement that support the annual statement of operations and Enrollee records--Retain for 6 years after the agreement term ends.

(c) Audit and Records - Negotiation. The provisions of FAR 52.215-2, "Audit and Records--Negotiation," when required, or FEHBAR 1652.246-70, "FEHB Inspection" apply to all experience-rated Carriers' Large Provider Agreements. The Carrier will insert the clauses at FAR 52.215-2, when applicable, or FEHBAR 1652.246-70 in all Large Provider Agreements. In FAR 52.215-2 the Carrier will substitute

(1) The term "Large Provider" for the term "Contractor" throughout the clause, and

(2) The term "Large Provider Agreement" for the term "Subcontracts" in paragraph (g) of FAR 52.215-2. The term "Contracting Officer" will mean the FEHB Program Contracting Officer at OPM. The Carrier will be responsible for ensuring the Large Provider complies with the provisions set forth in the clause.

(d) Prohibited Agreements. No provider agreement made under this contract will provide for payment on a cost-plus-a-percentage-of-cost basis.

(e) The Carrier will insert this clause, 1652.204-74, in all Large Provider Agreements.

SECTION 2.14
COORDINATION OF PRESCRIPTION DRUG BENEFITS WITH MEDICARE (JAN 2006)

(a) The Carrier shall comply with the Center for Medicare and Medicaid Services' (CMS) Part D Coordination of Benefits Guidance when the mechanisms and systems indicated in this guidance are in place and functioning properly. This guidance provides the requirements and procedures for coordination of benefits between Part D plans and other providers of prescription drug coverage.

(b) For Medicare Part B covered prescription drugs, the Carrier will coordinate benefits with Medicare except when such prescription drugs are purchased from retail or mail order pharmacies. The Carrier may pay its benefits on retail pharmacy or mail order drugs eligible for Medicare Part B coverage.

PART III - PAYMENTS, CHARGES AND ACCOUNTING

SECTION 3.1
PAYMENTS—EXPERIENCE-RATED CONTRACTS (JAN 2003) (FEHBAR 1652.232-71)

(a) OPM will pay to the Carrier, in full settlement of its obligations under this contract, subject to adjustment for error or fraud, the subscription charges received for the Plan by the Employees Health Benefits Fund (hereinafter called the Fund) less the amounts set aside by OPM for the Contingency Reserve and for the administrative expenses of OPM and amounts for obligations due pursuant to paragraph (b) of this clause, plus any payments made by OPM from the Contingency Reserve.

(b) OPM will notify the Carrier of amounts due for outstanding obligations under the contract. Not later than 60 days after the date of written notice from OPM, the Carrier shall reimburse OPM. If payment is not received within the prescribed time frame, OPM shall withhold the amount due from the subscription charges owed the Carrier under paragraph (a) of this clause.

(c) The specific subscription rates, charges, allowances and limitations applicable to the contract are set forth in Appendix B.

(d) Recurring payments from premiums shall be made available for carrier drawdown not later than thirty days after receipt by the Fund. The Contracting Officer may authorize special non-recurring payments from the Contingency Reserve in accordance with OPM's regulations.

(e) In the event this contract between the Carrier and OPM is terminated or not renewed in accordance with General Provision I.15, *Renewal and Withdrawal of Approval*, the Contingency Reserve of the Carrier held by OPM shall be available to the Carrier to pay the necessary and proper charges against this contract to the extent that the Carrier reserves are insufficient for that purpose.

SECTION 3.2
ACCOUNTING AND ALLOWABLE COST (JAN 2003) (FEHBAR 1652.216-71)

(a) Annual Accounting Statements.

(1) The Carrier shall furnish to OPM an accounting of its operations under the contract. In preparing the accounting, the Carrier shall follow the reporting requirements and statement formats prescribed by OPM in the OPM Annual and Fiscal Year Financial Reporting Instructions.

(2) The Carrier shall have its Annual Accounting Statements and that of its underwriter, if any, audited in accordance with the FEHBP Experienced-Rated Carrier and Service Organization Audit Guide (Guide). The Carrier shall submit the audit report and the Annual Accounting Statements to OPM in accordance with the requirements of the Guide.

(3) Based on the results of either the independent audit prescribed by the Guide or a Government audit, OPM may require the Carrier to adjust its annual accounting statements (i) by amounts found not to constitute actual, allowable, allocable and reasonable costs; or (ii) to reflect prior overpayments or underpayments.

(4) The Carrier shall develop corrective action plans to resolve audit findings identified in audits that were performed in accordance with the Guide. The corrective action plans will be prepared in accordance with and as defined by the Guide.

(b) Definition of costs. (1) The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable. In addition, the Carrier must:

(i) on request, document and make available accounting support for the cost to justify that the cost is actual, reasonable and necessary; and

(ii) determine the cost in accordance with: (A) the terms of this contract, and (B) Subpart 31.2 of the Federal Acquisition Regulation (FAR) and Subpart 1631.2 of the Federal Employees Health Benefits Program Acquisition Regulation (FEHBAR) applicable on the first day of the contract period.

(2) In the absence of specific contract terms to the contrary, the Carrier shall classify contract costs in accordance with the following criteria:

(i) Benefits. Benefit costs consist of payments made and liabilities incurred for covered health care services on behalf of FEHBP subscribers less any refunds, rebates, allowances or other credits received.

(ii) Administrative expenses. Administrative expenses consist of all actual, allowable, allocable and reasonable expenses incurred in the adjudication of subscriber benefit claims or incurred in the Carrier's overall operation of the business. Unless otherwise stated in the contract, administrative expenses include, in part: all taxes (excluding premium taxes, as provided in section 1631.205-41), insurance and reinsurance premiums, medical and dental consultants used in the adjudication process, concurrent or managed care review when not billed by a health care provider and other forms of utilization review, the cost of maintaining eligibility files, legal expenses incurred in the litigation of benefit payments and bank charges for letters of credit. Administrative expenses exclude the cost of Carrier personnel, equipment, and facilities directly used in the delivery of health care services, which are benefit costs, and the expense of managing the FEHBP investment program which is a reduction of investment income earned.

(iii) Investment income. While compliance with the checks presented letter of credit methodology will minimize funds on hand, the Carrier shall invest and reinvest all funds on hand, including any in the Special Reserve or any attributable to the reserve for incurred but unpaid claims, which are in excess of the funds needed to discharge promptly the obligations incurred under the contract. Investment income represents the net amount earned by the Carrier after deducting investment expenses. Investment expenses are those actual, allowable, allocable, and reasonable contract costs that are attributable to the investment of funds, such as consultant or management fees.

(iv) Other charges. (A) Mandatory statutory reserve. Charges for mandatory statutory reserves are not allowable unless specifically provided for in the contract. When the term "mandatory statutory reserve" is specifically identified as an allowable contract charge without further definition or explanation, it means a requirement imposed by State law upon the Carrier to set aside a specific amount or rate of funds into a restricted reserve that is accounted for separately from all other reserves and surpluses of the Carrier and which may be used only with the specific approval of the State official designated by law to make such approvals. The amount chargeable to the contract may not exceed an allocable portion of the amount actually set aside. If the statutory reserve is no longer required for the purpose for which it was created, and these funds become available for the general use of the Carrier, the Carrier shall return to the FEHBP a pro rata share based upon FEHBP's contribution to the total Carrier's set aside shall be returned to the FEHBP in accordance with FAR 31.201-5.

(B) Premium taxes. (1) When the term "premium taxes" is used in this contract without further definition or explanation, it means a tax, fee, or other monetary payment directly or indirectly imposed on FEHB premiums by any State, the District of Columbia, or the Commonwealth of Puerto Rico or by any political subdivision or other governmental authority of

those entities, with the sole exception of a tax on net income or profit, if that tax, fee, or payment is applicable to a broad range of business activity.

(2) For purposes of this paragraph (B), OPM has determined that the term "State" as used in 5 U.S.C. 8909(f) includes, but is not limited to, a territory or possession of the United States.

(c) Certification of Accounting Statement Accuracy. (1) The Carrier shall certify the annual and fiscal year accounting statements in the form set forth in paragraph (c)(3) of this clause. The Carrier's chief executive officer and the chief financial officer shall sign the certificate.

(2) The Carrier shall require an authorized agent of its underwriter, if any, also to certify the annual accounting statement.

(3) The certificate required shall be in the following form:

CERTIFICATION OF ACCOUNTING
STATEMENT ACCURACY

This is to certify that I have reviewed this accounting statement and to the best of my knowledge and belief:

1. The statement was prepared in conformity with the guidelines issued by the Office of Personnel Management and fairly presents the financial results of this reporting period in conformity with those guidelines.

2. The costs included in the statement are actual, allowable, allocable, and reasonable in accordance with the terms of the contract and with the cost principles of the Federal Employees Health Benefits Acquisition Regulation and the Federal Acquisition Regulation;

3. Income, rebates, allowances, refunds and other credits made or owed in accordance with the terms of the contract and applicable cost principles have been included in the statement;

4. If applicable, the letter of credit account was managed in accordance with 5 CFR part 890, 48 CFR chapter 16, and OPM guidelines.

Carrier Name: _____

Name of Chief Executive Officer:
(Type or Print)

_____

Name of Chief Financial Officer:

_____

Signature of Chief Executive Officer:

_____

Signature of Chief Financial Officer:

_____

Date Signed:

_____

Date Signed: _____
Underwriter:

_____

Name and Title of Responsible Corporate Official:
(Type or Print:)

_____

Signature of Responsible Corporate Official:

_____

Date Signed:_____

(FFS-2013)

(End of Certificate)

SECTION 3.3
SPECIAL RESERVE (JAN 2003)

(a) This contract is experience rated. The Special Reserve represents the cumulative difference between income to the plan (subscription income plus interest on investments [item (b)(2)(iii) in Section 3.2, *Accounting and Allowable Cost*, which also includes income gain or loss]) and plan expenses (benefit costs plus allowable administrative expenses and retentions). The Special Reserve held by or on behalf of the Carrier is to be used only for payment of charges against this contract.

(b) If this contract is terminated or not renewed and there is a positive balance remaining in the Special Reserve after all allowable costs chargeable to the contract in accordance with Section 3.2 plus an agreed-upon amount of administrative expenses for contract liquidation have been paid, the balance of any funds held by the Carrier, including current income on its investment, shall be paid to OPM for credit to the Carrier's Contingency Reserve maintained by OPM when the Carrier submits its annual accounting statement for the final contract year.

(c) The Carrier shall incorporate this clause in all agreements with underwriters of the Carrier's FEHB Plan.

SECTION 3.4
INVESTMENT INCOME (JAN 1998) (FEHBAR 1652.215-71)

(a) The Carrier shall invest and reinvest all FEHB funds on hand that are in excess of the funds needed to promptly discharge the obligations incurred under this contract. The Carrier shall seek to maximize investment income with prudent consideration to the safety and liquidity of investments.

(b) All investment income earned on FEHB funds shall be credited to the Special Reserve on behalf of the FEHBP.

(c) When the Contracting Officer concludes that the Carrier failed to comply with paragraphs (a) or (b) of this clause, the Carrier shall credit the Special Reserve with investment income that would have been earned, at the rate(s) specified in paragraph (f) of this clause, had it not been for the Carrier's noncompliance. "Failed to comply with paragraphs (a) or (b)" means: (1) making any charges against the contract which are not allowable, allocable, or reasonable; or (2) failing to credit any income due the contract and/or failing to place excess funds, including subscription income and payments from OPM not needed to discharge promptly the obligations incurred under the contract, refunds, credits, payments, deposits, investment income earned, uncashed checks, or other amounts owed the Special Reserve, in income producing investments and accounts.

(d) Investment income lost as a result of unallowable, unallocable, or unreasonable charges against the contract shall be paid from the first day of the contract term following the contract term in which the unallowable charge was made and shall end on the earlier of: (1) the date the amounts are returned to the Special Reserve (or the Office of Personnel Management); (2) the date specified by the Contracting Officer; or (3) the date of the Contracting Officer's Final Decision.

(e) Investment income lost as a result of failure to credit income due the contract or failure to place excess funds in income producing investments and accounts shall be paid from the date the

funds should have been invested or appropriate income was not credited and shall end on the earlier of: (1) the date the amounts are returned to the Special Reserve (or the Office of Personnel Management); (2) the date specified by the Contracting Officer; or (3) the date of the Contracting Officer's Final Decision.

(f) The Carrier shall credit the Special Reserve for income due in accordance with this clause. All lost investment income payable shall bear simple interest at the quarterly rate determined by the Secretary of the Treasury under the authority of 26 U.S.C. 6621(a)(2) applicable to the periods in which the amount becomes due, as provided in paragraphs (d) and (e) of this clause.

(g) The Carrier shall incorporate this clause into agreements with underwriters of the Carrier's FEHB plan and shall substitute "underwriter" or other appropriate reference for the term "Carrier".

SECTION 3.5
NON-COMMINGLING OF FUNDS (JAN 1991) (FEHBAR 1652.232-72)

(a) The Carrier and/or its underwriter shall keep all FEHBP funds for this contract (cash and investments) physically separate from funds obtained from other sources. Accounting for such FEHBP funds shall not be based on allocations or other sharing mechanisms and shall agree with the Carrier's accounting records.

(b) In certain instances the physical separation of FEHBP funds may not be practical or desirable. In such cases, the Carrier may request a waiver from this requirement from the Contracting Officer. The waiver shall be requested in advance and the Carrier shall demonstrate that accounting techniques have been established that will clearly measure FEHBP cash and investment income (*i.e.*, subsidiary ledgers). Reconciliations between amounts reported and actual amounts shown in accounting records shall be provided as supporting schedules to the Annual Accounting Statements.

(c) The Carrier shall incorporate this clause in all subcontracts that exceed $25,000 and shall substitute "contractor" or other appropriate reference for "Carrier and/or its underwriter".

SECTION 3.6
UNCASHED CHECKS (JAN 1996)

Payment of checks issued pursuant to this contract shall be voided if the checks have been outstanding for two (2) years. The amounts represented by these checks shall be credited to the Special Reserve of this contract no later than the 25th month after issuance. The term "Check" shall include any written instrument issued to pay or reimburse the payment of benefits, or any services, supplies or subcontracts hereunder.

SECTION 3.7
SERVICE CHARGE (JAN 1996)

(a) Any service charge negotiated shall be set forth in Appendix B and shall be the total profit that can be charged to the contract. The amount set forth in Appendix B shall encompass all profit (whether entitled service charge, profit, fee, contribution to reserves or surpluses or any other title) that may be included in major subcontracts in accordance with the provisions of FEHBAR 1631.205-80, Major Subcontractor Service Charges.

(b) One-twelfth of the service charge for the contract term accrues on the last day of each month during the contract term. The Carrier shall withdraw the service charge from the Special Reserve when it accrues.

(c) If this contract is renewed by operation of section 1.15(a), the amount of the service charge accrued under (b) shall be "one-twenty-fourth" rather than "one-twelfth." The remainder of the service charge not otherwise accrued during the contract term shall accrue on the last day of the contract term.

SECTION 3.8
CONTRACTOR RECORDS RETENTION (JUL 2005) (FEHBAR 1652.204-70)

Notwithstanding the provisions of Section 5.7 (FAR 52.215-2(f)). *Audit and Records - Negotiation* the Carrier will retain and make available all records applicable to a contract term that support the annual statement of operations and, for contracts that equal or exceed the threshold at FAR 15.403-4(a)(1), the rate submission for that contract term for a period of six years after the end of the contract term to which the records relate. This includes all records of Large Provider Agreements and subcontracts that equal or exceed the threshold requirements. In addition, individual Enrollee and/or patient claim records will be maintained for six years after the end of the contract term to which the claim records relate. This clause is effective prospectively as of the 2005 contract year.

SECTION 3.9
APPROVAL FOR ASSIGNMENT OF CLAIMS (JAN 1991) (FEHBAR 1652.232-73)

(a) Notwithstanding the provisions of Section 5.35 [FAR 52.232-23], *Assignment of Claims*, the Carrier shall not make any assignment under the Assignment of Claims Act without the prior written approval of the Contracting Officer.

(b) Unless a different period is specified in the Contracting Officer's written approval, an assignment shall be in force only for a period of one year from the date of the Contracting Officer's approval. However, assignments may be renewed upon their expiration.

SECTION 3.10
AUDIT, FINANCIAL, AND OTHER INFORMATION (JAN 2001)

The Carrier shall furnish to OPM audit, financial, and other information in the format and within the time frames specified in the Audit Guide for Financial Statement Audits, Reporting on Internal Controls and Compliance with Laws and Regulations, Attestation Reports, Agreed-Upon Procedures, and Reporting on Internal Controls of Third Party Servicing Organizations. Information and reports shall be furnished in the required number of copies to the addresses specified by OPM.

SECTION 3.11
SURVEY CHARGES (JAN 2002)

(a) If the Carrier participates in an FEHB annual consumer assessment survey, it shall pay OPM's contractor a pro rata share of the total cost of consolidating and reporting the survey

results to OPM. The Carrier shall pay a separate fee for each plan option and /or rating area. The Carrier agrees to pay the contractor's invoice within 30 days of the billing date. If the Carrier does not remit payment to the contractor within 60 days of the billing date, OPM shall withhold the amount due from the Carrier's subscription charges according to FEHBAR 1652.232-71, Payments--experience-rated contracts, and forward payment to the contractor.

(b) Costs incurred by the Carrier for contracting with a vendor to conduct the survey shall be the Carrier's responsibility and constitute allowable administrative charges.

SECTION 3.12
FEHB CLEARINGHOUSE (JAN 2012)

(a) The FEHB Clearinghouse will facilitate the reconciliation of enrollments between carriers and Federal agencies, and between Carriers and Tribal Employers. The Carrier shall pay a pro rata share based on its proportion of FEHB premiums as determined by OPM for the cost of developing and operating the Clearinghouse.

(b) OPM shall withhold the amount due from the Carrier's subscription charges under the authority of FEHBAR 1652.232-71, Payments--Experience-Rated Contracts, and shall forward payment to the FEHB Clearinghouse.

SECTION 3.13
TAXPAYER IDENTIFICATION NUMBER (JAN 2000) (FEHBAR 1652.204-73)

(a) Definitions.

Common parent, as used in this provision, means that corporate entity that owns or controls an affiliated group of corporations that files its Federal income tax returns on a consolidated basis, and of which the Carrier is a member.

Taxpayer Identification Number (TIN), as used in this provision, means the number required by the Internal Revenue Service (IRS) to be used by the Carrier in reporting income tax and other returns.

(b) The Carrier must submit the information required in paragraphs (d) through (f) of this clause to comply with debt collection requirements of 31 U.S.C. 7701(c) and 3325(d), reporting requirements of 26 U.S.C. 6041, 6041A, and 6050M, and implementing regulations issued by the IRS. The Carrier is subject to the payment reporting requirements described in Federal Acquisition Regulation (FAR) 4.904. The Carrier's failure or refusal to furnish the information will result in payment being withheld until the TIN number is provided.

(c) The Government may use the TIN to collect and report on any delinquent amounts arising out of the Carrier's relationship with the Government (31 U.S.C. 7701(c)(3)). The TIN provided hereunder may be matched with IRS records to verify its accuracy.

(d) Taxpayer Identification Number (TIN).

TIN: _____

(e) Type of organization.

☐ Sole proprietorship;
☐ Partnership;
☐ Corporate entity (not tax-exempt);
☐ Corporate entity (tax-exempt);
☐ Other_____.

(f) Common parent.

Carrier is not owned or controlled by a common parent as defined in paragraph (a) of this clause.

Name and TIN of common parent:

Name_____

TIN_____

SECTION 3.14
REPORTABLE OVERPAYMENTS (JAN 2011)

(a) If the Carrier becomes aware of either a duplicate letter of credit payment or a significant letter of credit overpayment made by OPM, the Carrier shall notify the Contracting Officer within a maximum of ten days and request instructions for disposition of the overpayment. See FAR § 3.1003(a)(3) for penalties applicable to the failure to timely report credible evidence of significant overpayments which shall mean letter of credit payments that are 25% or a percentage determined by the Contracting Officer above the total checks presented amount for the day(s) in question and are reoccurring with no corrective action plan in place.

SECTION 3.15
AUDIT RESOLUTIONS (JAN 2011)

When OIG issues a Draft Report of findings to the Carrier, the Carrier must respond with all available, accurate and relevant documentation to validate or invalidate the findings. This must be done within the timeframe specified in the OIG Draft Report transmittal letter. The Carriers shall promptly begin reconciling findings and not wait until the receipt of the Final Report to address disagreement with any findings previously communicated in the Draft Report.

OPM expects to fully resolve audits within 180 days of issuance of the final report. To enable this, Carriers must expeditiously tender all documentation necessary for resolution of the audit not later than 120 days from the date of the final audit report. This includes overpayment recoveries via check or certification, full documentation of the Carrier's position for findings being contested, evidence supporting due diligence assertions, and support for all other pertinent issues which OPM must consider, as appropriate. Fully supported requests for an extension will be evaluated by the Contracting Officer on a case-by-case basis.

SECTION 3.16 REPORTABLE FINDINGS (JAN 2013)

(a) Audit findings (except for claim payment findings) in the scope of an OIG audit are reportable as questioned charges unless the Carrier provides documentation supporting that the findings were already identified and corrected (i.e., administrative expense overcharges and untimely health benefit refunds were already processed and returned to the FEHBP) prior to audit notification.

(b) Claim payment findings (i.e., claim overpayments) in the scope of an OIG audit are reportable as questioned charges unless the Carrier provides documentation supporting that these findings were already identified (i.e., documentation that the plan initiated recovery efforts) prior

to audit notification and corrected (i.e., claims were adjusted and/or voided and overpayments were recovered and returned to the FEHBP) by the original due date of the draft report response.

Part IV-SPECIAL PROVISIONS is deleted and replaced with the following:

SECTION 4.1
ALTERATIONS IN CONTRACT (JAN 2011) (FAR 52.252-4)

Portions of this contract are altered as follows:

(a) Section 1.6 Confidentiality of Records. The following subsection is added:

(d) Local Blue Cross and/or Blue Shield Plans may combine the personal data and medical records of Federal subscribers, and information relating thereto, with the same information of other individuals who have health benefits coverage under the Local Blue Cross and/or Blue Shield Plan. This combined data may only be used and disclosed for the Plan's health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501). Such activities include, but are not limited to: care management; prevention, detection, and recovery of funds subject to fraud and abuse; and negotiation of provider contracts.

(e) As used in subsection (b)(1) of this section, "administration of this contract" means health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501).

(b) Section 1.9 Plan Performance—Experience-Rated FFS Contracts.

The Carrier may use the appropriate systems for measurement and/or collection of data on the quality of the health care services as described in subparagraph 1.9(b).

(c) Section 1.14, Misleading, Deceptive, or Unfair Advertising, is amended by removing the reference to the NAIC Advertisements of Accident and Sickness Insurance Model Regulation (Appendix D-b). Carrier should continue to use the FEHB Supplemental Literature Guidelines (now at the renumbered Appendix C) along with FEHBAR 1603.7002.

(d) Section 1.15 Renewal and Withdrawal of Approval (FEHBAR). The following subsections are added:

(d) If the agency suspends payment of the subscription charges for any reason, the Carrier may (1) suspend making benefit payments until payment of all subscription charges due is fully restored; or (2) terminate the contract without prior notice.

(e) Section 1.21 Patient Bill of Rights. For the purpose of compliance with this Section, the Carrier will conduct the following minimum activities: (1) the Carrier will provide subscribers with a Fact Sheet that includes information about the disenrollment rate in the Blue Cross and Blue Shield Service Benefit Plan, as well as Local Plan-specific information including compliance with Federal and State financial requirements, public corporate information, years in existence, and accreditation status; (2) Provider

Directories will include language advising subscribers to contact their providers directly to obtain information about the providers, including but not limited to board certifications, languages spoken, availability of interpreters, facility accessibility, and whether the provider is accepting new patients.

(f) Section 1.30 Health Information Technology Privacy and Security. Subsections (b) and (c) of Section 1.30 are amended to read as follows:

(b) The Carrier will promote consumer transparency by ensuring that at the point where the Federal member enters the subcontractor's, large provider's, or vendor's website or web portal the link to the subcontractor's, large provider's, or vendor's notice of privacy practices and/or privacy policies is displayed on the bottom, or prominently displayed elsewhere, on the website or web portal.

(c) Notice of privacy practices and/or privacy policies disclosures must describe the uses of individually identifiable protected health information and any potential disclosure to other entities as described in the HIPAA Privacy Rule.

(g) Section 2.2 Benefits Provided. The following paragraph is added to subsection 2.2(a):

(4) The Carrier may pay the Preferred Provider Organization level of benefits under this contract to ease the hardship of members affected by natural disasters such as earthquakes, floods, etc., when because of the natural disaster members have difficulty gaining access to Preferred network providers. The Carrier may pay the Preferred level of benefits without regard to the provider's contractual relationship with the Carrier and will determine an appropriate time frame based on local conditions during which the provision of this paragraph will apply. Benefits provided under this paragraph will be made available to all members similarly affected by the natural disaster.

(h) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Notwithstanding subsection (f) of Section 2.3, benefits provided under the contract are not assignable by the Member to any person without express written approval of the carrier, and in the absence of such approval, any such assignment shall be void. Notwithstanding such approval, no assignment of benefits may be made in any case prior to the time that a valid claim for benefits arises.

(i) Section 2.3 Payment of Benefits and Provision of Services and Supplies. The introductory paragraph of Subsection 2.3(g) is amended to read as follows:

(g) *Erroneous Payments.*

(i) If the Carrier or OPM determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider; the recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment under 48 C.F.R. 1631.201-70(h) regardless of any time period limitations in the written agreement with the provider.

(ii) The Carrier shall be deemed to have satisfied the requirements of

Subsection (g) (i) above by complying with Subsections (ii), (iii), and (iv). Local Blue Cross and Blue Shield Plans which have time period limitations in their provider contracts which prevent the Plan from recovering erroneous benefit payments made to providers will participate in an action plan. The action plan shall be developed by the Blue Cross and Blue Shield Association by December 31, 2008 and agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield Association and the Contracting Officer shall utilize standards of commercial reasonableness and neither shall unreasonably withhold agreement. The action plan shall be designed to reduce the occurrence of erroneous benefit payments, to identify and recover erroneous benefit payments within the time limits stipulated in their provider contracts, and to demonstrate due diligence in making an attempt to identify and recover within that provider contract timeframe such erroneous benefit payments.

(iii) The Blue Cross and Blue Shield Association shall be responsible for monitoring and determining whether each Blue Cross and Blue Shield Plan participating in the action plan is complying with its obligations under the action plan.

(iv) A Blue Cross and Blue Shield Plan which is in compliance with its obligations under the action plan shall be found to be in compliance with its obligation under this Section 2.3(g) to make a prompt and diligent effort to recover erroneous benefit payments. In the event that any Plan with such time period limitations is determined to be not in substantial compliance with the action plan, and that Plan is determined not to have pursued material benefit payments with promptness and diligence, then the Plan shall return the erroneous benefit payments to the Program.

(v) The Carrier shall follow general business practices and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall—

(j) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(7)(ii) of Section 2.3 is amended to read as follows:

Notwithstanding (g)(7)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that caused erroneous benefit payments) when the errors are egregious and repeated. These costs are deemed to be unreasonable and unallowable under Section 3.2(b). The term "repeated" in the previous sentence does not apply to situations in which a claims processing system error causes multiple erroneous payments or to situations that involve audit findings on errors that are endemic to the provision of insurance and claims processing.

(k) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(10) of Section 2.3 is amended to read as follows:

(10) In compliance with the Contracts Disputes Act, the Carrier shall return to the

Program an amount equal to the uncollected erroneous benefit payment where the Contracting Officer determines that the Carrier failed to make a prompt and diligent effort, as that term is described above, to recover the erroneous benefit payment. This provision applies to benefit payments which have been paid in error for any reason (except in the case of fraud or abuse).

(l) Section 2.4 Termination of Coverage and Conversion Privileges. The conversion contract set forth in Section 2.4(c) may be a contract that is regularly offered by the local Blue Cross and/or Blue Shield Plan.

(m) Section 2.5 Subrogation. The following subsections are added:

(c) To the extent that a Member has received benefits for covered services under this contract for an injury or illness caused by a third party, the Carrier shall have the right to be subrogated and succeed to any rights of recovery against any person or organization from whom the Member is legally entitled to receive all or part of those same benefits, including insurers of individuals (non-group) policies of liability insurance that are issued to and in the name of the Member. The obligation of the Carrier to recover amounts through subrogation is limited to making a reasonable effort to seek recovery of amounts to which it is entitled to recover in cases which are brought to its attention. The Carrier shall not be required to recover any amounts from any person or organization who causes an injury or illness for which the Member makes claims for benefits.

(d) The Carrier may also recover directly from the Member all amounts received by the Member by suit, settlement, or otherwise from any third party or its insurer, or the Member's insurer under an individual policy or liability insurance, for benefits which have also been paid under this contract.

(e) The Member shall take such action, furnish such information and assistance, and execute such papers as the Carrier or its representative believes are necessary to facilitate enforcement of its rights, and shall take no action which would prejudice the interests of the Carrier to subrogation.

(f) Effective January 1, 1997, all Participating Plans shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under the contract.

(n) Section 2.6 Coordination of Benefits (FEHBAR). The following subsections are added:

(g) The benefits payable by this Plan shall be determined, on a claim by claim basis, only for those claims in excess of $100, except where Medicare is the primary payer of benefits.

(h) Whenever payments which should have been made under this contract in accordance with this provision have been made under any other group health coverage, the Carrier shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amount it shall determine to be

warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this contract and, to the extent of such payments discharged from liability under the contract.

(o) Section 3.1 Payments (FEHBAR). The following sentence is added to the end of Section 3.1(a):

OPM will withhold from the subscription charges amounts for other obligations due under the contract only to the extent that OPM and the Carrier have agreed in writing to specific deductions for such other obligations.

(p) Section 3.1 Payments (FEHBAR). The following subsection is added:

(g) Except as required pursuant to Sections 1.25 and 2.12, in the event this contract is terminated or not renewed, the agency shall be liable for all sums due and unpaid, including subscription charges, for the period up to the last day of the Member's entitlement to benefits.

(q) Section 3.2 Accounting and Allowable Cost (FEHBAR). Section 3.2(b)(2)(ii) of this contract is amended to comply with 5 U.S.C. 8909(f) as follows:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(r) Section 3.2 Accounting and Allowable Cost (FEHBAR). The provision in Section 3.2 (b)(2)(iv)(A) is supplemented as follows:

Charges for mandatory statutory reserves (Section 3.2(b)(2)(iv)(A)) to satisfy mandatory statutory reserve requirements of Participating Plans are allowable to the extent that such requirements exceed that portion of the service charge at Appendix B, Subscription Rates, Charges, Allowances and Limitations applicable to such Plans.

(s) Section 3.2 Accounting and Allowable Cost (FEHBAR). This section is modified as follows:

The Carrier, as required by the Blue Cross and Blue Shield Service Benefit Plan Workplan, shall furnish OPM an accounting of its operations under the contract not less than 120 days after the end of the calendar year contract period.

(t) Section 3.3 Special Reserve. The provision in Section 3.3(a) is supplemented as follows:

The Special reserve held by or on behalf of the Carrier is to be used only for payment of charges against this contract, including advance payments to Participating Plans and to hospitals.

(u) Section 3.10, Audit, Financial, and Other Information. Compliance by the Carrier and Participating Blue Cross and Blue Shield Plans with the Blue Cross Blue Shield Service Benefit Plan Workplan, as agreed upon between the Carrier and OPM, will constitute compliance with the Audit Guide referred to in Sections 3.2 and 3.10.

SECTION 4.2
HOSPITAL (FACILITY) BENEFIT PAYMENTS AND CONDITIONS (JAN 1991)

(a) Benefits described in the agreed upon brochure text shall be provided to the extent practicable in the form of services rendered by hospitals, freestanding ambulatory facilities, and home health care agencies, and payment, therefore, by or on behalf of the carrier shall constitute a complete discharge of their obligations under this contract to the extent of services rendered in accordance with the terms and conditions of the contract.

(b) Benefits for inpatient hospital care shall be available only to a Member admitted to the hospital on the recommendation, and while under the active medical supervision of a duly licensed physician or alternative provider as described in section 8902(k)(1) of title 5 U.S.C. who is a member of the staff of, or acceptable to, the hospital selected.

(c) Hospital service is subject to all the rules and regulations of the hospital selected including rules governing admissions.

(d) While a Member may elect to be hospitalized in any hospital, the Carrier does not undertake to guarantee the admission of such Member to the hospital, nor the availability of any accommodations or services therein requested by the Member or his physician.

SECTION 4.3
DEFINITION OF CARRIER (JAN 1991)

The Carrier is the Blue Cross and Blue Shield Association, an Illinois not-for-profit corporation, acting on behalf of participating Blue Cross and Blue Shield Plans and pursuant to authority specified in Exhibit A for and in behalf of the organizations specified in Exhibit A (hereinafter sometimes referred to as "Participating Plans").

SECTION 4.4
AUDIT DISPUTES (JAN 2000)

(a) Any questioned costs or issues documented by or on behalf of OPM's Office of the Inspector General (OIG) in draft or final audit reports examining the Carrier's and Participating Plans' performance under this contract, that are provided to the Carrier and that were initially raised in the timeframe set forth in subsection (c) below, remain open until resolved. Audit issues related to monetary findings for which extensions of the

waiver period for the issuance of final decisions and processing of prior period adjustments were obtained in previous contract terms also remain open until resolved.

(b) Resolution of a questioned cost or issue can be the result of a resolution letter or the issuance of a final decision by the Contracting Officer, or by the processing of a prior period adjustment, an adjustment to the Special reserve, or submission of a claim to OPM (as appropriate) by the Carrier or Participating Plan. A prior period adjustment intended to partially or fully resolve an audit finding will not be considered closed until properly reported on the calendar year Annual Accounting Statement.

(c) A claim seeking, as a matter of right, the payment of money, in a sum certain, pursuant to 48 CFR section 52.233-1, shall not be made more than five years following the last day prescribed by the contract for filing the calendar year Annual Accounting Statement for the year with respect to which the claim arises. A claim includes, in the case of the carrier, a charge against the contract.

SECTION 4.5
ASSOCIATION DUES (JAN 2004)

A Participating local Blue Cross and Blue Shield Plan may charge to this contract Association Dues, with the exception of dues related to those lobbying costs and Special Assessments determined to be unallowable. In calculating the unallowable portion of dues related to lobbying costs for a contract year, the Blue Cross and Blue Shield Plan will rely on the percentage of dues, less any special assessments, as determined by the BCBSA for IRS purposes, to be not tax deductible from the previous contract year.

SECTION 4.6
TRAVEL COSTS (JAN 1996)

The Carrier may charge and account for travel expenses related to administration of the contract on a per diem basis, subject to the maximums prescribed by the Federal Travel Regulations. For those travel costs for each contract term that are subject to the Federal per diem rates set forth at 48 CFR section 31.205-46, the Carrier shall charge to the contract an amount equal to the lesser of:

(i) the actual aggregate charges for those costs, or
(ii) the aggregate charges calculated using the per diem rates set forth in the Federal Travel Regulations.

SECTION 4.7
MARKET RESEARCH COSTS (JAN 1996)

(a) Costs of market research surveys or studies are generally allowable if the survey or study is:

1. directed to current Members and Members who left the Blue Cross and Blue Shield Service Benefit Plan in the most recent Open season, or
2. focused on long-range planning, industry state-of-the-art developments, or product development issues for which a direct benefit or potential benefit to the FEHB Program

can be identified, or
3. pre-approved by the Contracting Officer.

(b) Costs of market research surveys or studies are generally not allowable if the primary purpose is to survey or study an otherwise unallowable cost item, such as: to determine the effectiveness of advertising or sales strategies; to evaluate image effectiveness or ways to achieve image enhancement; or to perform a competitive analysis with other carriers in the FEHB Program. Such costs are unallowable, regardless of who receives the research surveys or studies.

(c) This provision does not supersede other contract requirements, such as prior approval for subcontracts under Section 1.16 Subcontracts (FEHBAR 1652.244-70).

SECTION 4.8
PRESCRIPTION DRUG BENEFITS WAIVER PROVISIONS (JAN 2009)

(a) For the purposes of applying the special provisions in this section, the Standard Option Mail Service Prescription Drug Program service standards are:

(1) When a prescription order is placed that does not require additional information or clarification (i.e., a clean or non-diverted prescription), the prescription order shall be dispensed within three business days from the date of receipt so the enrollee may expect to receive the medication within 7 calendar days.

(2) When a prescription order is placed that does require additional information, clarification or resolution of payment issues (i.e., a diverted prescription), the prescription order shall be dispensed within seven business days from the date of receipt so the enrollee may expect to receive the medication within 14 calendar days. However the following situations will not be considered a diverted prescription for the purposes of this section:

(i) Prescriptions for refrigerated products that require prior arrangements between the mail order pharmacy and a Member before the Member can receive the Prescription;

(ii) Prescriptions requiring specific counseling obligations imposed by the pharmaceutical manufacturer, distributor or the FDA;

(iii) Prescriptions requiring "registration" with a pharmaceutical manufacturer.

(b) The special provisions described in paragraphs (c)(1), (2), and (3) shall become effective automatically when less than 98 percent of the prescriptions are filled within the service standards described in either paragraph (a)(1) or (a)(2) for 7 consecutive business days. The special provisions shall terminate when for 7 consecutive business days 98 percent or more of the prescriptions are filled within the service standards described in paragraphs (a)(1) and (a)(2) of this section.

(c) The special provisions are:

(1) The Carrier shall waive during the effective periods in paragraph (b) the coinsurance for a 21 day prescription filled at a Preferred retail pharmacy when the Mail Service Prescription Drug Program vendor is unable to fill the prescription within the service standards. This waiver of the coinsurance shall be in effect for 14 calendar days after notice to the enrollee as described in paragraph (c)(2) below.

(2) The Carrier shall deliver to the enrollee a written or telephone notice no later than 5 days from the date of receipt for clean or non-diverted prescriptions and no later than 12 days from the date of receipt for diverted prescriptions.
This notice shall:

(i) advise the enrollee that the Mail Service Prescription Drug Program may not be able to fill the prescription(s) within the service standard timeframes;

(ii) advise the enrollee that any applicable coinsurance will be waived for a 21 day supply of the medication(s) when filled at a Preferred retail pharmacy;

(iii) provide the enrollee with instructions on how to use the waiver, and

(iv) advise the enrollee when the waiver will expire.

(3) The Carrier may use next day delivery service at no additional cost to the enrollee in order to meet the service standards in (a)(1) and (a)(2).

SECTION 4.9
SMALL BUSINESS SUBCONTRACTING PLAN (JAN 2002) (FAR 52.219-9) (AS AMENDED)

An amended clause 52.219-9, Small Business Subcontracting Plan, is attached to Appendix E.

SECTION 4.10
LETTER OF CREDIT (JAN 1997)

As of January 1, 1997, OPM will administer Letter of Credit drawdowns directly with the local Plans.

SECTION 4.11
PILOTING OF COST CONTAINMENT PROGRAMS (JAN 2001)

Upon approval by the Contracting Officer, the Carrier may design and implement pilot programs in one or more local Plan areas that test the feasibility and examine the impact of various managed care initiatives. The Carrier shall brief the Contracting Officer on a pilot program prior to its implementation, advise the Contracting Officer of the progress of the pilot program and provide a written evaluation at the conclusion of the pilot program. The evaluation of the pilot program shall, at a minimum, assess the cost effectiveness, effect on quality of care and/or quality of life, and customer satisfaction, and recommend whether the pilot program should be continued or expanded.

SECTION 4.12
TRANSITION COSTS FOR PLAN TERMINATIONS (JAN 1999)

In the event a Participating Plan's license to use the Blue Cross and/or Blue Shield service marks is terminated, thereby rendering it ineligible to participate in this Contract, the costs of transitioning the terminated Plan's Service Benefit Plan subscribers to a successor Plan shall be subject to advance approval. The Carrier shall submit to OPM a proposed transition plan, together with a detailed estimate of costs, prior to the incurrence of any significant transition costs. OPM and the Carrier shall negotiate an advance agreement pursuant to FAR 31.109 that covers the extent of allowable transition costs.

SECTION 4.13
PAYMENT BY ELECTRONIC FUNDS TRANSFER-CENTRAL CONTRACTOR REGISTRATION (MAY 1999) (FAR 52.232-33)

The references to the Central Contractor Registration in FAR 52.232-33 are not applicable to this contract.

PART V - REQUIRED CLAUSES

SECTION 5.1
DEFINITIONS (JAN 2012) (FAR 52.202-1)

a) When a solicitation provision or contract clause uses a word or term that is defined in the Federal Acquisition Regulation (FAR), the word or term has the same meaning as the definition in FAR 2.101 in effect at the time the solicitation was issued, unless—
   (1) The solicitation, or amended solicitation, provides a different definition;
   (2) The contracting parties agree to a different definition;
   (3) The part, subpart, or section of the FAR where the provision or clause is prescribed provides a different meaning; or
   (4) The word or term is defined in FAR Part 31, for use in the cost principles and procedures.
b) The FAR Index is a guide to words and terms the FAR defines and shows where each definition is located. The FAR Index is available via the Internet at https://www.acquisition.gov/far at the end of the FAR, after the FAR Appendix.

SECTION 5.2
[RESERVED]

SECTION 5.3
GRATUITIES (APR 1984) (FAR 52.203-3)

(a) The right of the Contractor to proceed may be terminated by written notice if, after notice and hearing, the agency head or a designee determines that the Contractor, its agent, or another representative -
(1) Offered or gave a gratuity (e.g., an entertainment or gift) to an officer, official, or employee of the Government; and
(2) Intended, by the gratuity, to obtain a contract or favorable treatment under a contract.
(b) The facts supporting this determination may be reviewed by any court having lawful jurisdiction.
(c) If this contract is terminated under paragraph (a) above, the Government is entitled -
(1) To pursue the same remedies as in a breach of the contract; and
(2) In addition to any other damages provided by law, to exemplary damages of not less than 3 nor more than 10 times the cost incurred by the Contractor in giving gratuities to the person concerned, as determined by the agency head or a designee. (This subparagraph (c)(2) is applicable only if this contract uses money appropriated to the Department of Defense.)
(d) The rights and remedies of the Government provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this contract.

SECTION 5.4
COVENANT AGAINST CONTINGENT FEES (APR 1984) (FAR 52.203-5)

(a) The Contractor warrants that no person or agency has been employed or retained to solicit or obtain this contract upon an agreement or understanding for a contingent fee, except a bona fide employee or agency. For breach or violation of this warranty, the Government shall have the right to annul this contract without liability or, in its discretion, to deduct from the contract price or consideration, or otherwise recover, the full amount of the contingent fee.

(b) "Bona fide agency," as used in this clause, means an established commercial or selling agency, maintained by a contractor for the purpose of securing business, that neither exerts nor proposes to exert improper influence to solicit or obtain Government contracts nor holds itself out as being able to obtain any Government contract or contracts through improper influence.

"Bona fide employee," as used in this clause, means a person, employed by a contractor and subject to the contractor's supervision and control as to time, place, and manner of performance, who neither exerts nor proposes to exert improper influence to solicit or obtain Government contracts nor holds out as being able to obtain any Government contract or contracts through improper influence.

"Contingent fee", as used in this clause, means any commission, percentage, brokerage, or other fee that is contingent upon the success that a person or concern has in securing a Government contract.

"Improper influence," as used in this clause, means any influence that induces or tends to induce a Government employee or officer to give consideration or to act regarding a Government contract on any basis other than the merits of the matter.

SECTION 5.5
ANTI-KICKBACK PROCEDURES (OCT 2010) (FAR 52.203-7)

(a) Definitions.

"Kickback," as used in this clause, means any money, fee, commission, credit, gift, gratuity, thing of value, or compensation of any kind which is provided, directly or indirectly, to any prime Contractor, prime Contractor employee, subcontractor, or subcontractor employee for the purpose of improperly obtaining or rewarding favorable treatment in connection with a prime contract or in connection with a subcontract relating to a prime contract.

"Person," as used in this clause, means a corporation, partnership, business association of any kind, trust, joint-stock company, or individual.

"Prime contract," as used in this clause, means a contract or contractual action entered into by the United States for the purpose of obtaining supplies, materials, equipment, or services of any kind.

"Prime Contractor," as used in this clause, means a person who has entered into a prime contract with the United States.

"Prime Contractor employee," as used in this clause, means any officer, partner, employee, or agent of a prime Contractor.

"Subcontract," as used in this clause, means a contract or contractual action entered into by a prime Contractor or subcontractor for the purpose of obtaining supplies, materials, equipment, or services of any kind under a prime contract.

"Subcontractor," as used in this clause, (1) means any person, other than the prime Contractor, who offers to furnish or furnishes any supplies, materials, equipment, or services of any kind under a prime contract or a subcontract entered into in connection with such prime contract, and (2) includes any person who offers to furnish or furnishes general supplies to the prime

Contractor or a higher tier subcontractor.

"Subcontractor employee," as used in this clause, means any officer, partner, employee, or agent of a subcontractor.

(b) The Anti-Kickback Act of 1986 (41 U.S.C. 51-58) (the Act), prohibits any person from --

(1) Providing or attempting to provide or offering to provide any kickback;

(2) Soliciting, accepting, or attempting to accept any kickback; or

(3) Including, directly or indirectly, the amount of any kickback in the contract price charged by a prime Contractor to the United States or in the contract price charged by a subcontractor to a prime Contractor or higher tier subcontractor.

(c)(1) The Contractor shall have in place and follow reasonable procedures designed to prevent and detect possible violations described in paragraph (b) of this clause in its own operations and direct business relationships.

(2) When the Contractor has reasonable grounds to believe that a violation described in paragraph (b) of this clause may have occurred, the Contractor shall promptly report in writing the possible violation. Such reports shall be made to the inspector general of the contracting agency, the head of the contracting agency if the agency does not have an inspector general, or the Department of Justice.

(3) The Contractor shall cooperate fully with any Federal agency investigating a possible violation described in paragraph (b) of this clause.

(4) The Contracting Officer may (i) offset the amount of the kickback against any monies owed by the United States under the prime contract and/or (ii) direct that the Prime Contractor withhold, from sums owed a subcontractor under the prime contract, the amount of the kickback. The Contracting Officer may order the monies withheld under division (c)(4)(ii) of this clause be paid over to the Government unless the Government has already offset those monies under subdivision (c)(4)(i) of this clause. In either case, the Prime Contractor shall notify the Contracting Officer when the monies are withheld.

(5) The Contractor agrees to incorporate the substance of this clause, including this paragraph (c)(5) but excepting paragraph (c)(1), in all subcontracts under this contract which exceed $150,000.

SECTION 5.6
[RESERVED]

SECTION 5.7
AUDIT AND RECORDS-NEGOTIATION (OCT 2010) (FAR 52.215-2)

(a) As used in this clause, "records" includes books, documents, accounting procedures and practices, and other data, regardless of type and regardless of whether such items are in written form, in the form of computer data, or in any other form.

(b) *Examination of costs.* If this is a cost- reimbursement, incentive, time-and-materials, labor-hour, or price redeterminable contract, or any combination of these, the Contractor shall maintain and the Contracting Officer, or an authorized representative of the Contracting Officer, shall have the right to examine and audit all records and other evidence sufficient to reflect properly all costs claimed to have been incurred or anticipated to be incurred directly or indirectly in performance of this contract. This right of examination shall include inspection at all reasonable times of the Contractor's plants, or parts of them, engaged in performing the

contract.

(c) *Certified cost or pricing data.* If the Contractor has been required to submit certified cost or pricing data in connection with any pricing action relating to this contract, the Contracting Officer, or an authorized representative of the Contracting Officer, in order to evaluate the accuracy, completeness, and currency of the certified cost or pricing data, shall have the right to examine and audit all of the Contractor's records, including computations and projections, related to--

(1) The proposal for the contract, subcontract, or modification;

(2) The discussions conducted on the proposal(s), including those related to negotiating;

(3) Pricing of the contract, subcontract, or modification; or

(4) Performance of the contract, subcontract or modification.

(d) *Comptroller General* -- (1) The Comptroller General of the United States, or an authorized representative, shall have access to and the right to examine any of the Contractor's directly pertinent records involving transactions related to this contract or a subcontract hereunder and to interview any current employee regarding such transactions.

(2) This paragraph may not be construed to require the Contractor or subcontractor to create or maintain any record that the Contractor or subcontractor does not maintain in the ordinary course of business or pursuant to a provision of law.

(e) *Reports.* If the Contractor is required to furnish cost, funding, or performance reports, the Contracting Officer or an authorized representative of the Contracting Officer shall have the right to examine and audit the supporting records and materials, for the purpose of evaluating--(1) The effectiveness of the Contractor's policies and procedures to produce data compatible with the objectives of these reports and (2) The data reported.

(f) *Availability.* The Contractor shall make available at its office at all reasonable times the records, materials, and other evidence described in paragraphs (a), (b), (c), (d), and (e) of this clause, for examination, audit, or reproduction, until 3 years after final payment under this contract or for any shorter period specified in Subpart 4.7, Contractor Records Retention, of the Federal Acquisition Regulation (FAR), or for any longer period required by statute or by other clauses of this contract. In addition--(1) If this contract is completely or partially terminated, the Contractor shall make available the records relating to the work terminated until 3 years after any resulting final termination settlement; and (2) The Contractor shall make available records relating to appeals under the Disputes clause or to litigation or the settlement of claims arising under or relating to this contract until such appeals, litigation, or claims are finally resolved.

(g) The Contractor shall insert a clause containing all the terms of this clause, including this paragraph (g), in all subcontracts under this contract that exceed the simplified acquisition threshold and--

(1) That are cost-reimbursement, incentive, time-and-materials, labor-hour, or price-redeterminable type or any combination of these;

(2) For which certified cost or pricing data are required; or

(3) That require the subcontractor to furnish reports as discussed in paragraph (e) of this clause.

The clause may be altered only as necessary to identify properly the contracting parties and the Contracting Officer under the Government prime contract.

SECTION 5.8
PRICE REDUCTION FOR DEFECTIVE CERTIFIED COST OR PRICING DATA (AUG

2011) (FAR 52.215-10)

(a) If any price, including profit or fee, negotiated in connection with this contract, or any cost reimbursable under this contract, was increased by any significant amount because (1) the Contractor or a subcontractor furnished certified cost or pricing data that were not complete, accurate, and current as certified in its Certificate of Current Cost or Pricing Data, (2) a subcontractor or prospective subcontractor furnished the Contractor certified cost or pricing data that were not complete, accurate, and current as certified in the Contractor's Certificate of Current Cost or Pricing Data, or (3) any of these parties furnished data of any description that were not accurate, the price or cost shall be reduced accordingly and the contract shall be modified to reflect the reduction.

(b) Any reduction in the contract price under paragraph (a) of this clause due to defective data from a prospective subcontractor that was not subsequently awarded the subcontract shall be limited to the amount, plus applicable overhead and profit markup, by which (1) the actual subcontract; or (2) the actual cost to the Contractor, if there was no subcontract, was less than the prospective subcontract cost estimate submitted by the Contractor; provided, that the actual subcontract price was not itself affected by defective certified cost or pricing data.

(c)(1) If the Contracting Officer determines under paragraph (a) of this clause that a price or cost reduction should be made, the Contractor agrees not to raise the following matters as a defense:

(i) The Contractor or subcontractor was a sole source supplier or otherwise was in a superior bargaining position and thus the price of the contract would not have been modified even if accurate, complete, and current certified cost of pricing data had been submitted;

(ii) The Contracting Officer should have known that the certified cost or pricing data in issue were defective even though the Contractor or subcontractor took no affirmative action to bring the character of the data to the attention of the Contracting Officer;

(iii) The contract was based on an agreement about the total cost of the contract and there was no agreement about the cost of each item procured under the contract; or

(iv) The Contractor or subcontractor did not submit a Certificate of Current Cost or Pricing Data.

(2)(i) Except as prohibited by subdivision (c)(2)(ii) of this clause, an offset in an amount determined appropriate by the Contracting Officer based upon the facts shall be allowed against the amount of a contract price reduction if--

(A) The Contractor certifies to the Contracting Officer that, to the best of the Contractor's knowledge and belief, the Contractor is entitled to the offset in the amount requested; and

(B) The Contractor proves that the certified cost or pricing data were available before the "as of" date specified on its Certificate of Current Cost or Pricing Data, and that the data were not submitted before such date.

(ii) An offset shall not be allowed if--

(A) The understated data were known by the Contractor to be understated before the "as of" date specified on its Certificate of Current Cost or Pricing Data; or

(B) The Government proves that the facts demonstrate that the contract price would not have increased in the amount to be offset even if the available data had been submitted before the "as of" date specified on its Certificate of Current Cost or Pricing Data.

(d) If any reduction in the contract price under this clause reduces the price of items for which payment was made prior to the date of the modification reflecting the price reduction, the

Contractor shall be liable to and shall pay the United States at the time such overpayment is repaid--

(1) Interest compounded daily, as required by 26 U.S.C. 6622, on the amount of such overpayment to be computed from the date(s) of overpayment to the Contractor to the date the Government is repaid by the Contractor at the applicable underpayment rate effective for each quarter prescribed by the Secretary of the Treasury under 26 U.S.C. 6621(a)(2); and

(2) A penalty equal to the amount of the overpayment, if the Contractor or subcontractor knowingly submitted certified cost or pricing data which were incomplete, inaccurate, or noncurrent.

SECTION 5.9
[RESERVED]

SECTION 5.10
SUBCONTRACTOR CERTIFIED COST OR PRICING DATA (OCT 2010) (FAR 52.215-12)

(a) Before awarding any subcontract expected to exceed the threshold for submission of certified cost or pricing data at FAR 15.403-4, on the date of agreement on price or the date of award, whichever is later; or before pricing any subcontract modification involving a pricing adjustment expected to exceed the threshold for submission of certified cost or pricing data at FAR 15.403-4, the Contractor shall require the subcontractor to submit certified cost or pricing data (actually or by specific identification in writing), unless an exception under FAR 15.403-1 applies.

(b) The Contractor shall require the subcontractor to certify in substantially the form prescribed in FAR 15.406-2 that, to the best of its knowledge and belief, the data submitted under paragraph (a) of this clause were accurate, complete, and current as of the date of agreement on the negotiated price of the subcontract or subcontract modification.

(c) In each subcontract that exceeds the threshold for submission of certified cost or pricing data at FAR 15.403-4, when entered into, the Contractor shall insert either --

(1) The substance of this clause, including this paragraph (c), if paragraph (a) of this clause requires submission of certified cost or pricing data for the subcontract; or

(2) The substance of the clause at FAR 52.215-13, Subcontractor Certified Cost or Pricing Data - Modifications.

SECTION 5.11
[RESERVED]

SECTION 5.12
[RESERVED]

SECTION 5.13
[RESERVED]

SECTION 5.14
UTILIZATION OF SMALL BUSINESS CONCERNS[1] (JAN 2011) (FAR 52.219-8)

[1] Section 5.14 only applies to plans participating in the small business pilot (none are experience-rated HMOs).

(a) It is the policy of the United States that small business concerns, veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns, and women-owned small business concerns shall have the maximum practicable opportunity to participate in performing contracts let by any Federal agency, including contracts and subcontracts for subsystems, assemblies, components, and related services for major systems. It is further the policy of the United States that its prime contractors establish procedures to ensure the timely payment of amounts due pursuant to the terms of their subcontracts with small business concerns, veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns, and women-owned small business concerns.

(b) The Contractor hereby agrees to carry out this policy in the awarding of subcontracts to the fullest extent consistent with efficient contract performance. The Contractor further agrees to cooperate in any studies or surveys as may be conducted by the United States Small Business Administration or the awarding agency of the United States as may be necessary to determine the extent of the Contractor's compliance with this clause.

(c) *Definitions*. As used in this contract--

"HUBZone small business concern" means a small business concern that appears on the List of Qualified HUBZone Small Business Concerns maintained by the Small Business Administration.

"Service-disabled veteran-owned small business concern"--

(1) Means a small business concern--

(i) Not less than 51 percent of which is owned by one or more service-disabled veterans or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more service-disabled veterans; and

(ii) The management and daily business operations of which are controlled by one or more service-disabled veterans or, in the case of a veteran with permanent and severe disability, the spouse or permanent caregiver of such veteran.

(2) Service-disabled veteran means a veteran, as defined in 38 U.S.C. 101(2), with a disability that is service-connected, as defined in 38 U.S.C. 101(16).

"Small business concern" means a small business as defined pursuant to Section 3 of the Small Business Act and relevant regulations promulgated pursuant thereto.

"Small disadvantaged business concern" means a small business concern that represents, as part of its offer that--

(1)(i) It has received certification as a small disadvantaged business concern consistent with 13 CFR part 124, Subpart B;

(1)(ii) No material change in disadvantaged ownership and control has occurred since its certification;

(1)(iii) Where the concern is owned by one or more individuals, the net worth of each individual upon whom the certification is based does not exceed $750,000 after taking into account the applicable exclusions set forth at 13 CFR 124.104(c)(2); and

(1)(iv) It is identified, on the date of its representation, as a certified small disadvantaged business in the CCR Dynamic Small Business Search database maintained by the Small Business Administration, or

(2) It represents in writing that it qualifies as a small disadvantaged business (SDB) for any Federal subcontracting program, and believes in good faith that it is owned and controlled by one or more socially and economically disadvantaged individuals and meets the SDB eligibility criteria of 13 CFR 124.1002.

"Veteran-owned small business concern" means a small business concern--

(1) Not less than 51 percent of which is owned by one or more veterans (as defined at 38 U.S.C. 101(2)) or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more veterans; and

(2) The management and daily business operations of which are controlled by one or more veterans.

"Women-owned small business concern" means a small business concern--

(1) That is at least 51 percent owned by one or more women, or, in the case of any publicly owned business, at least 51 percent of the stock of which is owned by one or more women; and

(2) Whose management and daily business operations are controlled by one or more women.

(d)(1) Contractors acting in good faith may rely on written representations by their subcontractors regarding their status as a small business concern, a veteran-owned small business concern, a service-disabled veteran-owned small business concern, a HUBZone small business concern, a small disadvantaged business concern, or a women-owned small business concern.

(2) The Contractor shall confirm that a subcontractor representing itself as a HUBZone small business concern is certified by SBA as a HUBZone small business concern by accessing the Central Contractor Registration (CCR) database or by contacting the SBA. Options for contacting the SBA include—

(i) HUBZone small business database search application web page at http://dsbs.sba.gov/dsbs/search/dsp_searchhubzone.cfm; or http://www.sba.gov/hubzone;

(ii) In writing to the Director/HUB, U.S. Small Business Administration, 409 3rd Street, SW., Washington, DC 20416; or

(iii) The SBA HUBZone Help Desk at hubzone@sba.gov.

SECTION 5.15
[RESERVED]

SECTION 5.16
[RESERVED]

SECTION 5.17
CONVICT LABOR (JUN 2003) (FAR 52.222-3)

(a) Except as provided in paragraph (b) of this clause, the Contractor shall not employ in the performance of this contract any person undergoing a sentence of imprisonment imposed by any court of a State, the District of Columbia, Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, or the U.S. Virgin Islands.

(b) The Contractor is not prohibited from employing persons-

(1) On parole or probation to work at paid employment during the term of their sentence;

(2) Who have been pardoned or who have served their terms; or

(3) Confined for violation of the laws of any of the States, the District of Columbia, Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, or the U.S. Virgin Islands who are authorized to work at paid employment in the community under the laws of such jurisdiction, if-

(i) The worker is paid or is in an approved work training program on a voluntary basis;

(ii) Representatives of local union central bodies or similar labor union organizations have been consulted;

(iii) Such paid employment will not result in the displacement of employed workers, or be applied in skills, crafts, or trades in which there is a surplus of available gainful labor in the locality, or impair existing contracts for services;

(iv) The rates of pay and other conditions of employment will not be less than those paid or provided for work of a similar nature in the locality in which the work is being performed; and

(v) The Attorney General of the United States has certified that the work-release laws or regulations of the jurisdiction involved are in conformity with the requirements of Executive Order 11755, as amended by Executive Orders 12608 and 12943.

SECTION 5.18
CONTRACT WORK HOURS AND SAFETY STANDARDS ACT -- OVERTIME COMPENSATION (JUL 2005) (FAR 52.222-4)

(a) *Overtime requirements.* No Contractor or subcontractor employing laborers or mechanics (see Federal Acquisition Regulation 22.300) shall require or permit them to work over 40 hours in any workweek unless they are paid at least 1 and ½ times the basic rate of pay for each hour worked over 40 hours.

(b) *Violation; liability for unpaid wages; liquidated damages.* The responsible Contractor and subcontractor are liable for unpaid wages if they violate the terms in paragraph (a) of this clause. In addition, the Contractor and subcontractor are liable for liquidated damages payable to the Government. The Contracting Officer will assess liquidated damages at the rate of $10 per affected employee for each calendar day on which the employer required or permitted the employee to work in excess of the standard workweek of 40 hours without paying overtime wages required by the Contract Work Hours and Safety Standards Act.

(c) *Withholding for unpaid wages and liquidated damages.* The Contracting Officer will withhold from payments due under the contract sufficient funds required to satisfy any Contractor or subcontractor liabilities for unpaid wages and liquidated damages. If amounts withheld under the contract are insufficient to satisfy Contractor or subcontractor liabilities, the Contracting Officer will withhold payments from other Federal or federally assisted contracts held by the same Contractor that are subject to the Contract Work Hours and Safety Standards Act.

(d) *Payrolls and basic records.* (1) The Contractor and its subcontractors shall maintain payrolls and basic payroll records for all laborers and mechanics working on the contract during the contract and shall make them available to the Government until 3 years after contract completion. The records shall contain the name and address of each employee, social security number, labor classifications, hourly rates of wages paid, daily and weekly number of hours worked, deductions made, and actual wages paid. The records need not duplicate those required for construction work by Department of Labor regulations at 29 CFR 5.5(a)(3) implementing the Davis-Bacon Act.

(2) The contractor and its subcontractors shall allow authorized representatives of the Contracting Officer or the Department of Labor to inspect, copy, or transcribe records maintained under paragraph (d)(1) of this clause. The Contractor or subcontractor also shall allow authorized representatives of the Contracting Officer or Department of Labor to interview employees in the workplace during working hours.

(e) *Subcontracts*. The Contractor shall insert the provisions set forth in paragraphs (a) through (d) of this clause in subcontracts that may require or involve the employment of laborers and mechanics and require subcontractors to include these provisions in any such lower tier subcontracts. The Contractor shall be responsible for compliance by any subcontractor or lower-tier subcontractor with the provisions set forth in paragraphs (a) through (d) of this clause.

SECTION 5.19
EQUAL OPPORTUNITY (MAR 2007) (FAR 52.222-26)

(a) *Definition*. "United States," as used in this clause, means the 50 States, the District of Columbia, Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, the U.S. Virgin Islands, and Wake Island.

(b)(1) If, during any 12-month period (including the 12 months preceding the award of this contract), the Contractor has been or is awarded nonexempt Federal contracts and/or subcontracts that have an aggregate value in excess of $10,000, the Contractor shall comply with this clause, except for work performed outside the United States by employees who were not recruited within the United States. Upon request, the Contractor shall provide information necessary to determine the applicability of this clause.

(2) If the Contractor is a religious corporation, association, educational institution, or society, the requirements of this clause do not apply with respect to the employment of individuals of a particular religion to perform work connected with the carrying on of the Contractor's activities (41 CFR 60-1.5).

(c)(1) The Contractor shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, or national origin. However, it shall not be a violation of this clause for the Contractor to extend a publicly announced preference in employment to Indians living on or near an Indian reservation, in connection with employment opportunities on or near an Indian reservation, as permitted by 41 CFR 60-1.5.

(2) The Contractor shall take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, or national origin. This shall include, but not be limited to—

(i) Employment;
(ii) Upgrading;
(iii) Demotion;
(iv) Transfer;
(v) Recruitment or recruitment advertising;
(vi) Layoff or termination;
(vii) Rates of pay or other forms of compensation; and
(viii) Selection for training, including apprenticeship.

(3) The Contractor shall post in conspicuous places available to employees and applicants for employment the notices to be provided by the Contracting Officer that explain this clause.

(4) The Contractor shall, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, or national origin.

(5) The Contractor shall send, to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, the notice to be provided by the Contracting Officer advising the labor union or workers' representative of the Contractor's commitments under this clause, and post copies of the notice in conspicuous places available to employees and applicants for employment.

(6) The Contractor shall comply with Executive Order 11246, as amended, and the rules, regulations, and orders of the Secretary of Labor.

(7) The Contractor shall furnish to the contracting agency all information required by Executive Order 11246, as amended, and by the rules, regulations, and orders of the Secretary of Labor. The Contractor shall also file Standard Form 100 (EEO-1), or any successor form, as prescribed in 41 CFR Part 60-1. Unless the Contractor has filed within the 12 months preceding the date of contract award, the Contractor shall, within 30 days after contract award, apply to either the regional Office of Federal Contract Compliance Programs (OFCCP) or the local office of the Equal Employment Opportunity Commission for the necessary forms.

(8) The Contractor shall permit access to its premises, during normal business hours, by the contracting agency or the OFCCP for the purpose of conducting on-site compliance evaluations and complaint investigations. The Contractor shall permit the Government to inspect and copy any books, accounts, records (including computerized records), and other material that may be relevant to the matter under investigation and pertinent to compliance with Executive Order 11246, as amended, and rules and regulations that implement the Executive Order.

(9) If the OFCCP determines that the Contractor is not in compliance with this clause or any rule, regulation, or order of the Secretary of Labor, this contract may be canceled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further Government contracts, under the procedures authorized in Executive Order 11246, as amended. In addition, sanctions may be imposed and remedies invoked against the Contractor as provided in Executive Order 11246, as amended; in the rules, regulations, and orders of the Secretary of Labor; or as otherwise provided by law.

(10) The Contractor shall include the terms and conditions of this clause in every subcontract or purchase order that is not exempted by the rules, regulations, or orders of the Secretary of Labor issued under Executive Order 11246, as amended, so that these terms and conditions will be binding upon each subcontractor or vendor.

(11) The Contractor shall take such action with respect to any subcontract or purchase order as the Contracting Officer may direct as a means of enforcing these terms and conditions, including sanctions for noncompliance, provided, that if the Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of any direction, the Contractor may request the United States to enter into the litigation to protect the interests of the United States.

(d) Notwithstanding any other clause in this contract, disputes relative to this clause will be governed by the procedures in 41 CFR 60-1.1.

SECTION 5.20
[RESERVED]

SECTION 5.21

NOTIFICATION OF VISA DENIAL (JUN 2003) (FAR 52.222-29)

It is a violation of Executive Order 11246 for a Contractor to refuse to employ any applicant or not to assign any person hired in the United States, Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, the U.S. Virgin Islands, or Wake Island on the basis that the individual's race, color, religion, sex, or national origin is not compatible with the policies of the country where the work is to be performed or for whom the work will be performed (41 CFR 60-1.10). The Contractor shall notify the U.S. Department of State, Assistant Secretary, Bureau of Political-Military Affairs (PM), 2201 C Street NW, Room 6212, Washington, DC 20520, and the U.S. Department of Labor, Deputy Assistant Secretary for Federal Contract Compliance, when it has knowledge of any employee or potential employee being denied an entry visa to a country where this contract will be performed, and it believes the denial is attributable to the race, color, religion, sex, or national origin of the employee or potential employee.

SECTION 5.22
EQUAL OPPORTUNITY FOR VETERANS (SEP 2010) (FAR 52.222-35)

(a) *Definitions.* As used in this clause—

All employment openings means all positions except executive and senior management, those positions that will be filled from within the Contractor's organization, and positions lasting 3 days or less. This term includes full-time employment, temporary employment of more than 3 days duration, and part-time employment.

Armed Forces service medal veteran means any veteran who, while serving on active duty in the U.S. military, ground, naval, or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985 (61 FR 1209).

Disabled veteran means—

(1) A veteran of the U.S. military, ground, naval, or air service, who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or

(2) A person who was discharged or released from active duty because of a service-connected disability.

Executive and senior management means—

(1) Any employee—

(i) Compensated on a salary basis at a rate of not less than $455 per week (or $380 per week, if employed in American Samoa by employers other than the Federal Government), exclusive of board, lodging or other facilities;

(ii) Whose primary duty consists of the management of the enterprise in which the individual is employed or of a customarily recognized department or subdivision thereof;

(iii) Who customarily and regularly directs the work of two or more other employees; and

(iv) Who has the authority to hire or fire other employees or whose suggestions and recommendations as to the hiring or firing and as to the advancement and promotion or any other change of status of other employees will be given particular weight; or

(2) Any employee who owns at least a bona fide 20-percent equity interest in the enterprise in which the employee is employed, regardless of whether the business is a corporate or other type of organization, and who is actively engaged in its management.

Other protected veteran means a veteran who served on active duty in the U.S. military, ground, naval, or air service, during a war or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.

Positions that will be filled from within the Contractor's organization means employment openings for which the Contractor will give no consideration to persons outside the Contractor's organization (including any affiliates, subsidiaries, and parent companies) and includes any openings the Contractor proposes to fill from regularly established "recall" lists. The exception does not apply to a particular opening once an employer decides to consider applicants outside of its organization.

Qualified disabled veteran means a disabled veteran who has the ability to perform the essential functions of the employment positions with or without reasonable accommodation.

Recently separated veteran means any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval or air service.

(b) *General.*

(1) The Contractor shall not discriminate against any employee or applicant for employment because the individual is a disabled veteran, recently separated veteran, other protected veterans, or Armed Forces service medal veteran, regarding any position for which the employee or applicant for employment is qualified. The Contractor shall take affirmative action to employ, advance in employment, and otherwise treat qualified individuals, including qualified disabled veterans, without discrimination based upon their status as a disabled veteran, recently separated veteran, Armed Forces service medal veteran, and other protected veteran in all employment practices including the following:

(i) Recruitment, advertising, and job application procedures.

(ii) Hiring, upgrading, promotion, award of tenure, demotion, transfer, layoff, termination, right of return from layoff and rehiring.

(iii) Rate of pay or any other form of compensation and changes in compensation.

(iv) Job assignments, job classifications, organizational structures, position descriptions, lines of progression, and seniority lists.

(v) Leaves of absence, sick leave, or any other leave.

(vi) Fringe benefits available by virtue of employment, whether or not administered by the Contractor.

(vii) Selection and financial support for training, including apprenticeship, and on the job training under 38 U.S.C. 3687, professional meetings, conferences, and other related activities, and selection for leaves of absence to pursue training.

(viii) Activities sponsored by the Contractor including social or recreational programs.

(ix) Any other term, condition, or privilege of employment.

(2) The Contractor shall comply with the rules, regulations, and relevant orders of the Secretary of Labor issued under the Vietnam Era Veterans' Readjustment Assistance Act of 1972 (the Act), as amended (38 U.S.C. 4211 and 4212).

(3) The Department of Labor's regulations require contractors with 50 or more employees and a contract of $100,000 or more to have an affirmative action program for veterans. *See* 41 CFR part 60–300, subpart C.

(c) *Listing openings.*

(1) The Contractor shall immediately list all employment openings that exist at the time of the execution of this contract and those which occur during the performance of this contract,

including those not generated by this contract, and including those occurring at an establishment of the Contractor other than the one where the contract is being performed, but excluding those of independently operated corporate affiliates, at an appropriate employment service delivery system where the opening occurs. Listing employment openings with the State workforce agency job bank or with the local employment service delivery system where the opening occurs shall satisfy the requirement to list jobs with the appropriate employment service delivery system.

(2) The Contractor shall make the listing of employment openings with the appropriate employment service delivery system at least concurrently with using any other recruitment source or effort and shall involve the normal obligations of placing a bona fide job order, including accepting referrals of veterans and nonveterans. This listing of employment openings does not require hiring any particular job applicant or hiring from any particular group of job applicants and is not intended to relieve the Contractor from any requirements of Executive orders or regulations concerning nondiscrimination in employment.

(3) Whenever the Contractor becomes contractually bound to the listing terms of this clause, it shall advise the State workforce agency in each State where it has establishments of the name and location of each hiring location in the State. As long as the Contractor is contractually bound to these terms and has so advised the State agency, it need not advise the State agency of subsequent contracts. The Contractor may advise the State agency when it is no longer bound by this contract clause.

(d) *Applicability.* This clause does not apply to the listing of employment openings that occur and are filled outside the 50 States, the District of Columbia, Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, the U.S. Virgin Islands, and Wake Island.

(e) *Postings.* (1) The Contractor shall post employment notices in conspicuous places that are available to employees and applicants for employment.

(2) The employment notices shall—

(i) State the rights of applicants and employees as well as the Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified employees and applicants who are disabled veterans, recently separated veterans, Armed Forces service medal veterans, and other protected veterans; and

(ii) Be in a form prescribed by the Director, Office of Federal Contract Compliance Programs, and provided by or through the Contracting Officer.

(3) The Contractor shall ensure that applicants or employees who are disabled veterans are informed of the contents of the notice (*e.g.,* the Contractor may have the notice read to a visually disabled veteran, or may lower the posted notice so that it can be read by a person in a wheelchair).

(4) The Contractor shall notify each labor union or representative of workers with which it has a collective bargaining agreement, or other contract understanding, that the Contractor is bound by the terms of the Act and is committed to take affirmative action to employ, and advance in employment, qualified disabled veterans, recently separated veterans, other protected veterans, and Armed Forces service medal veterans.

(f) *Noncompliance.* If the Contractor does not comply with the requirements of this clause, the Government may take appropriate actions under the rules, regulations, and relevant orders of the Secretary of Labor. This includes implementing any sanctions imposed on a contractor by the Department of Labor for violations of this clause (52.222–35, Equal Opportunity for Veterans). These sanctions (see 41 CFR 60–300.66) may include—

(1) Withholding progress payments;

(2) Termination or suspension of the contract: or

(3) Debarment of the contractor.

(g) *Subcontracts.* The Contractor shall insert the terms of this clause in subcontracts of $100,000 or more unless exempted by rules, regulations, or orders of the Secretary of Labor. The Contractor shall act as specified by the Director, Office of Federal Contract Compliance Programs, to enforce the terms, including action for noncompliance.

SECTION 5.23
AFFIRMATIVE ACTION FOR WORKERS WITH DISABILITIES (OCT 2010) (FAR 52.222-36)

(a) General. (1) Regarding any position for which the employee or applicant for employment is qualified, the Contractor shall not discriminate against any employee or applicant because of physical or mental disability. The Contractor agrees to take affirmative action to employ, advance in employment, and otherwise treat qualified individuals with disabilities without discrimination based upon their physical or mental disabilities in all employment practices such as -

(i) Recruitment. Advertising, and job application procedures;

(ii) Hiring, upgrading, promotion, award of tenure, demotion, transfer, layoff, termination, right of return from layoff, and rehiring;

(iii) Rates of pay or any other form of compensation and changes in compensation;

(iv) Job assignments, job classifications, organizational structures, position descriptions, lines of progression, and seniority lists;

(v) Leaves of absence, sick leave, or any other leave;

(vi) Fringe benefits available by virtue of employment, whether or not administered by the Contractor;

(vii) Selection and financial support for training, including apprenticeships, professional meetings, conferences, and other related activities, and selection for leaves of absence to pursue training

(viii) Activities sponsored by the Contractor, including social or recreational programs; and

(ix) Any other term, condition, or privilege of employment.

(2) The Contractor agrees to comply with the rules, regulations, and relevant orders of the Secretary of Labor (Secretary) issued under the Rehabilitation Act of 1973 (29 U.S.C. 793) (the Act), as amended.

(b) Postings. (1) The Contractor agrees to post employment notices stating (i) the Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified individuals with disabilities; and (ii) the rights of applicants and employees.

(2) These notices shall be posted in conspicuous places that are available to employees and applicants for employment. The Contractor shall ensure that applicants and employees with disabilities are informed of the contents of the notice (e.g., the Contractor may have the notice read to a visually disabled individual, or may lower the posted notice so that it might be read by a person in a wheelchair). The notices shall be in a form prescribed by the Deputy Assistant Secretary for Federal Contract Compliance, of the U.S. Department of Labor (Deputy Assistant Secretary), and shall be provided by or through the Contracting Officer.

(3) The Contractor shall notify each labor union or representative of workers with which it has a collective bargaining agreement or other contract understanding, that the Contractor is bound

by the terms of Section 503 of the Act and is committed to take affirmative action to employ, and advance in employment, qualified individuals with physical or mental disabilities.

(c) Noncompliance. If the Contractor does not comply with the requirements of this clause, appropriate actions may be taken under the rules, regulations, and relevant orders of the Secretary issued pursuant to the Act.

(d) Subcontracts. The Contractor shall include the terms of this clause in every subcontract or purchase order in excess of $15,000 unless exempted by rules, regulations, or orders of the Secretary. The Contractor shall act as specified by the Deputy Assistant Secretary to enforce the terms, including action for noncompliance.

SECTION 5.24
[RESERVED]

SECTION 5.25
DRUG-FREE WORKPLACE (MAY 2001) (FAR 52.223-6)

(a) Definitions. As used in this clause,

"Controlled substance" means a controlled substance in schedules I through V of section 202 of the Controlled Substances Act (21 U.S.C. 812) and as further defined in regulation at 21 CFR 1308.11-1308.15.

"Conviction" means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes.

"Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, possession or use of any controlled substance.

"Drug-free workplace" means the site(s) for the performance of work done by the Contractor in connection with a specific contract where employees of the Contractor are prohibited from engaging in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance.

"Employee" means an employee of a Contractor directly engaged in the performance of work under a Government contract. Directly engaged is defined to include all direct cost employees and any other Contractor employee who has other than a minimal impact or involvement in contract performance.

"Individual" means an offeror/contractor that has no more than one employee including the offeror/contractor.

(b) The Contractor, if other than an individual, shall - within 30 days after award (unless a longer period is agreed to in writing for contracts of 30 days or more performance duration); or as soon as possible for contracts of less than 30 days performance duration -

(1) Publish a statement notifying its employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition;

(2) Establish an ongoing drug-free awareness program to inform such employees about-

(i) The dangers of drug abuse in the workplace;

(ii) The contractor's policy of maintaining a drug-free workplace;

(iii) Any available drug counseling, rehabilitation, and employee assistance programs; and

(iv) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace.

(3) Provide all employees engaged in performance of the contract with a copy of the statement required by subparagraph (b)(1) of this clause;

(4) Notify such employees in writing in the statement required by subparagraph (b)(1) of this clause that, as a condition of continued employment on this contract, the employee will -

(i) Abide by the terms of the statement; and

(ii) Notify the employer in writing of the employee's conviction under a criminal drug statute for a violation occurring in the workplace no later than 5 days after such conviction.

(5) Notify the Contracting Officer in writing within 10 days after receiving notice under subdivision (b)(4)(ii) of this clause, from an employee or otherwise receiving actual notice of such conviction. The notice shall include the position title of the employee:

(6) Within 30 days after receiving notice under subdivision (b)(4)(ii) of this clause of a conviction, take one of the following actions with respect to any employee who is convicted of a drug abuse violation occurring in the workplace:

(i) Taking appropriate personnel action against such employee, up to and including termination; or

(ii) Require such employee to satisfactorily participate in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and

(7) Make a good faith effort to maintain a drug-free workplace through implementation of subparagraphs (b)(1) through (b)(6) of this clause.

(c) The Contractor, if an individual, agrees by award of the contract or acceptance of a purchase order, not to engage in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance while performing this contract.

(d) In addition to other remedies available to the Government, the Contractor's failure to comply with the requirements of paragraphs (b) or (c) of this clause may, pursuant to FAR 23.506, render the Contractor subject to suspension of contract payments, termination of the contract for default, and suspension or debarment.

SECTION 5.26
[RESERVED]

SECTION 5.27
FEDERAL, STATE, AND LOCAL TAXES (STATE AND LOCAL ADJUSTMENTS) (APR 2003) (FAR 52.229-4)

(a) As used in this clause-

"After-imposed tax" means any new or increased Federal, State, or local tax or duty, or tax that was excluded on the contract date but whose exclusion was later revoked or amount of exemption reduced during the contract period, other than an excepted tax, on the transactions or property covered by this contract that the Contractor is required to pay or bear as the result of legislative, judicial, or administrative action taking effect after the contract date.

"After-relieved tax" means any amount of Federal, State, or local tax or duty, other than an excepted tax, that would otherwise have been payable on the transactions or property covered by this contract, but which the Contractor is not required to pay or bear, or for which the Contractor

obtains a refund or drawback, as the result of legislative, judicial, or administrative action taking effect after the contract date.

"All applicable Federal, State, and local taxes and duties" means all taxes and duties, in effect on the contract date, that the taxing authority is imposing and collecting on the transactions or property covered by this contract.

"Contract date" means the effective date of this contract and, for any modification to this contract, the effective date of the modification.

"Excepted tax" means social security or other employment taxes, net income and franchise taxes, excess profits taxes, capital stock taxes, transportation taxes, unemployment compensation taxes, and property taxes. "Excepted tax" does not include gross income taxes levied on or measured by sales or receipts from sales, property taxes assessed on completed supplies covered by this contract, or any tax assessed on the Contractor's possession of, interest in, or use of property, title to which is in the Government.

"Local taxes" includes taxes imposed by a possession or territory of the United States, Puerto Rico, or the Northern Mariana Islands, if the contract is performed wholly or partly in any of those areas.

(b) Unless otherwise provided in this contract, the contract price includes all applicable Federal, State, and local taxes and duties.

(c) The contract price shall be increased by the amount of any after-imposed tax, or of any tax or duty specifically excluded from the contract price by a term or condition of this contract that the Contractor is required to pay or bear, including any interest or penalty, if the Contractor states in writing that the contract price does not include any contingency for such tax and if liability for such tax, interest, or penalty was not incurred through the Contractor's fault, negligence, or failure to follow instructions of the Contracting Officer.

(d) The contract price shall be decreased by the amount of any after-relieved tax. The Government shall be entitled to interest received by the Contractor incident to a refund of taxes to the extent that such interest was earned after the Contractor was paid by the Government for such taxes. The Government shall be entitled to repayment of any penalty refunded to the Contractor to the extent that the penalty was paid by the Government.

(e) The contract price shall be decreased by the amount of any Federal, State, or local tax, other than an excepted tax, that was included in the contract price and that the Contractor is required to pay or bear, or does not obtain a refund of, through the Contractor's fault, negligence, or failure to follow instructions of the Contracting Officer.

(f) No adjustment shall be made in the contract price under this clause unless the amount of the adjustment exceeds $250.

(g) The Contractor shall promptly notify the Contracting Officer of all matters relating to Federal, State, and local taxes and duties that reasonably may be expected to result in either an increase or decrease in the contract price and shall take appropriate action as the Contracting Officer directs. The contract price shall be equitably adjusted to cover the costs of action taken by the Contractor at the direction of the Contracting Officer, including any interest, penalty, and reasonable attorneys' fees.

(h) The Government shall furnish evidence appropriate to establish exemption from any Federal, State, or local tax when-

(1) The Contractor requests such exemption and states in writing that it applies to a tax excluded from the contract price; and

(2) A reasonable basis exists to sustain the exemption.

SECTION 5.28
RESERVED

SECTION 5.29
TAXES - FOREIGN NEGOTIATED BENEFITS CONTRACTS (JAN 1998) (FEHBAR 1652.229-70)

(a) To the extent that this contract provides for performing services outside the United States, its possessions, and Puerto Rico, this clause applies in lieu of any Federal, State, and local taxes clause of the contract.

(b) "Contract date," as used in this clause, means the effective date of this contract or modification.

"Country concerned," as used in this clause, means any country, other than the United States, its possessions, and Puerto Rico, in which expenditures under this contract are made.

"Tax" and "taxes," as used in this clause, include fees and charges for doing business that are levied by the government of the country concerned or by its political subdivisions.

"All applicable taxes and duties," as used in this clause, means all taxes and duties, in effect on the contract date, that the taxing authority is imposing and collecting on the transactions covered by this contract, pursuant to written ruling or regulation in effect on the contract date.

"After-imposed tax," as used in this clause, means any new or increased tax or duty, or tax that was exempted or excluded on the contract date but whose exemption was later revoked or reduced during the contract period, other than excepted tax, on the transactions covered by this contract that the Carrier is required to pay or bear as the result of legislative, judicial, or administrative action taking effect after the contract date.

"After-relieved tax," as used in this clause, means any amount of tax or duty, other than an excepted tax, that would otherwise have been payable on the transactions covered by this contract, but which the Carrier is not required to pay or bear, or for which the Carrier obtains a refund, as the result of legislative, judicial, or administrative action taking effect after the contract date.

"Excepted tax," as used in this clause, means social security or other employment taxes, net income and franchise taxes, excess profits taxes, capital stock taxes, transportation taxes, unemployment compensation taxes, and property taxes. "Excepted tax" does not include gross income taxes levied on or measured by sales or receipts from sales covered by this contract, or any tax assessed on the Carrier's possession of, interest in, or use of property, title to which is in the U.S. Government.

(c) Unless otherwise provided in this contract, the contract price includes all applicable taxes and duties, except taxes and duties that the Government of the United States and the government of the country concerned have agreed shall not be applicable to expenditures in such country by or on behalf of the United States.

(d) The contract price shall be increased by the amount of any after-imposed tax or of any tax or duty specifically excluded from the contract price by a provision of this contract that the Carrier is required to pay or bear, including any interest or penalty, if the Carrier states in writing that the contract price does not include any contingency for such tax and if liability for such tax, interest, or penalty was not incurred through the Carrier's fault, negligence, or failure to follow instructions of the Contracting Officer or to comply with the provisions of paragraph (i) below.

(e) The contract price shall be decreased by the amount of any after-relieved tax, including any interest or penalty. The Government of the United States shall be entitled to interest received by the Carrier incident to a refund of taxes to the extent that such interest was earned after the Carrier was paid by the Government of the United States for such taxes. The Government of the United States shall be entitled to repayment of any penalty refunded to the Carrier to the extent that the penalty was paid by the Government.

(f) The contract price shall be decreased by the amount of any tax or duty, other than an excepted tax, that was included in the contract and that the Carrier is required to pay or bear, or does not obtain a refund of, through the Carrier's fault, negligence, or failure to follow instructions of the Contracting Officer or to comply with the provisions of paragraph (i) below.

(g) No adjustment shall be made in the contract price under this clause unless the amount of the adjustment exceeds $250.

(h) If the Carrier obtains a reduction in tax liability under the United States Internal Revenue Code (Title 26, U.S. Code) because of the payment of any tax or duty that either was included in the contract price or was the basis of an increase in the contract price, the amount of the reduction shall be paid or credited to the Government of the United States as the Contracting Officer directs.

(i) The Carrier shall take all reasonable action to obtain exemption from or refund of any taxes or duties, including interest or penalty, from which the United States Government, the Carrier, any subcontractor, or the transactions covered by this contract are exempt under the laws of the country concerned or its political subdivisions or which the governments of the United States and of the country concerned have agreed shall not be applicable to expenditures in such country by or on behalf of the United States.

(j) The Carrier shall promptly notify the Contracting Officer of all matters relating to taxes or duties that reasonably may be expected to result in either an increase or decrease in the contract price and shall take appropriate action as the Contracting Officer directs. The contract price shall be equitably adjusted to cover the costs of action taken by the Carrier at the direction of the Contracting Officer, including any interest, penalty, and reasonable attorneys' fees.

SECTION 5.30
[RESERVED]

SECTION 5.31
[RESERVED]

SECTION 5.32
[RESERVED]

SECTION 5.33
DISCOUNTS FOR PROMPT PAYMENT (FEB 2002) (FAR 52.232-8)

(a) Discounts for prompt payment will not be considered in the evaluation of offers. However, any offered discount will form a part of the award, and will be taken if payment is made within the discount period indicated in the offer by the offeror. As an alternative to offering a discount for prompt payment in conjunction with the offer, offerors awarded contracts may include discounts for prompt payment on individual invoices.

(b) In connection with any discount offered for prompt payment, time shall be computed from the date of the invoice. If the Contractor has not placed a date on the invoice, the due date shall be calculated from the date the designated billing office receives a proper invoice, provided the agency annotates such invoice with the date of receipt at the time of receipt. For the purpose of computing the discount earned, payment shall be considered to have been made on the date that appears on the payment check or, for an electronic funds transfer, the specified payment date. When the discount date falls on a Saturday, Sunday, or legal holiday when Federal Government offices are closed and Government business is not expected to be conducted, payment may be made on the following business day.

SECTION 5.34
INTEREST (OCT 2010) (FAR 52.232-17) FEHBAR (JAN 1995)

(a) Except as otherwise provided in this contract under a Price Reduction for Defective Certified Cost or Pricing Data clause or a Cost Accounting Standards clause, all amounts that become payable by the Contractor to the Government under this contract shall bear simple interest from the date due until paid unless paid within 30 days of becoming due. The interest rate shall be the interest rate established by the Secretary of the Treasury as provided in Section 611 of the Contract Disputes Act of 1978 (Public Law 95-563), which is applicable to the period in which the amount becomes due, as provided in paragraph (e) of this clause, and then at the rate applicable for each six-month period as fixed by the Secretary until the amount is paid.

(b) The Government may issue a demand for payment to the Contractor upon finding a debt is due under the contract.

(c) Final Decisions. The Contracting Officer will issue a final decision as required by 33.211 if—

(1) The Contracting Officer and the Contractor are unable to reach agreement on the existence or amount of a debt in a timely manner;

(2) The Contractor fails to liquidate a debt previously demanded by the Contracting Officer within the timeline specified in the demand for payment unless the amounts were not repaid because the Contractor has requested an installment payment agreement; or

(3) The Contractor requests a deferment of collection on a debt previously demanded by the Contracting Officer (see 32.607-2).

(d) If a demand for payment was previously issued for the debt, the demand for payment included in the final decision shall identify the same due date as the original demand for payment.

(e) Amounts shall be due at the earliest of the following dates:

(1) The date fixed under this contract.

(2) The date of the first written demand for payment, including any demand resulting from a default termination.

(f) The interest charge shall be computed for the actual number of calendar days involved beginning on the due date and ending on—

(1) The date on which the designated office receives payment from the Contractor;

(2) The date of issuance of a Government check to the Contractor from which an amount otherwise payable has been withheld as a credit against the contract debt; or

(3) The date on which an amount withheld and applied to the contract debt would otherwise have become payable to the Contractor.

(c) The interest charge made under this clause may be reduced under the procedures prescribed in 32.608-2 of the Federal Acquisition Regulation in effect on the date of this contract.

SECTION 5.35
ASSIGNMENT OF CLAIMS (JAN 1986) (FAR 52.232-23)

(a) The Contractor, under the Assignment of Claims Act, as amended. 31 U.S.C. 3727, 41 U.S.C. 15 (hereafter referred to as "the Act"). may assign its rights to be paid amounts due or to become due as a result of the performance of this contract to a bank. trust company. or other financing institution, including any Federal lending agency. The assignee under such an assignment may thereafter further assign or reassign its right under the original assignment to any type of financing institution described in the preceding sentence.

(b) Any assignment or reassignment authorized under the Act and this clause shall cover all unpaid amounts payable under this contract. and shall not be made to more than one party. except that an assignment or reassignment may be made to one party as agent or trustee for two or more parties participating in the financing of this contract.

(c) The Contractor shall not furnish or disclose to any assignee under this contract any classified document (including this contract) or information related to work under this contract until the Contracting Officer authorizes such action in writing.

SECTION 5.36
DISPUTES (JUL 2002) (FAR 52.233-1)

(a) This contract is subject to the Contract Disputes Act of 1978. as amended (41 U.S.C. 601-613).

(b) Except as provided in the Act, all disputes arising under or relating to this contract shall be resolved under this clause.

(c) "Claim," as used in this clause, means a written demand or written assertion by one of the contracting parties seeking, as a matter of right, the payment of money in a sum certain, the adjustment or interpretation of contract terms, or other relief arising under or relating to this contract. However, a written demand or written assertion by the Contractor seeking the payment of money exceeding $100,000 is not a claim under the Act until certified. A voucher, invoice, or other routine request for payment that is not in dispute when submitted is not a claim under the Act. The submission may be converted to a claim under the Act, by complying with the submission and certification requirements of this clause, if it is disputed either as to liability or amount or is not acted upon in a reasonable time.

(d)(1) A claim by the Contractor shall be made in writing and, unless otherwise stated in this contract, submitted within 6 years after accrual of the claim to the Contracting Officer for a written decision. A claim by the Government against the Contractor shall be subject to a written decision by the Contracting Officer.

(2)(i) The Contractor shall provide the certification specified in paragraph (d)(2)(iii) of this clause when submitting any claim exceeding $100,000.

(ii) The certification requirement does not apply to issues in controversy that have not been submitted as all or part of a claim.

(iii) The certification shall state as follows: "I certify that the claim is made in good faith; that the supporting data are accurate and complete to the best of my knowledge and belief; that the amount requested accurately reflects the contract adjustment for which the Contractor believes the Government is liable; and that I am duly authorized to certify the claim on behalf of the Contractor."

(3) The certification may be executed by any person duly authorized to bind the Contractor with respect to the claim.

(e) For Contractor claims of $100,000 or less, the Contracting Officer must, if requested in writing by the Contractor, render a decision within 60 days of the request. For Contractor-certified claims over $100,000, the Contracting Officer must, within 60 days, decide the claim or notify the Contractor of the date by which the decision will be made.

(f) The Contracting Officer's decision shall be final unless the Contractor appeals or files a suit as provided in the Act.

(g) If the claim by the Contractor is submitted to the Contracting Officer or a claim by the Government is presented to the Contractor, the parties, by mutual consent, may agree to use alternative dispute resolution (ADR). If the Contractor refuses an offer for ADR, the Contractor shall inform the Contracting Officer, in writing, of the Contractor's specific reasons for rejecting the offer.

(h) The Government shall pay interest on the amount found due and unpaid from (1) the date that the Contracting Officer receives the claim (certified, if required); or (2) the date that payment otherwise would be due, if that date is later, until the date of payment. With regard to claims having defective certifications, as defined in FAR 33.201, interest shall be paid from the date that the Contracting Officer initially receives the claim. Simple interest on claims shall be paid at the rate, fixed by the Secretary of the Treasury as provided in the Act, which is applicable to the period during which the Contracting Officer receives the claim and then at the rate applicable for each 6-month period as fixed by the Treasury Secretary during the pendency of the claim.

(i) The Contractor shall proceed diligently with performance of this contract, pending final resolution of any request for relief, claim, appeal, or action arising under or relating to the contract, and comply with any decision of the Contracting Officer.

SECTION 5.37
NOTICE OF INTENT TO DISALLOW COSTS (APR 1984) (FAR 52.242-1)

(a) Notwithstanding any other clause of this contract--

(1) The Contracting Officer may at any time issue to the Contractor a written notice of intent to disallow specified costs incurred or planned for incurrence under this contract that have been determined not to be allowable under the contract terms; and

(2) The Contractor may, after receiving a notice under subparagraph (1) above, submit a written response to the Contracting Officer, with justification for allowance of the costs. If the Contractor does respond within 60 days, the Contracting Officer shall, within 60 days of receiving the response, either make a written withdrawal of the notice or issue a written decision.

(b) Failure to issue a notice under this Notice of Intent to Disallow Costs clause shall not affect the Government's right to take exception to incurred costs.

SECTION 5.38

CHANGES--NEGOTIATED BENEFITS CONTRACTS (JAN 1998) (FEHBAR 1652.243-70)

(a) The Contracting Officer may at any time, by written order, and without notice to the sureties, if any, make changes within the general scope of this contract in any one or more of the following:

(1) Description of services to be performed.

(2) Time of performance (i.e., hours of the day, days of the week, etc.).

(3) Place of performance of the services.

(b) If any such change causes an increase or decrease in the cost of, or the time required for, performance of any part of the work under this contract, whether or not changed by the order, the Contracting Officer shall make an equitable adjustment in the contract price, the delivery schedule, or both, and shall modify the contract.

(c) The Carrier must assert its right to an adjustment under this clause within 30 days from the date of receipt of the written order. However, if the Contracting Officer decides that the facts justify it, the Contracting Officer may receive and act upon a proposal submitted before final payment of the contract.

(d) Failure to agree to any adjustment shall be a dispute under the Disputes clause. However, nothing in this clause shall excuse the Carrier from proceeding with the contract as changed.

SECTION 5.39
COMPETITION IN SUBCONTRACTING (DEC 1996) (FAR 52.244-5)

(a) The Contractor shall select subcontractors (including suppliers) on a competitive basis to the maximum practical extent consistent with the objectives and requirements of the contract.

(b) If the Contractor is an approved mentor under the Department of Defense Pilot Mentor-Protégé Program (Pub. L. 101-510, section 831 as amended), the Contractor may award subcontracts under this contract on a noncompetitive basis to its protégés.

SECTION 5.40
GOVERNMENT PROPERTY (NEGOTIATED BENEFITS CONTRACTS) (JAN 1998) (FEHBAR 1652.245-70)

(a) Government-furnished property. (1) The Government shall deliver to the Carrier, for use in connection with and under the terms of this contract, the Government-furnished property described in this contract together with any related data and information that the Carrier may request and is reasonably required for the intended use of the property (hereinafter referred to as "Government-furnished property").

(2) The delivery or performance dates for this contract are based upon the expectation that Government-furnished property suitable for use (except for property furnished "as-is") will be delivered to the Carrier at the times stated in this contract or, if not so stated, in sufficient time to enable the Carrier to meet the contract's performance dates.

(3) If Government-furnished property is received by the Carrier in a condition not suitable for the intended use, the Carrier shall, upon receipt of it, notify the Contracting Officer, detailing the facts, and, as directed by the Contracting Officer and at Government expense, either repair, modify, return, or otherwise dispose of the property. After completing the directed action and

upon written request of the Carrier, the Contracting Officer shall make an equitable adjustment as provided in paragraph (h) of this clause.

(b) Changes in Government-furnished property. (1) The Contracting Officer may, by written notice, (i) decrease the Government-furnished property provided or to be provided under this contract, or (ii) substitute other Government-furnished property for the property to be provided by the Government, or to be acquired by the Carrier for the Government, under this contract. The Carrier shall promptly take such action as the Contracting Officer may direct regarding the removal, shipment, or disposal of the property covered by such notice.

(2) Upon the Carrier's written request, the Contracting Officer shall make an equitable adjustment to the contract in accordance with paragraph (h) of this clause, if the Government has agreed in this contract to make the property available for performing this contract and there is any -

(i) Decrease or substitution in this property pursuant to subparagraph (b)(1) above; or

(ii) Withdrawal of authority to use this property, if provided under any other contract or lease.

(c) Title in Government property. (1) The Government shall retain title to all Government-furnished property.

(2) All Government-furnished property and all property acquired by the Carrier, title to which vests in the Government under this paragraph (collectively referred to as "Government property"), are subject to the provisions of this clause. Title to Government property shall not be affected by its incorporation into or attachment to any property not owned by the Government, nor shall Government property become a fixture or lose its identity as personal property by being attached to any real property.

(d) Use of Government property. The Government property shall be used only for performing this contract, unless otherwise provided in this contract or approved by the Contracting Officer.

(e) Property administration. (1) The Carrier shall be responsible and accountable for all Government property provided under this contract and shall comply with Federal Acquisition Regulation (FAR) subpart 45.5, as in effect on the date of this contract.

(2) The Carrier shall establish and maintain a program for the use, maintenance, repair, protection, and preservation of Government property in accordance with sound industrial practice and the applicable provisions of subpart 45.5 of the FAR.

(3) If damage occurs to Government property, the risk of which has been assumed by the Government under this contract, the Government shall replace the items or the Carrier shall make such repairs as the Government directs. However, if the Carrier cannot effect such repairs within the time required, the Carrier shall dispose of the property as directed by the Contracting Officer. When any property for which the Government is responsible is replaced or repaired, the Contracting Officer shall make an equitable adjustment in accordance with paragraph (h) of this clause.

(4) The Carrier represents that the contract price does not include any amount for repairs or replacement for which the Government is responsible. Repair or replacement of property for which the Carrier is responsible shall be accomplished by the Carrier at its own expense.

(f) Access. The Government and all its designees shall have access at all reasonable times to the premises in which any Government property is located for the purpose of inspecting the Government property.

(g) Risk of loss. Unless otherwise provided in this contract, the Carrier assumes the risk of, and shall be responsible for, any loss or destruction of, or damage to, Government property upon its delivery to the Carrier. However, the Carrier is not responsible for reasonable wear and tear

to Government property or for Government property properly consumed in performing this contract.

(h) Equitable adjustment. When this clause specifies an equitable adjustment, it shall be made to any affected contract provision in accordance with the procedures of the Changes clause. When appropriate, the Contracting Officer may initiate an equitable adjustment in favor of the Government. The right to an equitable adjustment shall be the Carrier's exclusive remedy. The Government shall not be liable to suit for breach of contract for --

(1) Any delay in delivery of Government-furnished property;

(2) Delivery of Government-furnished property in a condition not suitable for its intended use;

(3) A decrease in or substitution of Government-furnished property; or

(4) Failure to repair or replace Government property for which the Government is responsible.

(i) Final accounting and disposition of Government property. Upon completing this contract, or at such earlier dates as may be fixed by the Contracting Officer, the Carrier shall submit, in a form acceptable to the Contracting Officer, inventory schedules covering all items of Government property (including any resulting scrap) not consumed in performing this contract or delivered to the Government. The Carrier shall prepare for shipment, deliver f.o.b. origin, or dispose of the Government property as may be directed or authorized by the Contracting Officer. The net proceeds of any such disposal shall be credited to the contract price or shall be paid to the Government as the Contracting Officer directs.

(j) Abandonment and restoration of Carrier's premises. Unless otherwise provided herein, the Government -

(1) May abandon any Government property in place, at which time all obligations of the Government regarding such abandoned property shall cease; and

(2) Has no obligation to restore or rehabilitate the Carrier's premises under any circumstances (e.g., abandonment, disposition upon completion of need, or upon contract completion). However, if the Government-furnished property is withdrawn or is unsuitable for the intended use, or if other Government property is substituted, then the equitable adjustment under paragraph (h) of this clause may properly include restoration or rehabilitation costs.

(k) Communications. All communications under this clause shall be in writing.

(l) Overseas contracts. If this contract is to be performed outside of the United States of America, its territories, or possessions, the words "Government" and "Government- furnished" (wherever they appear in this clause) shall be construed as "United States Government" and "United States Government-furnished", respectively.

SECTION 5.41
LIMITATION OF LIABILITY -- SERVICES (FEB 1997) (FAR 52.246-25)

(a) Except as provided in paragraphs (b) and (c) below, and except to the extent that the Contractor is expressly responsible under this contract for deficiencies in the services required to be performed under it (including any materials furnished in conjunction with those services), the Contractor shall not be liable for loss of or damage to property of the Government that (1) occurs after Government acceptance of services performed under this contract and (2) results from any defects or deficiencies in the services performed or materials furnished.

(b) The limitation of liability under paragraph (a) above shall not apply when a defect or deficiency in, or the Government's acceptance of, services performed or materials furnished results from willful misconduct or lack of good faith on the part of any of the Contractor's managerial

personnel. The term Contractor's managerial personnel, as used in this clause, means the Contractor's directors, officers, and any of the Contractor's managers, superintendents, or equivalent representatives who have supervision or direction of --

(1) All or substantially all of the Contractor's business;

(2) All or substantially all of the Contractor's operations at any one plant, laboratory, or separate location at which the contract is being performed; or

(3) A separate and complete major industrial operation connected with the performance of this contract.

(c) If the Contractor carries insurance, or has established a reserve for self-insurance, covering liability for loss or damage suffered by the Government through the Contractor's performance of services or furnishing of materials under this contract, the Contractor shall be liable to the Government, to the extent of such insurance or reserve, for loss of or damage to property of the Government occurring after Government acceptance of, and resulting from any defects and deficiencies in, services performed or materials furnished under this contract.

SECTION 5.42
PREFERENCE FOR U.S.-FLAG AIR CARRIERS (JUN 2003) (FAR 52.247-63)

(a) *Definitions*. As used in this clause-

"International air transportation" means transportation by air between a place in the United States and a place outside the United States or between two places both of which are outside the United States.

"United States" means the 50 States, the District of Columbia, and outlying areas.

"U.S.-flag air carrier" means an air carrier holding a certificate under 49 U.S.C. Chapter 411.

(b) Section 5 of the International Air Transportation Fair Competitive Practices Act of 1974 (49 U.S.C. 40118) (Fly America Act) requires that all Federal agencies and Government contractors and subcontractors use U.S.-flag air carriers for U.S. Government-financed international air transportation of personnel (and their personal effects) or property, to the extent that service by those carriers is available. It requires the Comptroller General of the United States, in the absence of satisfactory proof of the necessity for foreign-flag air transportation, to disallow expenditures from funds, appropriated or otherwise established for the account of the United States, for international air transportation secured aboard a foreign-flag air carrier if a U.S.-flag air carrier is available to provide such services.

(c) If available, the Contractor, in performing work under this contract, shall use U.S.-flag carriers for international air transportation of personnel (and their personal effects) or property.

(d) In the event that the Contractor selects a carrier other than a U.S.-flag air carrier for international air transportation, the Contractor shall include a statement on vouchers involving such transportation essentially as follows:

STATEMENT OF UNAVAILABILITY OF U.S.-FLAG AIR CARRIERS

International air transportation of persons (and their personal effects) or property by U.S.-flag air carrier was not available or it was necessary to use foreign-flag air carrier service for the following reasons (see section 47.403 of the Federal Acquisition Regulation):

(State reasons):
(End of statement)

(e) The Contractor shall include the substance of this clause, including this paragraph (e), in each subcontract or purchase under this contract that may involve international air transportation.

SECTION 5.43
GOVERNMENT SUPPLY SOURCES (AUG 2010) (FAR 52.251-1)

The Contracting Officer may issue the Contractor an authorization to use Government supply sources in the performance of this contract. Title to all property acquired by the Contractor under such an authorization shall vest in the Government unless otherwise specified in the contract. Such property shall not be considered to be Government-furnished property, as distinguished from Government property. The provisions of the clause entitled "Government Property," at 52.245-1, shall apply to all property acquired under such authorization.

SECTION 5.44
AUTHORIZED DEVIATIONS IN CLAUSES (APR 1984) (FAR 52.252-6)

(a) The use in this solicitation or contract of any Federal Acquisition Regulation (48 CFR Chapter 1) clause with an authorized deviation is indicated by the addition of "(DEVIATION)" after the date of the clause.

(b) The use in this solicitation or contract of any Federal Employees Health Benefits Acquisition Regulation (48 CFR Chapter 16) clause with an authorized deviation is indicated by the addition of "(DEVIATION)" after the name of the regulation.

SECTION 5.45
LIMITATION ON PAYMENTS TO INFLUENCE CERTAIN FEDERAL TRANSACTIONS (OCT 2010) (FAR 52.203-12)

(a) *Definitions*. As used in this clause—

"Agency" means "executive agency" as defined in Federal Acquisition Regulation (FAR) 2.101.

"Covered Federal action" means any of the following actions:

(1) Awarding any Federal contract.

(2) Making any Federal grant.

(3) Making any Federal loan.

(4) Entering into any cooperative agreement.

(5) Extending, continuing, renewing, amending, or modifying any Federal contract, grant, loan, or cooperative agreement.

"Indian tribe" and "tribal organization" have the meaning provided in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b) and include Alaskan Natives.

"Influencing or attempting to influence" means making, with the intent to influence, any communication to or appearance before an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any covered Federal action.

"Local government" means a unit of government in a State and, if chartered, established, or otherwise recognized by a State for the performance of a governmental duty, including a local public authority, a special district, an intrastate district, a council of governments, a sponsor group representative organization, and any other instrumentality of a local government.

"Officer or employee of an agency" includes the following individuals who are employed by an agency:

(1) An individual who is appointed to a position in the Government under Title 5, United States Code, including a position under a temporary appointment.

(2) A member of the uniformed services, as defined in subsection 101(3), Title 37, United States Code.

(3) A special Government employee, as defined in section 202, Title 18, United States Code.

(4) An individual who is a member of a Federal advisory committee, as defined by the Federal Advisory Committee Act, Title 5, United States Code, appendix 2.

"Person" means an individual, corporation, company, association, authority, firm, partnership, society, State, and local government, regardless of whether such entity is operated for profit, or not for profit. This term excludes an Indian tribe, tribal organization, or any other Indian organization eligible to receive Federal contracts, grants, cooperative agreements, or loans from an agency, but only with respect to expenditures by such tribe or organization that are made for purposes specified in paragraph (b) of this clause and are permitted by other Federal law.

"Reasonable compensation" means, with respect to a regularly employed officer or employee of any person, compensation that is consistent with the normal compensation for such officer or employee for work that is not furnished to, not funded by, or not furnished in cooperation with the Federal Government.

"Reasonable payment" means, with respect to professional and other technical services, a payment in an amount that is consistent with the amount normally paid for such services in the private sector.

"Recipient" includes the Contractor and all subcontractors. This term excludes an Indian tribe, tribal organization, or any other Indian organization eligible to receive Federal contracts, grants, cooperative agreements, or loans from an agency, but only with respect to expenditures by such tribe or organization that are made for purposes specified in paragraph (b) of this clause and *are* permitted by other Federal law.

"Regularly employed" means, with respect to an officer or employee of a person requesting or receiving a Federal contract, an officer or employee who is employed by such person for at least 130 working days within 1 year immediately preceding the date of the submission that initiates agency consideration of such person for receipt of such contract. An officer or employee who is employed by such person for less than 130 working days within 1 year immediately preceding the date of the submission that initiates agency consideration of such person shall be considered to be regularly employed as soon as he or she is employed by such person for 130 working days.

"State" means a State of the United States, the District of Columbia, or an outlying area of the United States, an agency or instrumentality of a State, and multi-State, regional, or interstate entity having governmental duties and powers.

(b) *Prohibition.* 31 U.S.C. 1352 prohibits a recipient of a Federal contract, grant, loan, or cooperative agreement from using appropriated funds to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any

covered Federal actions. In accordance with 31 U.S.C. 1352 the Contractor shall not use appropriated funds to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of this contractor the extension, continuation, renewal, amendment, or modification of this contract.

(1) The term *appropriated funds* does not include profit or fee from a covered Federal action.

(2) To the extent the Contractor can demonstrate that the Contractor has sufficient monies, other than Federal appropriated funds, the Government will assume that these other monies were spent for any influencing activities that would be unallowable if paid for with Federal appropriated funds.

(c) *Exceptions*. The prohibition in paragraph (b) of this clause does not apply under the following conditions:

(1) *Agency and legislative liaison by Contractor employees*.

(i) Payment of reasonable compensation made to an officer or employee of the Contractor if the payment is for agency and legislative liaison activities not directly related to this contract. For purposes of this paragraph, providing any information specifically requested by an agency or Congress is permitted at any time.

(ii) Participating with an agency in discussions that are not related to a specific solicitation for any covered Federal action, but that concern—

(A) The qualities and characteristics (including individual demonstrations) of the person's products or services, conditions or terms of sale, and service capabilities; or

(B) The application or adaptation of the person's products or services for an agency's use.

(iii) Providing prior to formal solicitation of any covered Federal action any information not specifically requested but necessary for an agency to make an informed decision about initiation of a covered Federal action;

(iv) Participating in technical discussions regarding the preparation of an unsolicited proposal prior to its official submission; and

(v) Making capability presentations prior to formal solicitation of any covered Federal action by persons seeking awards from an agency pursuant to the provisions of the Small Business Act, as amended by Pub. L. 95-507, and subsequent amendments.

(2) *Professional and technical services*.

(i) A payment of reasonable compensation made to an officer or employee of a person requesting or receiving a covered Federal action or an extension, continuation, renewal, amendment, or modification of a covered Federal action, if payment is for professional or technical services rendered directly in the preparation, submission, or negotiation of any bid, proposal, or application for that Federal action or for meeting requirements imposed by or pursuant to law as a condition for receiving that Federal action.

(ii) Any reasonable payment to a person, other than an officer or employee of a person requesting or receiving a covered Federal action or an extension, continuation, renewal, amendment, or modification of a covered Federal action if the payment is for professional or technical services rendered directly in the preparation, submission, or negotiation of any bid, proposal, or application for that Federal action or for meeting requirements imposed by or pursuant to law as a condition for receiving that Federal action. Persons other than officers or

employees of a person requesting or receiving a covered Federal action include consultants and trade associations.

(iii) As used in paragraph (c)(2) of this clause, "professional and technical services" are limited to advice and analysis directly applying any professional or technical discipline (for examples, see FAR 3.803(a)(2)(iii)).

(iv) Requirements imposed by or pursuant to law as a condition for receiving a covered Federal award include those required by law or regulation and any other requirements in the actual award documents.

(3) Only those communications and services expressly authorized by paragraphs (c)(1) and (2) of this clause are permitted.

(d) *Disclosure*.

(1) If the Contractor did not submit OMB Standard Form LLL, Disclosure of Lobbying Activities, with its offer, but registrants under the Lobbying Disclosure Act of 1995 have subsequently made a lobbying contact on behalf of the Contractor with respect to this contract, the Contractor shall complete and submit OMB Standard Form LLL to provide the name of the lobbying registrants, including the individuals performing the services.

(2) If the Contractor did submit OMB Standard Form LLL disclosure pursuant to paragraph (d) of the provision at FAR 52.203-11, Certification and Disclosure Regarding Payments to Influence Certain Federal Transactions, and a change occurs that affects Block 10 of the OMB Standard Form LLL (name and address of lobbying registrant or individuals performing services), the Contractor shall, at the end of the calendar quarter in which the change occurs, submit to the Contracting Officer within 30 days an updated disclosure using OMB Standard Form LLL.

(e) *Penalties*.

(1) Any person who makes an expenditure prohibited under paragraph (b) of this clause or who fails to file or amend the disclosure to be filed or amended by paragraph (d) of this clause shall be subject to civil penalties as provided for by 31 U.S.C. 1352. An imposition of a civil penalty does not prevent the Government from seeking any other remedy that may be applicable.

(2) Contractors may rely without liability on the representation made by their subcontractors in the certification and disclosure form.

(f) *Cost allowability*. Nothing in this clause makes allowable or reasonable any costs which would otherwise be unallowable or unreasonable. Conversely, costs made specifically unallowable by the requirements in this clause will not be made allowable under any other provision.

(g) *Subcontracts*.

(1) The Contractor shall obtain a declaration, including the certification and disclosure in paragraphs (c) and (d) of the provision at FAR 52.203-11, Certification and Disclosure Regarding Payments to Influence Certain Federal Transactions, from each person requesting or receiving a subcontract exceeding $150,000 under this contract. The Contractor or subcontractor that awards the subcontract shall retain the declaration.

(2) A copy of each subcontractor disclosure form (but not certifications) shall be forwarded from tier to tier until received by the prime Contractor. The prime Contractor shall, at the end of the calendar quarter in which the disclosure form is submitted by the subcontractor, submit to the Contracting Officer within 30 days a copy of all disclosures. Each subcontractor certification shall be retained in the subcontract file of the awarding Contractor.

(3) The Contractor shall include the substance of this clause, including this paragraph (g), in any subcontract exceeding $150,000.

SECTION 5.46
[RESERVED]

SECTION 5.47
PROTECTING THE GOVERNMENT'S INTEREST WHEN SUBCONTRACTING WITH CONTRACTORS DEBARRED, SUSPENDED OR PROPOSED FOR DEBARMENT (DEC 2010) (FAR 52.209-6)

(a) *Definition. Commercially available off-the-shelf (COTS)* item, as used in this clause—

(1) Means any item of supply (including construction material) that is—

(i) A commercial item (as defined in paragraph (1) of the definition in FAR 2.101);

(ii) Sold in substantial quantities in the commercial marketplace; and

(iii) Offered to the Government, under a contract or subcontract at any tier, without modification, in the same form in which it is sold in the commercial marketplace; and

(2) Does not include bulk cargo, as defined in section 3 of the Shipping Act of 1984 (46 U.S.C. App. 1702), such as agricultural products and petroleum products.

(b) The Government suspends or debars Contractors to protect the Government's interests. Other than a subcontract for a commercially available off-the-shelf item, the Contractor shall not enter into any subcontract, in excess of $30,000 with a Contractor that is debarred, suspended, or proposed for debarment by any executive agency unless there is a compelling reason to do so.

(c) The Contractor shall require each proposed subcontractor whose subcontract will exceed $30,000, other than a subcontractor providing a commercially available off-the-shelf item, to disclose to the Contractor, in writing, whether as of the time of award of the subcontract, the subcontractor, or its principals, is or is not debarred, suspended, or proposed for debarment by the Federal Government.

(d) A corporate officer or a designee of the Contractor shall notify the Contracting Officer, in writing, before entering into a subcontract with a party (other than a subcontractor providing a commercially available off-the-shelf item) that is debarred, suspended, or proposed for debarment (*see* FAR 9.404 for information on the Excluded Parties List System). The notice must include the following:

(1) The name of the subcontractor.

(2) The Contractor's knowledge of the reasons for the subcontractor being in the Excluded Parties List System.

(3) The compelling reason(s) for doing business with the subcontractor notwithstanding its inclusion in the Excluded Parties List System.

(4) The systems and procedures the Contractor has established to ensure that it is fully protecting the Government's interests when dealing with such subcontractor in view of the specific basis for the party's debarment, suspension, or proposed debarment.

(e) *Subcontracts.* Unless this is a contract for the acquisition of commercial items, the Contractor shall include the requirements of this clause, including this paragraph (e) (appropriately modified for the identification of the parties), in each subcontract that—

(1) Exceeds $30,000 in value; and
(2) Is not a subcontract for commercially available off-the-shelf items.

SECTION 5.48
BANKRUPTCY (JUL 1995) (FAR 52.242-13)

In the event the Contractor enters into proceedings relating to bankruptcy, whether voluntary or involuntary, the Contractor agrees to furnish, by certified mail or electronic commerce method authorized by the contract, written notification of the bankruptcy to the Contracting Office responsible for administering the contract. This notification shall be furnished within five days of the initiation of the proceedings relating to bankruptcy filing. This notification shall include the date on which the bankruptcy petition was filed, the identity of the court in which the bankruptcy petition was filed, and a listing of Government contract numbers and contracting offices for all Government contracts against which final payment has not been made. This obligation remains in effect until final payment under this contract.

SECTION 5.49
FEHBP TERMINATION FOR CONVENIENCE OF THE GOVERNMENT--NEGOTIATED BENEFITS CONTRACTS (JAN 1998) (FEHBAR 1652.249-71)

(a) The Government may terminate performance of work under this contract in whole or, from time to time, in part if the Contracting Officer determines that a termination is in the Government's interest. The Contracting Officer shall terminate by delivering to the Carrier a Notice of Termination specifying the extent of terminating and the effective date.
(b) After receipt of a Notice of Termination, and except as directed by the Contracting Officer, the Carrier shall immediately proceed with the following obligations, regardless of any delay in determining or adjusting any amounts due under this clause:
(1) Stop work as specified in the notice.
(2) Place no further subcontracts except as necessary to complete the continued portion of the contract.
(3) Terminate all subcontracts to the extent they relate to the work terminated.
(4) Assign to the Government, as directed by the Contracting Officer, all right, title, and interest of the Carrier under the subcontracts terminated, in which case the Government shall have the right to settle or to pay any termination settlement proposal arising out of those terminations.
(5) With approval or ratification to the extent required by the Contracting Officer, settle all outstanding liabilities and termination settlement proposals arising from the termination of subcontracts; the approval or ratification will be final for purposes of this clause.
(6) As directed by the Contracting Officer, deliver to the Government any data, reports, or studies that, if the contract had been completed, would be required to be furnished to the Government.
(7) Complete performance of the work not terminated.
(c) After termination, the Carrier shall submit a final termination settlement proposal to the Contracting Officer in the form and with the certification prescribed by the Contracting Officer. The Carrier shall submit the proposal promptly, but no later than 1 year from the effective date of termination, unless extended in writing by the Contracting Officer upon written request of the

Carrier within this 1-year period. However, if the Contracting Officer determines that the facts justify it, a termination settlement proposal may be received and acted on after 1 year or any extension. If the Carrier fails to submit the proposal within the time allowed, the Contracting Officer may determine, on the basis of information available, the amount, if any, due the Carrier because of the termination and shall pay the amount determined.

(d) Subject to paragraph (c) of this clause, the Carrier and the Contracting Officer may agree upon the whole or any part of the amount to be paid or remaining to be paid because of the termination. The amount may include a reasonable allowance for profit on work done. However, the agreed amount, whether under this paragraph (d) or paragraph (e) of this clause, exclusive of costs shown in subparagraph (e)(3) of this clause, may not exceed the total contract price as reduced by (1) the amount of payments previously made and (2) the contract price of work not terminated. The contract shall be modified, and the Carrier paid the agreed amount. Paragraph (e) of this clause shall not limit, restrict, or affect the amount that may be agreed upon to be paid under this paragraph.

(e) If the Carrier and the Contracting Officer fail to agree on the whole amount to be paid because of the termination of work, the Contracting Officer shall pay the Carrier the amounts determined by the Contracting Officer as follows, but without duplication of any amounts agreed on under paragraph (d) above:

(1) The contract price for completed services accepted by the Government not previously paid for.

(2) The total of--

(i) The costs incurred in the performance of the work terminated, including initial costs and preparatory expense allocable thereto, but excluding any costs attributable to services paid or to be paid under paragraph (e)(1) of this clause;

(ii) The cost of settling and paying termination settlement proposals under terminated subcontracts that are properly chargeable to the terminated portion of the contract if not included in subdivision (e)(2)(i) of this clause; and

(iii) A sum, as profit on subdivision (e)(2)(i) of this clause, determined by the Contracting Officer under 49.202 of the Federal Acquisition Regulation, in effect on the date of this contract, to be fair and reasonable.

(3) The reasonable costs of settlement of the work terminated, including--

(i) Accounting, legal, clerical, and other expenses reasonably necessary for the preparation of termination settlement proposals and supporting data;

(ii) The termination and settlement of subcontracts (excluding the amounts of such settlements); and

(f) The cost principles and procedures of part 31 of the Federal Acquisition Regulation, in effect on the date of this contract, shall govern all costs claimed, agreed to, or determined under this clause.

(g) The Carrier shall have the right of appeal, under the Disputes clause, from any determination made by the Contracting Officer under paragraph (c), (e), or (i) of this clause, except that if the Carrier failed to submit the termination settlement proposal or request for equitable adjustment within the time provided in paragraph (c) or (i), respectively, and failed to request a time extension, there is no right of appeal.

(h) In arriving at the amount due the Carrier under this clause, there shall be deducted--

(1) All unliquidated advance or other payments to the Carrier under the terminated portion of this contract;

(2) Any claim which the Government has against the Carrier under this contract; and

(i) If the termination is partial, the Carrier may file a proposal with the Contracting Officer for an equitable adjustment of the price(s) of the continued portion of the contract. The Contracting Officer shall make any equitable adjustment agreed upon. Any proposal by the Carrier for an equitable adjustment under this clause shall be requested within 90 days from the effective date of termination unless extended in writing by the Contracting Officer.

(j)(1) The Government may, under the terms and conditions it prescribes, make partial payments and payments against costs incurred by the Carrier for the terminated portion of the contract, if the Contracting Officer believes the total of these payments will not exceed the amount to which the Carrier will be entitled.

(2) If the total payments exceed the amount finally determined to be due, the Carrier shall repay the excess to the Government upon demand, together with interest computed at the rate established by the Secretary of the Treasury under 50 U.S.C. App. 1215(b)(2). Interest shall be computed for the period from the date the excess payment is received by the Carrier to the date the excess is repaid.

(k) Unless otherwise provided in this contract or by statute, the Carrier shall maintain all records and documents relating to the terminated portion of this contract for 3 years after final settlement. This includes all books and other evidence bearing on the Carrier's costs and expenses under this contract. The Carrier shall make these records and documents available to the Government, at the Carrier's office, at all reasonable times, without any direct charge. If approved by the Contracting Officer, photographs, microphotographs, or other authentic reproductions may be maintained instead of original records and documents.

SECTION 5.50
FEHBP TERMINATION FOR DEFAULT-- NEGOTIATED BENEFITS CONTRACTS (JAN 1998) (FEHBAR 1652.249-72)

(a) (1) The Government may, subject to paragraphs (c) and (d) below, by written notice of default to the Carrier, terminate this contract in whole or in part if the Carrier fails to--

(i) Perform the services within the time specified in this contract or any extension;

(ii) Make progress, so as to endanger performance of this contract (but see subparagraph (a)(2) below); or

(iii) Perform any of the other provisions of this contract (but see subparagraph (a)(2) below).

(2) The Government's right to terminate this contract under subdivisions (1)(ii) and (1)(iii) above, may be exercised if the Carrier does not cure such failure within 10 days (or more if authorized in writing by the Contracting Officer) after receipt of the notice from the Contracting Officer specifying the failure.

(b) If the Government terminates this contract in whole or in part, it may acquire, under the terms and in the manner the Contracting Officer considers appropriate, supplies or service similar to those terminated, and the Carrier will be liable to the Government for any excess costs for those supplies or services. However, the Carrier shall continue the work not terminated.

(c) Except for defaults of subcontractors at any tier, the Carrier shall not be liable for any excess costs if the failure to perform the contract arises from causes beyond the control and without the fault or negligence of the Carrier. Examples of such causes include (1) acts of God or of the public enemy, (2) acts of the Government in either its sovereign or contractual capacity, (3) fires, (4) floods, (5) epidemics, (6) quarantine restrictions, (7) strikes, (8) freight embargoes,

and (9) unusually severe weather. In each instance the failure to perform must be beyond the control and without the fault or negligence of the Carrier.

(d) If the failure to perform is caused by the default of a subcontractor at any tier, and if the cause of the default is beyond the control of both the Carrier and subcontractor, and without the fault or negligence of either, the Carrier shall not be liable for any excess costs for failure to perform, unless the subcontracted supplies or services were obtainable from other sources in sufficient time for the Carrier to meet the required delivery schedule.

(e) If this contract is terminated for default, the Government may require the Carrier to transfer title and deliver to the Government, as directed by the Contracting Officer, any completed or partially completed information and contract rights that the Carrier has specifically produced or acquired for the terminated portion of this contract.

(f) If, after termination, it is determined that the Carrier was not in default, or that the default was excusable, the rights and obligations of the parties shall be the same as if the termination had been issued for the convenience of the Government.

(g) The rights and remedies of the Government in this clause are in addition to any other rights and remedies provided by law or under this contract.

SECTION 5.51
PENSION ADJUSTMENTS AND ASSET REVERSIONS (OCT 2010) (FAR 52.215-15)

(a) The Contractor shall promptly notify the Contracting Officer in writing when it determines that it will terminate a defined benefit pension plan or otherwise recapture such pension fund assets.

(b) For segment closings, pension plan terminations, or curtailment of benefits, the amount of the adjustment shall be-

(1) For contracts and subcontracts that are subject to full coverage under Cost Accounting Standards (CAS) Board rules and regulations (48 CFR Chapter 99), the amount measured, assigned, and allocated in accordance with 48 CFR 9904.413-50(c)(12); and

(2) For contracts and subcontracts that are not subject to full coverage under CAS, the amount measured, assigned, and allocated in accordance with 48 CFR 9904.413-50(c)(12), except the numerator of the fraction at 48 CFR 9904.413-50(c)(12)(vi)shall be the sum of the pension plan costs allocated to all non-CAS-covered contracts and subcontracts that are subject to Federal Acquisition Regulation (FAR) Subpart 31.2 or for which certified cost or pricing data were submitted.

(c) For all other situations where assets revert to the Contractor, or such assets are constructively received by it for any reason, the Contractor shall, at the Government's option, make a refund or give a credit to the Government for its equitable share of the gross amount withdrawn. The Government's equitable share shall reflect the Government's participation in pension costs through those contracts for which certified cost or pricing data were submitted or that are subject to FAR Subpart 31.2.

(d) The Contractor shall include the substance of this clause in all subcontracts under this contract that meet the applicability requirement of FAR 15.408(g).

SECTION 5.52
REVERSION OR ADJUSTMENT OF PLANS FOR POSTRETIREMENT BENEFITS (PRB) OTHER THAN PENSIONS (JUL 2005) (FAR 52.215-18)

(a) The Contractor shall promptly notify the Contracting Officer in writing when it determines that it will terminate or reduce a PRB plan.

(b) If PRB fund assets revert, or inure to the Contractor, or are constructively received by it under a plan termination or otherwise, the Contractor shall make a refund or give a credit to the Government for its equitable share as required by 31.205-6(o)(6) of the Federal Acquisition Regulation (FAR). When determining or agreeing on the method for recovery of the Government's equitable share, the contracting parties should consider the following methods: cost reduction, amortizing the credit over a number of years (with appropriate interest), cash refund, or some other agreed upon method. Should the parties be unable to agree on the method for recovery of the Government's equitable share, through good faith negotiations, the Contracting Officer shall designate the method of recovery.

(c)The Contractor shall insert the substance of this clause in all subcontracts that meet the applicability requirements of FAR 15.408(j).

SECTION 5.53
NOTICE TO THE GOVERNMENT OF LABOR DISPUTES (FEB 1997) (FAR 52.222-1)

If the Contractor has knowledge that any actual or potential labor dispute is delaying or threatens to delay the timely performance of this contract, the Contractor shall immediately give notice, including all relevant information, to the Contracting Officer.

SECTION 5.54
PENALTIES FOR UNALLOWABLE COSTS (MAY 2001) (FAR 52.242-3)

(a) Definition. Proposal, as used in this clause, means either --

(1) A final indirect cost rate proposal submitted by the Contractor after the expiration of its fiscal year which--

(i) Relates to any payment made on the basis of billing rates; or

(ii) Will be used in negotiating the final contract price; or

(2) The final statement of costs incurred and estimated to be incurred under the Incentive Price Revision clause (if applicable), which is used to establish the final contract price.

(b) Contractors which include unallowable indirect costs in a proposal may be subject to penalties. The penalties are prescribed in 10 U.S.C. 2324 or 41 U.S.C. 256, as applicable, which is implemented in Section 42.709 of the Federal Acquisition Regulation (FAR).

(c) The Contractor shall not include in any proposal any cost that is unallowable, as defined in Subpart 2.1of the FAR, or an executive agency supplement to the FAR.

(d) If the Contracting Officer determines that a cost submitted by the Contractor in its proposal is expressly unallowable under a cost principle in the FAR, or an executive agency supplement to the FAR, that defines the allowability of specific selected costs, the Contractor shall be assessed a penalty equal to--

(1) The amount of the disallowed cost allocated to this contract; plus

(2) Simple interest, to be computed--

(i) On the amount the Contractor was paid (whether as a progress or billing payment) in excess of the amount to which the Contractor was entitled; and

(ii) Using the applicable rate effective for each six-month interval prescribed by the Secretary of the Treasury pursuant to Pub. L. 92-41 (85 Stat. 97).

(e) If the Contracting Officer determines that a cost submitted by the Contractor in its proposal includes a cost previously determined to be unallowable for that Contractor, then the Contractor will be assessed a penalty in an amount equal to two times the amount of the disallowed cost allocated to this contract.

(f) Determinations under paragraphs (d) and (e) of this clause are final decisions within the meaning of the Contract Disputes Act of 1978 (41 U.S.C. 601, et seq.).

(g) Pursuant to the criteria in FAR 42.709-5, the Contracting Officer may waive the penalties in paragraph (d) or (e) of this clause.

(h) Payment by the Contractor of any penalty assessed under this clause does not constitute repayment to the Government of any unallowable cost which has been paid by the Government to the Contractor.

SECTION 5.55
EMPLOYMENT REPORTS ON VETERANS (SEP 2010) (FAR 52.222-37)

(a) *Definitions.* As used in this clause, "Armed Forces service medal veteran," "disabled veteran," "other protected veteran," and "recently separated veteran," have the meanings given in the Equal Opportunity for Veterans clause 52.222–35.

(b) Unless the Contractor is a State or local government agency, the Contractor shall report at least annually, as required by the Secretary of Labor, on—

(1) The total number of employees in the contractor's workforce, by job category and hiring location, who are disabled veterans, other protected veterans, Armed Forces service medal veterans, and recently separated veterans.

(2) The total number of new employees hired during the period covered by the report, and of the total, the number of disabled veterans, other protected veterans, Armed Forces service medal veterans, and recently separated veterans; and

(3) The maximum number and the minimum number of employees of the Contractor or subcontractor at each hiring location during the period covered by the report.

(c) The Contractor shall report the above items by completing the Form VETS-100A, entitled "Federal Contractor Veterans' Employment Report (VETS-100A Report)."

(d) The Contractor shall submit VETS-100A Reports no later than September 30 of each year.

(e) The employment activity report required by paragraphs (b)(2) and (b)(3) of this clause shall reflect total new hires, and maximum and minimum number of employees, during the most recent 12-month period preceding the ending date selected for the report. Contractors may select an ending date—

(1) As of the end of any pay period between July 1 and August 31 of the year the report is due; or

(2) As of December 31, if the Contractor has prior written approval from the Equal Employment Opportunity Commission to do so for purposes of submitting the Employer Information Report EEO-1 (Standard Form 100).

(f) The number of veterans reported must be based on data known to the contractor when completing the VETS–100A. The contractor's knowledge of veterans status may be obtained in a variety of ways, including an invitation to applicants to self-identify (in accordance with 41 CFR 60–300.42), voluntary self-disclosure by employees, or actual knowledge of veteran status by the

contractor. This paragraph does not relieve an employer of liability for discrimination under 38 U.S.C. 4212.

(g) The Contractor shall insert the terms of this clause in subcontracts of $100,000 or more unless exempted by rules, regulations, or orders of the Secretary of Labor.

SECTION 5.56
AUTHORIZATION AND CONSENT (DEC 2007) (FAR 52.227-1)

(a) The Government authorizes and consents to all use and manufacture, in performing this contract or any subcontract at any tier, of any invention described in and covered by a United States patent—

(1) Embodied in the structure or composition of any article the delivery of which is accepted by the Government under this contract; or

(2) Used in machinery, tools, or methods whose use necessarily results from compliance by the Contractor or a subcontractor with (i) specifications or written provisions forming a part of this contract or (ii) specific written instructions given by the Contracting Officer directing the manner of performance. the entire liability to the Government for infringement of a United States patent shall be determined solely by the provisions of the indemnity clause, if any, included in this contract or any subcontract hereunder (including any lower-tier subcontract), and the Government assumes liability for all other infringement to the extent of the authorization and consent hereinabove granted.

(b) The Contractor shall include the substance of this clause, including this paragraph (b), in all subcontracts that are expected to exceed the simplified acquisition threshold. However, omission of this clause from any subcontract, including those at or below the simplified acquisition threshold, does not affect this authorization and consent.

SECTION 5.57
NOTICE AND ASSISTANCE REGARDING PATENT AND COPYRIGHT INFRINGEMENT (DEC 2007) (FAR 52.227-2)

a) The Contractor shall report to the Contracting Officer, promptly and in reasonable written detail, each notice or claim of patent or copyright infringement based on the performance of this contract of which the Contractor has knowledge.

(b) In the event of any claim or suit against the Government on account of any alleged patent or copyright infringement arising out of the performance of this contract or out of the use of any supplies furnished or work or services performed under this contract, the Contractor shall furnish to the Government, when requested by the Contracting Officer, all evidence and information in the Contractor's possession pertaining to such claim or suit. Such evidence and information shall be furnished at the expense of the Government except where the Contractor has agreed to indemnify the Government.

(c) The Contractor shall include the substance of this clause, including this paragraph (c), in all subcontracts that are expected to exceed the simplified acquisition threshold.

SECTION 5.58
PAYMENT BY ELECTRONIC FUNDS TRANSFER--CENTRAL CONTRACTOR REGISTRATION (OCT 2003)(FAR 52.232-33)

(a) *Method of payment.*

(1) All payments by the Government under this contract shall be made by electronic funds transfer (EFT), except as provided in paragraph (a)(2) of this clause. As used in this clause, the term "EFT" refers to the funds transfer and may also include the payment information transfer.

(2) In the event the Government is unable to release one or more payments by EFT, the Contractor agrees to either --

(i) Accept payment by check or some other mutually agreeable method of payment; or

(ii) Request the Government to extend the payment due date until such time as the Government can make payment by EFT (but see paragraph (d) of this clause).

(b) *Contractor's EFT information.* The Government shall make payment to the Contractor using the EFT information contained in the Central Contractor Registration (CCR) database. In the event that the EFT information changes, the Contractor shall be responsible for providing the updated information to the CCR database.

(c) *Mechanisms for EFT payment.* The Government may make payment by EFT through either the Automated Clearing House (ACH) network, subject to the rules of the National Automated Clearing House Association, or the Fedwire Transfer System. The rules governing Federal payments through the ACH are contained in 31 CFR part 210.

(d) *Suspension of payment.* If the Contractor's EFT information in the CCR database is incorrect, then the Government need not make payment to the Contractor under this contract until correct EFT information is entered into the CCR database; and any invoice or contract financing request shall be deemed not to be a proper invoice for the purpose of prompt payment under this contract. The prompt payment terms of the contract regarding notice of an improper invoice and delays in accrual of interest penalties apply.

(e) *Liability for uncompleted or erroneous transfers.* (1) If an uncompleted or erroneous transfer occurs because the Government used the Contractor's EFT information incorrectly, the Government remains responsible for –

(i) Making a correct payment;

(ii) Paying any prompt payment penalty due; and

(iii) Recovering any erroneously directed funds.

(2) If an uncompleted or erroneous transfer occurs because the Contractor's EFT information was incorrect, or was revised within 30 days of Government release of the EFT payment transaction instruction to the Federal Reserve System, and –

(i) If the funds are no longer under the control of the payment office, the Government is deemed to have made payment and the Contractor is responsible for recovery of any erroneously directed funds; or

(ii) If the funds remain under the control of the payment office, the Government shall not make payment, and the provisions of paragraph (d) of this clause shall apply.

(f) *EFT and prompt payment.* A payment shall be deemed to have been made in a timely manner in accordance with the prompt payment terms of this contract if, in the EFT payment transaction instruction released to the Federal Reserve System, the date specified for settlement of the payment is on or before the prompt payment due date, provided the specified payment date is a valid date under the rules of the Federal Reserve System.

(g) *EFT and assignment of claims.* If the Contractor assigns the proceeds of this contract as provided for in the assignment of claims terms of this contract, the Contractor shall require as a

condition of any such assignment, that the assignee shall register separately in the CCR database and shall be paid by EFT in accordance with the terms of this clause. Notwithstanding any other requirement of this contract, payment to an ultimate recipient other than the Contractor, or a financial institution properly recognized under an assignment of claims pursuant to subpart 32.8 is not permitted. In all respects, the requirements of this clause shall apply to the assignee as if it were the Contractor. EFT information that shows the ultimate recipient of the transfer to be other than the Contractor, in the absence of a proper assignment of claims acceptable to the Government, is incorrect EFT information within the meaning of paragraph (d) of this clause.
(h) *Liability for change of EFT information by financial agent.* The Government is not liable for errors resulting from changes to EFT information made by the Contractor's financial agent.
(i) *Payment information.* The payment or disbursing office shall forward to the Contractor available payment information that is suitable for transmission as of the date of release of the EFT instruction to the Federal Reserve System. The Government may request the Contractor to designate a desired format and method(s) for delivery of payment information from a list of formats and methods the payment office is capable of executing. However, the Government does not guarantee that any particular format or method of delivery is available at any particular payment office and retains the latitude to use the format and delivery method most convenient to the Government. If the Government makes payment by check in accordance with paragraph (a) of this clause, the Government shall mail the payment information to the remittance address contained in the CCR database.
(End of clause)

SECTION 5.59
PROHIBITION OF SEGREGATED FACILITIES (FEB 1999) (FAR 52.222-21)

(a) "Segregated facilities," as used in this clause, means any waiting rooms, work areas, rest rooms and wash rooms, restaurants and other eating areas, time clocks, locker rooms and other storage or dressing areas, parking lots, drinking fountains, recreation or entertainment areas, transportation, and housing facilities provided for employees, that are segregated by explicit directive or are in fact segregated on the basis of race, color, religion, sex, or national origin because of written or oral policies or employee custom. The term does not include separate or single-user rest rooms or necessary dressing or sleeping areas provided to assure privacy between the sexes.
(b) The Contractor agrees that it does not and will not maintain or provide for its employees any segregated facilities at any of its establishments, and that it does not and will not permit its employees to perform their services at any location under its control where segregated facilities are maintained. The Contractor agrees that a breach of this clause is a violation of the Equal Opportunity clause in this contract.
(c) The Contractor shall include this clause in every subcontract and purchase order that is subject to the Equal Opportunity clause of this contract.

SECTION 5.60
SUBCONTRACTS FOR COMMERCIAL ITEMS (DEC 2010) (FAR 52.244-6)

(a) *Definitions.* As used in this clause—

"Commercial item" has the meaning contained in Federal Acquisition Regulation 2.101, Definitions.

"Subcontract" includes a transfer of commercial items between divisions, subsidiaries, or affiliates of the Contractor or subcontractor at any tier.

(b) To the maximum extent practicable, the Contractor shall incorporate, and require its subcontractors at all tiers to incorporate, commercial items or nondevelopmental items as components of items to be supplied under this contract.

(c)(1) The Contractor shall insert the following clauses in subcontracts for commercial items:

(i) 52.203-13, Contractor Code of Business Ethics and Conduct (APR 2010) (Pub. L. 110-252, Title VI, Chapter 1 (41 U.S.C. 251 note), if the subcontract exceeds $5,000,000 and has a performance period of more than 120 days. In altering this clause to identify the appropriate parties, all disclosures of violation of the civil False Claims Act or of Federal criminal law shall be directed to the agency Office of the Inspector General, with a copy to the Contracting Officer.

(ii) 52.203-15, Whistleblower Protections Under the American Recovery and Reinvestment Act of 2009 (JUN 2010) (Section 1553 of Pub. L. 111-5), if the subcontract is funded under the Recovery Act.

(iii) 52.219-8, Utilization of Small Business Concerns (DEC 2010) (15 U.S.C. 637(d)(2) and (3)), if the subcontract offers further subcontracting opportunities. If the subcontract (except subcontracts to small business concerns) exceeds $650,000 $1.5 million for construction of any public facility), the subcontractor must include 52.219-8 in lower tier subcontracts that offer subcontracting opportunities.

(iv) 52.222-26, Equal Opportunity (Mar 2007) (E.O. 11246).

(v) 52.222–35, Equal Opportunity for Veterans (SEP 2010) (38 U.S.C. 4212(a))

(vi) 52.222-36, Affirmative Action for Workers with Disabilities (OCT 2010) (29 U.S.C. 793).

(vii) 52.222–40, Notification of Employee Rights Under the National Labor Relations Act (Dec 2010) (E.O. 13496), if flow down is required in accordance with paragraph (f) of FAR clause 52.222–40.

(viii) [Reserved].

(ix) 52.247-64, Preference for Privately Owned U.S.-Flag Commercial Vessels (Feb 2006) (46 U.S.C. App. 1241 and 10 U.S.C. 2631), if flow down is required in accordance with paragraph (d) of FAR clause 52.247-64).

(2) While not required, the Contractor may flow down to subcontracts for commercial items a minimal number of additional clauses necessary to satisfy its contractual obligations.

(d) The Contractor shall include the terms of this clause, including this paragraph (d), in subcontracts awarded under this contract.

SECTION 5.61
NOTIFICATION OF EMPLOYEE RIGHTS UNDER NATIONAL LABOR RELATIONS ACT (DEC 2010)

(a) During the term of this contract, the Contractor shall post an employee notice, of such size and in such form, and containing such content as prescribed by the Secretary of Labor, in conspicuous places in and about its plants and offices where employees covered by the National Labor Relations Act engage in activities relating to the performance of the contract, including all

places where notices to employees are customarily posted both physically and electronically, in the languages employees speak, in accordance with 29 CFR 471.2(d) and (f).

(1) Physical posting of the employee notice shall be in conspicuous places in and about the Contractor's plants and offices so that the notice is prominent and readily seen by employees who are covered by the National Labor Relations Act and engage in activities related to the performance of the contract.

(2) If the Contractor customarily posts notices to employees electronically, then the Contractor shall also post the required notice electronically by displaying prominently, on any Web site that is maintained by the Contractor and is customarily used for notices to employees about terms and conditions of employment, a link to the Department of Labor's Web site that contains the full text of the poster. The link to the Department's Web site, as referenced in (b)(3) of this section, must read, "Important Notice about Employee Rights to Organize and Bargain Collectively with Their Employers."

(b) This required employee notice, printed by the Department of Labor, may be—

(1) Obtained from the Division of Interpretations and Standards, Office of Labor-Management Standards, U.S. Department of Labor, 200 Constitution Avenue, NW., Room N–5609, Washington, DC 20210, (202) 693–0123, or from any field office of the Office of Labor-Management Standards or Office of Federal Contract Compliance Programs;

(2) Provided by the Federal contracting agency if requested;

(3) Downloaded from the Office of Labor-Management Standards Web site at *http://www.dol.gov/olms/regs/compliance/EO13496.htm;* or

(4) Reproduced and used as exact duplicate copies of the Department of Labor's official poster.

(c) The required text of the employee notice referred to in this clause is located at Appendix A, Subpart A, 29 CFR Part 471.

(d) The Contractor shall comply with all provisions of the employee notice and related rules, regulations, and orders of the Secretary of Labor.

(e) In the event that the Contractor does not comply with the requirements set forth in paragraphs (a) through (d) of this clause, this contract may be terminated or suspended in whole or in part, and the Contractor may be suspended or debarred in accordance with 29 CFR 471.14 and subpart 9.4. Such other sanctions or remedies may be imposed as are provided by 29 CFR part 471, which implements Executive Order 13496 or as otherwise provided by law.

(f) *Subcontracts.*

(1) The Contractor shall include the substance of this clause, including this paragraph (f), in every subcontract that exceeds $10,000 and will be performed wholly or partially in the United States, unless exempted by the rules, regulations, or orders of the Secretary of Labor issued pursuant to section 3 of Executive Order 13496 of January 30, 2009, so that such provisions will be binding upon each subcontractor.

(2) The Contractor shall not procure supplies or services in a way designed to avoid the applicability of Executive Order 13496 or this clause.

(3) The Contractor shall take such action with respect to any such subcontract as may be directed by the Secretary of Labor as a means of enforcing such provisions, including the imposition of sanctions for noncompliance.

(4) However, if the Contractor becomes involved in litigation with a subcontractor, or is threatened with such involvement, as a result of such direction, the Contractor may request the

United States, through the Secretary of Labor, to enter into such litigation to protect the interests of the United States.

SECTION 5.62
APPLICABLE LAW FOR BREACH OF CONTRACT CLAIM (OCT 2004) (FAR 52.233-4)

United States law will apply to resolve any claim of breach of this contract.

SECTION 5.63
CENTRAL CONTRACTOR REGISTRATION (FEB 2012) (FAR 52.204-7)

(a) Definitions. As used in this clause—

"Central Contractor Registration (CCR) database" means the primary Government repository for Contractor information required for the conduct of business with the Government.

"Data Universal Numbering System (DUNS) number" means the 9-digit number assigned by Dun and Bradstreet, Inc. (D&B) to identify unique business entities.

"Data Universal Numbering System +4 (DUNS+4) number" means the DUNS number assigned by D&B plus a 4-character suffix that may be assigned by a business concern. (D&B has no affiliation with this 4-character suffix.) This 4-character suffix may be assigned at the discretion of the business concern to establish additional CCR records for identifying alternative Electronic Funds Transfer (EFT) accounts (see the FAR at Subpart 32.11) for the same concern.

"Registered in the CCR database" means that—

(1) The Contractor has entered all mandatory information, including the DUNS number or the DUNS+4 number, into the CCR database; and

(2) The Government has validated all mandatory data fields, to include validation of the Taxpayer Identification Number (TIN) with the Internal Revenue Service (IRS), and has marked the record "Active". The Contractor will be required to provide consent for TIN validation to the Government as a part of the CCR registration process.

(b)(1) By submission of an offer, the offeror acknowledges the requirement that a prospective awardee shall be registered in the CCR database prior to award, during performance, and through final payment of any contract, basic agreement, basic ordering agreement, or blanket purchasing agreement resulting from this solicitation.

(2) The offeror shall enter, in the block with its name and address on the cover page of its offer, the annotation "DUNS" or "DUNS +4" followed by the DUNS or DUNS +4 number that identifies the offeror's name and address exactly as stated in the offer. The DUNS number will be used by the Contracting Officer to verify that the offeror is registered in the CCR database.

(c) If the offeror does not have a DUNS number, it should contact Dun and Bradstreet directly to obtain one.

(1) An offeror may obtain a DUNS number—

(i) Via the Internet at http://fedgov.dnb.com/webform or if the offeror does not have internet access, it may call Dun and Bradstreet at 1-866-705-5711 if located within the United States; or

(ii) If located outside the United States, by contacting the local Dun and Bradstreet office. The offeror should indicate that it is an offeror for a U.S. Government contract when contacting the local Dun and Bradstreet office.

(2) The offeror should be prepared to provide the following information:

(i) Company legal business.

(ii) Tradestyle, doing business, or other name by which your entity is commonly recognized.

(iii) Company Physical Street Address, City, State, and ZIP Code.

(iv) Company Mailing Address, City, State and ZIP Code (if separate from physical).

(v) Company Telephone Number.

(vi) Date the company was started.

(vii) Number of employees at your location.

(viii) Chief executive officer/key manager.

(ix) Line of business (industry).

(x) Company Headquarters name and address (reporting relationship within your entity).

(d) If the Offeror does not become registered in the CCR database in the time prescribed by the Contracting Officer, the Contracting Officer will proceed to award to the next otherwise successful registered Offeror.

(e) Processing time, which normally takes 48 hours, should be taken into consideration when registering. Offerors who are not registered should consider applying for registration immediately upon receipt of this solicitation.

(f) The Contractor is responsible for the accuracy and completeness of the data within the CCR database, and for any liability resulting from the Government's reliance on inaccurate or incomplete data. To remain registered in the CCR database after the initial registration, the Contractor is required to review and update on an annual basis from the date of initial registration or subsequent updates its information in the CCR database to ensure it is current, accurate and complete. Updating information in the CCR does not alter the terms and conditions of this contract and is not a substitute for a properly executed contractual document.

(g)

(1)

(i) If a Contractor has legally changed its business name, "doing business as" name, or division name (whichever is shown on the contract), or has transferred the assets used in performing the contract, but has not completed the necessary requirements regarding novation and change-of-name agreements in Subpart 42.12, the Contractor shall provide the responsible Contracting Officer a minimum of one business day's written notification of its intention to (A) change the name in the CCR database; (B) comply with the requirements of Subpart 42.12 of the FAR; and (C) agree in writing to the timeline and procedures specified by the responsible Contracting Officer. The Contractor must provide with the notification sufficient documentation to support the legally changed name.

(ii) If the Contractor fails to comply with the requirements of paragraph (g)(1)(i) of this clause, or fails to perform the agreement at paragraph (g)(1)(i)(C) of this clause, and, in the absence of a properly executed novation or change-of-name agreement, the CCR information that shows the Contractor to be other than the Contractor indicated in the contract will be considered to be incorrect information within the meaning of the "Suspension of Payment" paragraph of the electronic funds transfer (EFT) clause of this contract.

(2) The Contractor shall not change the name or address for EFT payments or manual payments, as appropriate, in the CCR record to reflect an assignee for the purpose of assignment of claims (see FAR Subpart 32.8, Assignment of Claims). Assignees shall be separately registered in the CCR database. Information provided to the Contractor's CCR record that indicates payments, including those made by EFT, to an ultimate recipient other than that

Contractor will be considered to be incorrect information within the meaning of the "Suspension of payment" paragraph of the EFT clause of this contract.
(h) Offerors and Contractors may obtain information on registration and annual confirmation requirements via the internet at https://www.acquisition.gov or by calling 1-888-227-2423, or 269-961-5757.

SECTION 5.64
CONTRACTOR CODE OF BUSINESS ETHICS AND CONDUCT (APR 2010) (FAR 52.203-13).

(a) *Definitions*. As used in this clause--
Agent means any individual, including a director, an officer, an employee, or an independent Contractor, authorized to act on behalf of the organization.
Full cooperation--(1) Means disclosure to the Government of the information sufficient for law enforcement to identify the nature and extent of the offense and the individuals responsible for the conduct. It includes providing timely and complete response to Government auditors' and investigators' request for documents and access to employees with information;
(2) Does not foreclose any Contractor rights arising in law, the FAR, or the terms of the contract. It does not require--
(i) A Contractor to waive its attorney-client privilege or the protections afforded by the attorney work product doctrine; or
(ii) Any officer, director, owner, or employee of the Contractor, including a sole proprietor, to waive his or her attorney client privilege or Fifth Amendment rights; and
(3) Does not restrict a Contractor from--
(i) Conducting an internal investigation; or
(ii) Defending a proceeding or dispute arising under the contract or related to a potential or disclosed violation.
Principal means an officer, director, owner, partner, or a person having primary management or supervisory responsibilities within a business entity (e.g., general manager; plant manager; head of a division, or business segment; and similar positions).
Subcontract means any contract entered into by a subcontractor to furnish supplies or services for performance of a prime contract or a subcontract.
Subcontractor means any supplier, distributor, vendor, or firm that furnished supplies or services to or for a prime contractor or another subcontractor.
United States means the 50 States, the District of Columbia, and outlying areas.
(b) *Code of business ethics and conduct*. (1) Within 30 days after contract award, unless the Contracting Officer establishes a longer time period, the Contractor shall—
(i) Have a written code of business ethics and conduct;
(ii) Make a copy of the code available to each employee engaged in performance of the contract.
(2) The Contractor shall--
(i) Exercise due diligence to prevent and detect criminal conduct; and
(ii) Otherwise promote an organizational culture that encourages ethical conduct and a commitment to compliance with the law.
(3)(i) The Contractor shall timely disclose, in writing, to the agency Office of the Inspector General (OIG), with a copy to the

Contracting Officer, whenever, in connection with the award, performance, or closeout of this contract or any subcontract thereunder, the Contractor has credible evidence that a principal, employee, agent, or subcontractor of the Contractor has committed--

(A) A violation of Federal criminal law involving fraud, conflict of interest, bribery, or gratuity violations found in Title 18 of the United States Code; or

(B) A violation of the civil False Claims Act (31 U.S.C. 3729-3733).

(ii) The Government, to the extent permitted by law and regulation, will safeguard and treat information obtained pursuant to the Contractor's disclosure as confidential where the information has been marked ``confidential'' or ``proprietary'' by the company. To the extent permitted by law and regulation, such information will not be released by the Government to the public pursuant to a Freedom of Information Act request, 5 U.S.C. Section 552, without prior notification to the Contractor. The Government may transfer documents provided by the Contractor to any department or agency within the Executive Branch if the information relates to matters within the organization's jurisdiction.

(iii) If the violation relates to an order against a Governmentwide acquisition contract, a multi-agency contract, a multiple-award schedule contract such as the Federal Supply Schedule, or any other procurement instrument intended for use by multiple agencies, the Contractor shall notify the OIG of the ordering agency and the IG of the agency responsible for the basic contract.

(c) Business ethics awareness and compliance program and internal control system. This paragraph (c) does not apply if the Contractor has represented itself as a small business concern pursuant to the award of this contract or if this contract is for the acquisition of a commercial item as defined at FAR 2.101. The Contractor shall establish the following within 90 days after contract award, unless the Contracting Officer establishes a longer time period:

(1) An ongoing business ethics awareness and compliance program.

(i) This program shall include reasonable steps to communicate periodically and in a practical manner the Contractor's standards and procedures and other aspects of the Contractor's business ethics awareness and compliance program and internal control system, by conducting effective training programs and otherwise disseminating information appropriate to an individual's respective roles and responsibilities.

(ii) The training conducted under this program shall be provided to the Contractor's principals and employees, and as appropriate, the Contractor's agents and subcontractors.

(2) An internal control system.

(i) The Contractor's internal control system shall--

(A) Establish standards and procedures to facilitate timely discovery of improper conduct in connection with Government contracts; and

(B) Ensure corrective measures are promptly instituted and carried out.

(ii) At a minimum, the Contractor's internal control system shall provide for the following:

(A) Assignment of responsibility at a sufficiently high level and adequate resources to ensure effectiveness of the business ethics awareness and compliance program and internal control system.

(B) Reasonable efforts not to include an individual as a principal, whom due diligence would have exposed as having engaged in conduct that is in conflict with the Contractor's code of business ethics and conduct.

(C) Periodic reviews of company business practices, procedures, policies, and internal controls for compliance with the Contractor's code of business ethics and conduct and the special requirements of Government contracting, including--

(1) Monitoring and auditing to detect criminal conduct;

(2) Periodic evaluation of the effectiveness of the business ethics awareness and compliance program and internal control system, especially if criminal conduct has been detected; and

(3) Periodic assessment of the risk of criminal conduct, with appropriate steps to design, implement, or modify the business ethics awareness and compliance program and the internal control system as necessary to reduce the risk of criminal conduct identified through this process.

(D) An internal reporting mechanism, such as a hotline, which allows for anonymity or confidentiality, by which employees may report suspected instances of improper conduct, and instructions that encourage employees to make such reports.

(E) Disciplinary action for improper conduct or for failing to take reasonable steps to prevent or detect improper conduct.

(F) Timely disclosure, in writing, to the agency OIG, with a copy to the Contracting Officer, whenever, in connection with the award, performance, or closeout of any Government contract performed by the Contractor or a subcontractor thereunder, the Contractor has credible evidence that a principal, employee, agent, or subcontractor of the Contractor has committed a violation of Federal criminal law involving fraud, conflict of interest, bribery, or gratuity violations found in Title 18 U.S.C. or a violation of the civil False Claims Act (31 U.S.C. 3729-3733).

(1) If a violation relates to more than one Government contract, the Contractor may make the disclosure to the agency OIG and Contracting Officer responsible for the largest dollar value contract impacted by the violation.

(2) If the violation relates to an order against a Governmentwide acquisition contract, a multi-agency contract, a multiple-award schedule contract such as the Federal Supply Schedule, or any other procurement instrument intended for use by multiple agencies, the contractor shall notify the OIG of the ordering agency and the IG of the agency responsible for the basic contract, and the respective agencies' contracting officers.

(3) The disclosure requirement for an individual contract continues until at least 3 years after final payment on the contract.

(4) The Government will safeguard such disclosures in accordance with paragraph (b)(3)(ii) of this clause.

(G) Full cooperation with any Government agencies responsible for audits, investigations, or corrective actions.

(d) Subcontracts. (1) The Contractor shall include the substance of this clause, including this paragraph (d), in subcontracts that have a value in excess of $5,000,000 and a performance period of more than 120 days.

(2) In altering this clause to identify the appropriate parties, all disclosures of violation of the civil False Claims Act or of Federal criminal law shall be directed to the agency Office of the Inspector General, with a copy to the Contracting Officer.

SECTION 5.65
EMPLOYMENT ELIGIBILITY VERIFICATION (JAN 2009) (FAR 52.222-54).

(a) Definitions. As used in this clause--Commercially available off-the-shelf (COTS) item--

(1) Means any item of supply that is--

(i) A commercial item (as defined in paragraph (1) of the definition at 2.101);

(ii) Sold in substantial quantities in the commercial marketplace; and

(iii) Offered to the Government, without modification, in the same form in which it is sold in the commercial marketplace; and

(2) Does not include bulk cargo, as defined in section 3 of the Shipping Act of 1984 (46 U.S.C. App. 1702), such as agricultural products and petroleum products. Per 46 CFR 525.1(c)(2), "bulk cargo" means cargo that is loaded and carried in bulk onboard ship without mark or count, in a loose unpackaged form, having homogenous characteristics. Bulk cargo loaded into intermodal equipment, except LASH or Seabee barges, is subject to mark and count and, therefore, ceases to be bulk cargo.

Employee assigned to the contract means an employee who was hired after November 6, 1986, who is directly performing work, in the United States, under a contract that is required to include the clause prescribed at 22.1803. An employee is not considered to be directly performing work under a contract if the employee--

(1) Normally performs support work, such as indirect or overhead functions; and

(2) Does not perform any substantial duties applicable to the contract.

Subcontract means any contract, as defined in 2.101, entered into by a subcontractor to furnish supplies or services for performance of a prime contract or a subcontract. It includes but is not limited to purchase orders, and changes and modifications to purchase orders.

Subcontractor means any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime Contractor or another subcontractor.

United States, as defined in 8 U.S.C. 1101(a)(38), means the 50 States, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands.

(b) Enrollment and verification requirements. (1) If the Contractor is not enrolled as a Federal Contractor in E-Verify at time of contract award, the Contractor shall--

(i) Enroll. Enroll as a Federal Contractor in the E-Verify program within 30 calendar days of contract award;

(ii) Verify all new employees. Within 90 calendar days of enrollment in the E-Verify program, begin to use E-Verify to initiate verification of employment eligibility of all new hires of the Contractor, who are working in the United States, whether or not assigned to the contract, within 3 business days after the date of hire (but see paragraph (b)(3) of this section); and

(iii) Verify employees assigned to the contract. For each employee assigned to the contract, initiate verification within 90 calendar days after date of enrollment or within 30 calendar days of the employee's assignment to the contract, whichever date is later (but see paragraph (b)(4) of this section).

(2) If the Contractor is enrolled as a Federal Contractor in E-Verify at time of contract award, the Contractor shall use E-Verify to initiate verification of employment eligibility of--

(i) All new employees. (A) Enrolled 90 calendar days or more.

The Contractor shall initiate verification of all new hires of the Contractor, who are working in the United States, whether or not assigned to the contract, within 3 business days after the date of hire (but see paragraph (b)(3) of this section); or

(B) Enrolled less than 90 calendar days. Within 90 calendar days after enrollment as a Federal Contractor in E-Verify, the Contractor shall initiate verification of all new hires of the Contractor, who are working in the United States, whether or not assigned to the contract, within 3 business days after the date of hire (but see paragraph (b)(3) of this section); or

(ii) Employees assigned to the contract. For each employee assigned to the contract, the Contractor shall initiate verification within 90 calendar days after date of contract award or within 30 days after assignment to the contract, whichever date is later (but see paragraph (b)(4) of this section).

(3) If the Contractor is an institution of higher education (as defined at 20 U.S.C. 1001(a)); a State or local government or the government of a Federally recognized Indian tribe; or a surety performing under a takeover agreement entered into with a Federal agency pursuant to a performance bond, the Contractor may choose to verify only employees assigned to the contract, whether existing employees or new hires. The Contractor shall follow the applicable verification requirements at (b)(1) or (b)(2), respectively, except that any requirement for verification of new employees applies only to new employees assigned to the contract.

(4) Option to verify employment eligibility of all employees.

The Contractor may elect to verify all existing employees hired after November 6, 1986, rather than just those employees assigned to the contract. The Contractor shall initiate verification for each existing employee working in the United States who was hired after November 6, 1986, within 180 calendar days of--

(i) Enrollment in the E-Verify program; or

(ii) Notification to E-Verify Operations of the Contractor's decision to exercise this option, using the contact information provided in the E-Verify program Memorandum of Understanding (MOU).

(5) The Contractor shall comply, for the period of performance of this contract, with the requirements of the E-Verify program MOU.

(i) The Department of Homeland Security (DHS) or the Social Security Administration (SSA) may terminate the Contractor's MOU and deny access to the E-Verify system in accordance with the terms of the MOU. In such case, the Contractor will be referred to a suspension or debarment official.

(ii) During the period between termination of the MOU and a decision by the suspension or debarment official whether to suspend or debar, the Contractor is excused from its obligations under paragraph (b) of this clause. If the suspension or debarment official determines not to suspend or debar the Contractor, then the Contractor must reenroll in E-Verify.

(c) Web site. Information on registration for and use of the E-Verify program can be obtained via the Internet at the Department of Homeland Security Web site: http://www.dhs.gov/E-Verify.

(d) Individuals previously verified. The Contractor is not required by this clause to perform additional employment verification using E-Verify for any employee--

(1) Whose employment eligibility was previously verified by the Contractor through the E-Verify program;

(2) Who has been granted and holds an active U.S. Government security clearance for access to confidential, secret, or top secret information in accordance with the National Industrial Security Program Operating Manual; or

(3) Who has undergone a completed background investigation and been issued credentials pursuant to Homeland Security Presidential Directive (HSPD)-12, Policy for a Common Identification Standard for Federal Employees and Contractors.

(e) Subcontracts. The Contractor shall include the requirements of this clause, including this paragraph (e) (appropriately modified for identification of the parties), in each subcontract that-

(1) Is for--(i) Commercial or noncommercial services (except for commercial services that are part of the purchase of a COTS item (or an item that would be a COTS item, but for minor

modifications), performed by the COTS provider, and are normally provided for that COTS item); or

(ii) Construction;

(2) Has a value of more than $3,000; and

(3) Includes work performed in the United States.

SECTION 5.66
UPDATES OF PUBLICALLY AVAILABLE INFORMATION REGARDING RESPONSIBILITY MATTERS (FEB 2012) (FAR 52.209-9)

(a) The Contractor shall update the information in the Federal Awardee Performance and integrity Information System (FAPIIS) on a semi-annual basis, throughout the life of the contract, by posting the required information in the Central Contractor Registration database via https://www.acquisition.gov.

(b) As required by section 3010 of the Supplemental Appropriations Act, 2010 (Pub. L. 111-212), all information posted in FAPIIS on or after April 15, 2011, except past performance reviews, will be publicly available. FAPIIS consists of two segments—

(1) The non-public segment, into which Government officials and the Contractor post information, which can only be viewed by—

(i) Government personnel and authorized users performing business on behalf of the Government; or

(ii) The Contractor, when viewing data on itself; and

(2) The publicly-available segment, to which all data in the non-public segment of FAPIIS is automatically transferred after a waiting period of 14 calendar days, except for—

(i) Past performance reviews required by subpart 42.15;

(ii) Information that was entered prior to April 15, 2011; or

(iii) Information that is withdrawn during the 14-calendar-day waiting period by the Government official who posted it in accordance with paragraph (c)(1) of this clause.

(c) The Contractor will receive notification when the Government posts new information to the Contractor's record.

(1) If the Contractor asserts in writing within 7 calendar days, to the Government official who posted the information, that some of the information posted to the non-public segment of FAPIIS is covered by a disclosure exemption under the Freedom of Information Act, the Government official who posted the information must within 7 calendar days remove the posting from FAPIIS and resolve the issue in accordance with agency Freedom of Information procedures, prior to reposting the releasable information. The contractor must cite 52.209-9 and request removal within 7 calendar days of the posting to FAPIIS.

(2) The Contractor will also have an opportunity to post comments regarding information that has been posted by the Government. The comments will be retained as long as the associated information is retained, i.e., for a total period of 6 years. Contractor comments will remain a part of the record unless the Contractor revises them.

(3) As required by section 3010 of Pub. L. 111-212, all information posted in FAPIIS on or after April 15, 2011, except past performance reviews, will be publicly available.

(d) Public requests for system information posted prior to April 15, 2011, will be handled under Freedom of Information Act procedures, including, where appropriate, procedures

promulgated under E.O. 12600.

SECTION 5.67
PERSONAL IDENTITY VERIFICATION OF CONTRACTOR PERSONNEL (JAN 2011)
(FAR 52.204-9)

(a) The Contractor shall comply with agency personal identity verification procedures identified in the contract that implement Homeland Security Presidential Directive-12 (HSPD-12), Office of Management and Budget (OMB) guidance M-05-24 and Federal Information Processing Standards Publication (FIPS PUB) Number 201.

(b) The Contractor shall account for all forms of Government-provided identification issued to the Contractor employees in connection with performance under this contract. The Contractor shall return such identification to the issuing agency at the earliest of any of the following, unless otherwise determined by the Government:

(1) When no longer needed for contract performance.

(2) Upon completion of the Contractor employee's employment.

(3) Upon contract completion or termination.

(c) The Contracting Officer may delay final payment under a contract if the Contractor fails to comply with these requirements.

(d) The Contractor shall insert the substance of this clause, including this paragraph (d), in all subcontracts when the subcontractor's employees are required to have routine physical access to a Federally-controlled facility and/or routine access to a Federally-controlled information system. It shall be the responsibility of the prime Contractor to return such identification to the issuing agency in accordance with the terms set forth in paragraph (b) of this section, unless otherwise approved in writing by the Contracting Officer.

[Note: For purposes of this Contract, a Federally-controlled information system means the OPM Letter of Credit System.]

SECTION 5.68
PRIVACY OR SECURITY SAFEGUARDS (AUG 1996) (FAR 52.239-1)

(a) The Contractor shall not publish or disclose in any manner, without the Contracting Officer's written consent, the details of any safeguards either designed or developed by the Contractor under this contract or otherwise provided by the Government.

(b) To the extent required to carry out a program of inspection to safeguard against threats and hazards to the security, integrity, and confidentiality of Government data, the Contractor shall afford the Government access to the Contractor's facilities, installations, technical capabilities, operations, documentation, records, and databases.

(c) If new or unanticipated threats or hazards are discovered by either the Government or the Contractor, or if existing safeguards have ceased to function, the discoverer shall immediately bring the situation to the attention of the other party.

[Note: For purposes of this Contract and this clause, privacy or security safeguards pertain to the OPM Letter of Credit System.]

SECTION 5.69
ENCOURAGING CONTRACTOR POLICIES TO BAN TEXT MESSAGING WHILE DRIVING (AUG 2011) (FAR 52.223-18)

(a) Definitions. As used in this clause—

"Driving"–

(1) Means operating a motor vehicle on an active roadway with the motor running, including while temporarily stationary because of traffic, a traffic light, stop sign, or otherwise.

(2) Does not include operating a motor vehicle with or without the motor running when one has pulled over to the side of, or off, an active roadway and has halted in a location where one can safely remain stationary.

"Text messaging" means reading from or entering data into any handheld or other electronic device, including for the purpose of short message service texting, e-mailing, instant messaging, obtaining navigational information, or engaging in any other form of electronic data retrieval or electronic data communication. The term does not include glancing at or listening to a navigational device that is secured in a commercially designed holder affixed to the vehicle, provided that the destination and route are programmed into the device either before driving or while stopped in a location off the roadway where it is safe and legal to park.

(b) This clause implements Executive Order 13513, Federal Leadership on Reducing Text Messaging While Driving, dated October 1, 2009.

(c) The Contractor is encouraged to—

(1) Adopt and enforce policies that ban text messaging while driving—

(i) Company-owned or -rented vehicles or Government-owned vehicles; or

(ii) Privately-owned vehicles when on official Government business or when performing any work for or on behalf of the Government.

(2) Conduct initiatives in a manner commensurate with the size of the business, such as—

(i) Establishment of new rules and programs or re-evaluation of existing programs to prohibit text messaging while driving; and

(ii) Education, awareness, and other outreach to employees about the safety risks associated with texting while driving.

(d) Subcontracts. The Contractor shall insert the substance of this clause, including this paragraph (d), in all subcontracts that exceed the micro-purchase threshold.

APPENDIX A

2013

Brochure Text

For a copy of the 2013 brochure, please go to www.fepblue.org.

(FFS-2013)

APPENDIX B

SUBSCRIPTION RATES, CHARGES, ALLOWANCES AND LIMITATIONS

Fee-For-Service Carrier

(Blue Cross and Blue Shield Association)
CONTRACT NO. CS 1039
Effective January 1, 2013

(a) Biweekly net-to-carrier rates, with appropriate adjustments for Enrollees paid on other than a biweekly basis, are as follows:

Standard Option		Basic Option	
Self Only	$266.11	Self Only	$227.21
Self and Family	$601.05	Self and Family	$532.02

(b) The amount of administrative expenses and charges to be included in the Annual Accounting Statement required by Section 3.2 shall be as set out in the schedule below:

Item	Amount
(i) Administrative Expenses	Actual, but not to exceed the Contractual Expense Limitation for 2013.* plus an amount sufficient to cover the costs needed to pay the Plan's Independent Public Accountant to undertake the audits and agreed upon procedures required in the "FEHBP Experienced-Rated Carrier and Service Organization Audit Guide."
(ii) Taxes	Actual (except that premium taxes as defined are not allowable).
(iii) Service Charge	REDACTED

*The Contractual Expense Limitation for 2013 is the Contractual Expense Limitation for 2012 (REDACTED), plus or minus adjustments for inflation and enrollment changes. Notwithstanding Section 3.2(b) of this Contract, costs of "activities that improve health care quality", as determined in accordance with the medical loss ratio provision of the Affordable Care Act (Section 2718 of the Public Health Service Act; 42 U.S.C. § 300gg-18, and its implementing regulations), are accounted for as benefits and are not counted toward the

Contractual Expense Limit. The base shall be adjusted by percentage changes in enrollment (from OPM's March 2012 to March 2013 headcount) and by the percentage change in the average monthly Consumer Price Index for All Urban Consumers (published monthly by the Bureau of Labor Statistics) from the 12 month period ending on June 30, 2012, to the 12 month period ending on June 30, 2013.

APPENDIX C
FEHB Supplemental Literature Guidelines
(RV JAN 2013)

This is the primary guide a Carrier should use to assess whether the Carrier's supplemental marketing literature, including website material, complies with FEHBAR 1603.70, Misleading, Deceptive or Unfair Advertising. (Use the NAIC Guidelines for additional guidance when needed.)

a) GENERAL

1. Section 1.13 of the FEHB contract requires that the Carrier may not distribute or display marketing materials or other supplemental literature (including provider directories) in a Federal or Tribal Employer facility or arrange for the distribution of such documents by Federal agencies or Tribal Employers unless the documents have been prepared in accordance with FEHBAR 1652.203-70, and the Carrier has certified to OPM that is the case.

2. Review supplemental marketing material for compliance each year, whether or not it changed from the past year.

3. Word the literature simply and concisely to get a readily understandable, attractive marketing piece.

4. Include sufficient detail to ensure accuracy.

5. Under the FEHBP, the FEHB brochure is based on text approved by OPM and is a complete statement of benefits, limitations, and exclusions. Include the following statement (website material should include the statement as a preface) in all supplemental literature which in any way discusses Plan benefits:

"This is a summary [or brief description] of the features of the [insert Plan's name]. Before making a final decision, please read the Plan's Federal brochure ([insert brochure number]). All benefits are subject to the definitions, limitations, and exclusions set forth in the Federal brochure."

6. You may include non-FEHBP benefits, i.e., benefits which are not FEHB benefits and are not guaranteed under the Federal contract with the following disclaimer:

"These benefits are neither offered nor guaranteed under contract with the FEHB Program, but are made available to all Enrollees and family members who become members of [insert Plan's name]."

7. Supplemental literature must be clearly distinguishable from the Federal brochure.

8. Do not use the FEHB logo in your supplemental literature.

9. Do not use material which conflicts with the Federal brochure. If your material conflicts, you must change the material or not distribute it.

b) RATE PRESENTATIONS

Under the FEHBP there are only two categories of enrollment, Self Only and Self and Family. For most enrollments, the premium for each Enrollee's enrollment is shared between the Enrollee and the Government or Tribal Employer. The Government or Tribal Employer contribution is based on the formula provided in the FEHB law. Deductions for most Enrollees' share, along with the Government's contribution or Tribal Employer's contribution, are made in accordance with the schedule on which the employee, Tribal Employee, or annuitant's (retiree)

salary or annuitant check is issued by the Enrollee's agency, Tribal Employer, or retiree's retirement system. Most employees are paid biweekly. Annuitants are issued monthly checks.

Employees, Tribal Employees, and annuitants do not have separate categories of enrollment. They pay the same rates, whether on a biweekly, semimonthly, or monthly basis, and receive the same benefits when they are in the same FEHB Plan, except that active Postal employees pay a lesser share, as their cost sharing formula with the Postal Service calls for a greater Government contribution.

The Enrollee's share for each FEHB Plan for each type of enrollment (Self Only, Self and Family) is listed in the Guide to Federal Benefits. This Guide is prepared each Open Season and is distributed directly to agencies by OPM; they in turn distribute the Guide to employees. The Guide will be made available to Tribal Employers to distribute to Tribal Employees. Biweekly and monthly rates are also shown on an insert you prepare for your brochure. Separate guides are prepared for special groups of Enrollees, including those for which the agency or Tribal Employer makes no premium contribution, such as former spouses and employees and family members with temporarily continued coverage.

In making your rate presentations:

1. With the exception of the Summary of Benefits and Coverage referenced at section 1.13(e), list your FEHB rates in each piece of supplemental material which lists benefits. Do not list the rates of any competitor Plan.

2. Immediately above the rates include the following statement:

"These rates do not apply to all Enrollees. If you are in a special enrollment category, please refer to your special Guide to Federal Benefits or contact the agency or Tribal Employer which maintains your health benefits enrollment."

3. If you wish to list Postal rates in addition to non-Postal rates, Postal and non-Postal rates should be clearly identified and listed separately. (Please note there are no monthly Postal rates; upon retirement, Postal employees receive the non-postal contribution.)

c) BENEFIT PRESENTATIONS

Please note the following:

1. Do not compare your benefits or operations with that of any other Plan.
2. Accurately describe your FEHB benefits offering.
3. Avoid incomplete or overstated benefit descriptions, or those which conflict with the Federal brochure.
4. Show applicable coverage limitations, such as day or dollar limitations, coinsurance or deductibles.
5. Do not list exclusions and limitations not listed in the Federal brochure.
6. Do not include general references not in the brochure.
7. Do not reference coverage for which a Federal employee, Tribal Employee, or retiree would have to drop FEHB coverage. Exception: 5 CFR 890.301 provides that an annuitant or former spouse, as defined in 5 U.S.C. 8901(10), who cancels FEHBP enrollment for the purpose of enrolling in a prepaid health Plan under sections 1833 or 1876 of the Social Security Act may register to re-enroll. Therefore, if yours is such a prepaid Plan contracting with Medicare you must describe your Medicare supplemental program for Medicare-covered retirees.

d) ENROLLMENT INSTRUCTIONS

Enrollment under the FEHBP is governed solely by the Federal Employees Health Benefits law and applicable regulations. The various Federal agencies and Tribal Employers have responsibility for administering the law and regulations during the annual open enrollment

period (Open Season) and at all other times during the year. Agency and Tribal Employer personnel offices perform the basic health benefits functions, such as instructing employees about the conduct of the Open Season and other health benefits matters, answering employee questions, and processing elections and changes of enrollment, including determinations of eligibility and assignment of effective dates of coverage. Agency and Tribal Employer payroll offices make the necessary salary deductions.

The Federal instrument for electing to enroll in a Plan or changing an existing enrollment in a Plan from Self Only to Self and Family (or the reverse) is the Standard Form (SF) 2809, or alternative electronic or telephonic method approved by OPM. Carriers must be able to accept electronic file transfers. The effective date for Open Season enrollments is the first day of the first pay period which begins on or after January 1 for employees; the effective date generally is January 1 for annuitants and Tribal Employees. The specific effective date for an individual will be assigned by the individual's personnel office.

Covered Family Members are as defined in the FEHB regulations. Basically, Family Members are immediate family members, including spouse and children under age 26. When Self and Family coverage is established for an individual, all family members as defined under the regulations are automatically covered as of the effective date assigned by the personnel office, whether or not they are listed on the SF 2809, on other documents, or communicated by electronic or telephonic transmittal. Family members (e.g., newborns) who are added under an existing Self and Family enrollment are automatically covered from the date the individual becomes a family member, e.g., from birth. Personnel offices do not issue any notification when a new Family Member is added under an existing Self and Family enrollment and the Enrollee does not submit a new SF 2809 or other election instrument.

The agencies and Tribal Employers are the primary contact point for employees and Tribal Employees on health benefits enrollment matters. OPM's Office of Retirement Programs performs this function for annuitants (retirees). As highlighted below, Carriers may not impose their own enrollment requirements and procedures.

1. Do not give specific instructions on enrollment. Statements regarding election of coverage or change of enrollment procedures, requirements, or eligibility must be limited to referring individuals to their personnel office for the appropriate instructions; your plan's Self Only and Self and Family enrollment codes; and notice for retirees to contact their retirement system for instructions.

2. While the Carrier may ask Enrollees for information (see Section f) and may follow-up with Enrollees and, when necessary, the employing office, the Carrier will not require a member complete plan specific enrollment or application forms. (You may ask the Enrollee to complete "information" forms.) You may ask the Enrollee to keep you advised of family member changes and you may verify the change, but failure to complete a form does not render an eligible Family Member ineligible.

3. Personnel offices will not stock your Plan's forms. Do not indicate otherwise.

4. If supplemental literature is directed to potential members rather than just-enrolled members, do not include statements indicating otherwise.

5. Again, the Federal brochure, rather than any other plan document, is the Member's complete statement of benefits. Do not indicate otherwise.

e) PROVIDER DIRECTORIES

The provider directory must conform to the requirements listed below. Carriers must provide access to the provider directory on their website and send a provider directory to any Enrollee who requests one.

Please note that a Federal employee, Tribal Employee, or annuitant choosing your Plan during the Open Season is doing so with the expectation that the Plan's provider directory is accurate and that providers shown will be available starting January 1.

1. Show the Plan's hospitals, individual physicians, and group practice medical facilities. State the addresses of the medical facilities and show the general location within the service area for individual doctors and hospitals.

2. In the directory, display prominently the following statement: "It is important to know when you enroll in this Plan, benefits are available as described in the Plan's Federal brochure, but the continued participation of any one doctor, hospital or other provider cannot be guaranteed."

3. Do not list enrollment or eligibility requirements on the provider directory.

f) INFORMATION FORMS

You may distribute forms to obtain information from Enrollees about the Enrollee and any Family Members. For instance, to obtain the information regarding Medicare you will need for rate-setting purposes under the Federal Program, you may ask who is enrolled under Medicare Part A, Medicare Part B or Medicare Parts A and B. For another example, Carriers may ask that a primary care doctor be selected for a Point of Service product. If you wish to distribute an information form, you may find such forms are more readily returned if they are postage-paid. Do not indicate enrollment in the Plan is contingent upon completing and returning the form.

APPENDIX D
RULES FOR COORDINATION OF BENEFITS

Model Regulation Service--July 2005
National Association of Insurance Commissioners

When a person is covered by two (2) or more plans. the rules for determining the order of benefit payments are as follows:

A. (1) The primary plan shall pay or provide its benefits as if the secondary plan or plans did not exist.

(2) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(3) When multiple contracts providing coordinated coverage are treated as a single plan under this regulation, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan shall be responsible for the plan's compliance with this regulation.

(4) If a person is covered by more than one secondary plan, the order of benefit determination rules of this regulation decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the rules of this regulation, has its benefits determined before those of that secondary plan.

B. (1) Except as provided in Paragraph (2), a plan that does not contain order of benefit determination provisions that are consistent with this regulation is always the primary plan unless the provisions of both plans, regardless of the provisions of this paragraph, state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A plan may take into consideration the benefits paid or provided by another plan only when, under the rules of this regulation, it is secondary to that other plan.

D. Order of Benefit Determination

Each plan determines its order of benefits using the first of the following rules that applies:

(1) Non-Dependent or Dependent

(a) Subject to Subparagraph (b) of this paragraph, the plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

(b) (i) If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(I) Secondary to the plan covering the person as a dependent; and

(II) Primary to the plan covering the person as other than a dependent (e.g. a retired employee),

(ii) Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

Drafting Note: The provisions of Subparagraph (b) address the situation where federal law requires Medicare to be secondary with respect to group health plans in certain situations despite state law order of benefit determination provisions to the contrary. One example of this type of situation arises when a person, who is a Medicare beneficiary, is also covered under his or her own group health plan as a retiree and under a group health plan as a dependent of an active employee. In this situation, each of the three plans is secondary to the other as the following illustrates: (1) Medicare is secondary to the group health plan covering the person as a dependent of an active employee as required pursuant to the Medicare secondary payer rules; (2) the group health plan covering the person as a dependent of an active employee is secondary to the group health plan covering the person as a retiree, as required under Subparagraph (a); and (3) the group health plan covering the claimant as retiree is secondary to Medicare because the plan is designed to supplement Medicare when Medicare is the primary plan. Subparagraph (b) resolves this problem by making the group health plan covering the person as a dependent of an active employee the primary plan. The dependent coverage pays before the non-dependent coverage even though under state law order of benefit determination provisions in the absence of Subparagraph (b), the non-dependent coverage (e.g. retiree coverage) would be expected to pay before the dependent coverage. Therefore, in cases that involve Medicare, generally, the dependent coverage pays first as the primary plan, Medicare

pays second as the secondary plan, and the non-dependent coverage (e.g. retiree coverage) pays third.

The reason why Subparagraph (b) provides for this order of benefits making the plan covering the person as dependent of an active employee primary is because Medicare will not be primary in most situations to any coverage that a dependent has on the basis of active employment and, as such, Medicare will not provide any information as to what Medicare would have paid had it been primary. The plan covering the person as a retiree cannot determine its payment as a secondary plan unless it has information about what the primary plan paid. The plan covering the person as a dependent of an active employee could be subject to penalties under the Medicare secondary payer rules if it refuses to pay its benefits. The plan covering the person as a retiree is not subject to the same penalties because, in this particular situation, as described above, which does not involve a person eligible for Medicare based on end-stage renal disease (ESRD), the plan can never be primary to Medicare. As such, out of the three plans providing coverage to the person, the plan covering the person as a dependent of an active employee can determine its benefits most easily.

(2) Dependent Child Covered Under More Than One Plan

Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(ii) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

(b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;

(ii)If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits: or

(iv) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(I) The plan covering the custodial parent:

(II) The plan covering the custodial parent's spouse:

(III) The plan covering the non-custodial parent: and then

(IV) The plan covering the non-custodial parent's spouse.

(c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph (a) or (b) of this paragraph as if those individuals were parents of the child.

Drafting Note: Subparagraph (c) addresses the situation where individuals other than the parents of a child are responsible for the child's health care expenses or provide health care coverage for the child under each of their plans. In this situation, for the purpose of determining the order of benefits under this paragraph, Subparagraph (c) requires that these individuals be treated in the same manner as parents of the child.

(3) Active Employee or Retired or Laid-Off Employee

(a) The plan that covers a person as an active employee that is, an employee who is neither laid off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

(b) If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

(c) This rule does not apply if the rule in Paragraph (1) can determine the order of benefits.

Drafting Note: This rule applies only in the situation when the same person is covered under two plans, one of which is provided on the basis of active employment and the other of which is provided to retired or laid-off employees. The rule in Paragraph (1) does not apply because the person is covered either as a non-dependent under both plans (i.e. the person is covered under one

plan as an active employee and at the same time is covered as a retired or laid-off employee under the other plan) or as a dependent under both plans (i.e. the person is covered under one plan as a dependent of an active employee and at the same time is covered under the other plan as a dependent of a retired or laid-off employee). This rule does not apply when a person is covered under his or her own plan as an active employee or retired or laid-off employee and a dependent under a spouse's plan provided to the spouse on the basis of active employment. In this situation, the rule in Paragraph (1) applies because the person is covered as a non-dependent under one plan (i.e. the person is covered as an active employee or retired or laid-off employee) and at the same time is covered as a dependent under the other plan (i.e. the person is covered as a dependent under a plan provided on the basis of active employment or a plan that is provided to retired or laid-off employees).

(4) COBRA or State Continuation Coverage

(a) If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

(b) If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(c) This rule does not apply if the rule in Paragraph (1) can determine the order of benefits

Drafting Note: COBRA originally provided that coverage under a new group health plan caused the COBRA coverage to end. An amendment passed as part of P.L. 101-239, the Omnibus Budget Reconciliation Act of 1989 (OBRA 89), allows the COBRA coverage to continue if the newly acquired group health plan contains any preexisting condition exclusion or limitation. In this instance two group health plans will cover the person, and the rule above will be used to determine which of the plans determines its benefits first. In addition, some states have continuation provisions comparable to COBRA.

Drafting Note: This rule applies only in the situation when a person has coverage pursuant to COBRA or under a right of continuation pursuant to state or other federal law and has coverage under another plan on the basis of employment. The rule under Paragraph (1) does not apply because the person is covered either: (a) as a non-dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as an employee or as a retired employee and is covered under his or her own plan as an employee, member, subscriber or retiree); or (b) as a dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as a dependent of an employee, member or subscriber or retired employee and is covered under the other plan as a dependent of an employee, member, subscriber or retiree). The rule under Paragraph (1)

applies when the person is covered pursuant to COBRA or under a right of continuation pursuant to state or other federal law as a non-dependent and covered under the other plan as a dependent of an employee, member, subscriber or retiree. The rule in this paragraph does not apply because the person is covered as a non-dependent under one of the plans and as a dependent under the other plan.

(5) Longer or Shorter Length of Coverage

(a) If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

(b) To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.

(c) The start of a new plan does not include:

(i) A change in the amount or scope of a plan's benefits;

(ii) A change in the entity that pays, provides or administers the plan's benefits; or

(iii) A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

(d) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

(6) If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.

APPENDIX E

Small Business Subcontracting Plan (JUL 2005)

(a) This clause does not apply to small business concerns.

(b) *Definitions*. As used in this clause—

"Commercial item" means a product or service that satisfies the definition of commercial item in section 2.101 of the Federal Acquisition Regulation.

"Commercial plan" means a subcontracting plan (including goals) that covers the offeror's fiscal year and that applies to the entire production of commercial items sold by either the entire company or a portion thereof (*e.g.*, division, plant, or product line).

"Individual contract plan" means a subcontracting plan that covers the entire contract period (including option periods), applies to a specific contract, and has goals that are based on the offeror's planned subcontracting in support of the specific contract, except that indirect costs incurred for common or joint purposes may be allocated on a prorated basis to the contract.

"Master plan" means a subcontracting plan that contains all the required elements of an individual contract plan, except goals, and may be incorporated into individual contract plans, provided the master plan has been approved.

"Subcontract" means any agreement (other than one involving an employer-employee relationship) entered into by a Federal Government prime Contractor or subcontractor calling for supplies or services required for performance of the contract or subcontract.

(c) The offeror, upon request by the Contracting Officer, shall submit and negotiate a subcontracting plan, where applicable, that separately addresses subcontracting with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business concerns, small disadvantaged business, and women-owned small business concerns. If the offeror is submitting an individual contract plan, the plan must separately address subcontracting with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns, with a separate part for the basic contract and separate parts for each option (if any). The plan shall be included in and made a part of the resultant contract. The subcontracting plan shall be negotiated within the time specified by the Contracting Officer. Failure to submit and negotiate the subcontracting plan shall make the offeror ineligible for award of a contract.

(d) The offeror's subcontracting plan shall include the following:

(1) Goals, expressed in terms of percentages of total planned subcontracting dollars, for the use of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns as subcontractors. The offeror shall include all subcontracts that contribute to contract performance, and may include a proportionate share of products and services that are normally allocated as indirect costs.

(2) A statement of—

(i) Total dollars planned to be subcontracted for an individual contract plan; or the offeror's total projected sales, expressed in dollars, and the total value of projected subcontracts to support the sales for a commercial plan;

(ii) Total dollars planned to be subcontracted to small business concerns;

(iii) Total dollars planned to be subcontracted to veteran-owned small business concerns;

(iv) Total dollars planned to be subcontracted to service-disabled veteran-owned small business;

(v) Total dollars planned to be subcontracted to HUBZone small business concerns;

(vi) Total dollars planned to be subcontracted to small disadvantaged business concerns; and

(vii) Total dollars planned to be subcontracted to women-owned small business concerns.

(3) A description of the principal types of supplies and services to be subcontracted, and an identification of the types planned for subcontracting to—

(i) Small business concerns;

(ii) Veteran-owned small business concerns;

(iii) Service-disabled veteran-owned small business concerns;

(iv) HUBZone small business concerns;

(v) Small disadvantaged business concerns; and

(vi) Women-owned small business concerns.

(4) A description of the method used to develop the subcontracting goals in paragraph (d)(1) of this clause.

(5) A description of the method used to identify potential sources for solicitation purposes (*e.g.*, existing company source lists, the Procurement Marketing and Access Network (PRO-Net) of the Small Business Administration (SBA), veterans service organizations, the National Minority Purchasing Council Vendor Information Service, the Research and Information Division of the Minority Business Development Agency in the Department of Commerce, or small, HUBZone, small disadvantaged, and women-owned small business trade associations). A firm may rely on the information contained in PRO-Net as an accurate representation of a concern's size and ownership characteristics for the purposes of maintaining a small, veteran-owned small, service-disabled veteran-owned small, HUBZone small, small disadvantaged, and women-owned small business source list. Use of PRO-Net as its source list does not relieve a firm of its responsibilities (*e.g.*, outreach, assistance, counseling, or publicizing subcontracting opportunities) in this clause.

(6) A statement as to whether or not the offeror included indirect costs in establishing subcontracting goals, and a description of the method used to determine the proportionate share of indirect costs to be incurred with—

(i) Small business concerns;

(ii) Veteran-owned small business concerns;

(iii) Service-disabled veteran-owned small business concerns;

(iv) HUBZone small business concerns;

(v) Small disadvantaged business concerns; and

(vi) Women-owned small business concerns.

(7) The name of the individual employed by the offeror who will administer the offeror's subcontracting program, and a description of the duties of the individual.

(8) A description of the efforts the offeror will make to assure that small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns have an equitable opportunity to compete for subcontracts.

(9) Assurances that the offeror will include the clause of this contract entitled "Utilization of Small Business Concerns" in all subcontracts that offer further subcontracting opportunities, and that the offeror will require all subcontractors (except small business concerns) that receive

subcontracts in excess of $500,000 ($1,000,000 for construction of any public facility) to adopt a subcontracting plan that complies with the requirements of this clause.

(10) Assurances that the offeror will—

(i) Cooperate in any studies or surveys as may be required;

(ii) Submit periodic reports so that the Government can determine the extent of compliance by the offeror with the subcontracting plan;

(iii) Submit Standard Form (SF) 294, Subcontracting Report for Individual Contracts, and/or SF 295, Summary Subcontract Report, in accordance with paragraph (j) of this clause. The reports shall provide information on subcontract awards to small business concerns, veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns, women-owned small business concerns, and Historically Black Colleges and Universities and Minority Institutions. Reporting shall be in accordance with the instructions on the forms or as provided in agency regulations.

(iv) Ensure that its subcontractors agree to submit SF 294 and SF 295.

(11) A description of the types of records that will be maintained concerning procedures that have been adopted to comply with the requirements and goals in the plan, including establishing source lists; and a description of the offeror's efforts to locate small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns and award subcontracts to them. The records shall include at least the following (on a plant-wide or company-wide basis, unless otherwise indicated):

(i) Source lists (*e.g.*, PRO-Net), guides, and other data that identify small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns.

(ii) Organizations contacted in an attempt to locate sources that are small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, or women-owned small business concerns.

(iii) Records on each subcontract solicitation resulting in an award of more than $100,000, indicating—

(A) Whether small business concerns were solicited and, if not, why not;

(B) Whether veteran-owned small business concerns were solicited and, if not, why not;

(C) Whether service-disabled veteran-owned small business concerns were solicited and, if not, why not;

(D) Whether HUBZone small business concerns were solicited and, if not, why not;

(E) Whether small disadvantaged business concerns were solicited and, if not, why not;

(F) Whether women-owned small business concerns were solicited and, if not, why not; and

(G) If applicable, the reason award was not made to a small business concern.

(iv) Records of any outreach efforts to contact—

(A) Trade associations;

(B) Business development organizations;

(C) Conferences and trade fairs to locate small, HUBZone small, small disadvantaged, and women-owned small business sources; and

(D) Veterans service organizations.

(v) Records of internal guidance and encouragement provided to buyers through—

(A) Workshops, seminars, training, etc.; and

(B) Monitoring performance to evaluate compliance with the program's requirements.

(vi) On a contract-by-contract basis, records to support award data submitted by the offeror to the Government, including the name, address, and business size of each subcontractor. Contractors having commercial plans need not comply with this requirement.

(e) In order to effectively implement this plan to the extent consistent with efficient contract performance, the Contractor shall perform the following functions:

(1) Assist small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns by arranging solicitations, time for the preparation of bids, quantities, specifications, and delivery schedules so as to facilitate the participation by such concerns. Where the Contractor's lists of potential small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business subcontractors are excessively long, reasonable effort shall be made to give all such small business concerns an opportunity to compete over a period of time.

(2) Provide adequate and timely consideration of the potentialities of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns in all "make-or-buy" decisions.

(3) Counsel and discuss subcontracting opportunities with representatives of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business firms.

(4) Confirm that a subcontractor representing itself as a HUBZone small business concern is identified as a certified HUBZone small business concern by accessing the Central Contractor Registration (CCR) database or by contacting SBA.

(5) Provide notice to subcontractors concerning penalties and remedies for misrepresentations of business status as small, veteran-owned small business, HUBZone small, small disadvantaged, or women-owned small business for the purpose of obtaining a subcontract that is to be included as part or all of a goal contained in the Contractor's subcontracting plan.

(f) A master plan on a plant or division-wide basis that contains all the elements required by paragraph (d) of this clause, except goals, may be incorporated by reference as a part of the subcontracting plan required of the offeror by this clause; provided—

(1) The master plan has been approved;

(2) The offeror ensures that the master plan is updated as necessary and provides copies of the approved master plan, including evidence of its approval, to the Contracting Officer; and

(3) Goals and any deviations from the master plan deemed necessary by the Contracting Officer to satisfy the requirements of this contract are set forth in the individual subcontracting plan.

(g) A commercial plan is the preferred type of subcontracting plan for contractors furnishing commercial items. The commercial plan shall relate to the offeror's planned subcontracting generally, for both commercial and Government business, rather than solely to the Government contract. Commercial plans are also preferred for subcontractors that provide commercial items under a prime contract, whether or not the prime contractor is supplying a commercial item.

(h) Prior compliance of the offeror with other such subcontracting plans under previous contracts will be considered by the Contracting Officer in determining the responsibility of the offeror for award of the contract.

(i) The failure of the Contractor or subcontractor to comply in good faith with—

(1) The clause of this contract entitled "Utilization Of Small Business Concerns;" or

(2) An approved plan required by this clause, shall be a material breach of the contract.

(j) The Contractor shall submit the following reports:

(1) *Standard Form 294, Subcontracting Report for Individual Contracts.* This report shall be submitted to the Contracting Officer semiannually and at contract completion. The report covers subcontract award data related to this contract. This report is not required for commercial plans.

(2) *Standard Form 295, Summary Subcontract Report.* This report encompasses all of the contracts with the awarding agency. It must be submitted semi-annually for contracts with the Department of Defense and annually for contracts with civilian agencies. If the reporting activity is covered by a commercial plan, the reporting activity must report annually all subcontract awards under that plan. All reports submitted at the close of each fiscal year (both individual and commercial plans) shall include a breakout, in the Contractor's format, of subcontract awards, in whole dollars, to small disadvantaged business concerns by North American Industry Classification System (NAICS) Industry Subsector. For a commercial plan, the Contractor may obtain from each of its subcontractors a predominant NAICS Industry Subsector and report all awards to that subcontractor under its predominant NAICS Industry Subsector.

(End of clause)

Alternate I (Oct 2001). When contracting by sealed bidding rather than by negotiation, substitute the following paragraph (c) for paragraph (c) of the basic clause:

(c) The apparent low bidder, upon request by the Contracting Officer, shall submit a subcontracting plan, where applicable, that separately addresses subcontracting with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns. If the bidder is submitting an individual contract plan, the plan must separately address subcontracting with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns, with a separate part for the basic contract and separate parts for each option (if any). The plan shall be included in and made a part of the resultant contract. The subcontracting plan shall be submitted within the time specified by the Contracting Officer. Failure to submit the subcontracting plan shall make the bidder ineligible for the award of a contract.

Alternate II (Oct 2001). As prescribed in 19.708(b)(1), substitute the following paragraph (c) for paragraph (c) of the basic clause:

(c) Proposals submitted in response to this solicitation shall include a subcontracting plan that separately addresses subcontracting with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns. If the offeror is submitting an individual contract plan, the plan must separately address subcontracting with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns, with a separate part for the basic contract and separate parts for each

option (if any). The plan shall be included in and made a part of the resultant contract. The subcontracting plan shall be negotiated within the time specified

EXHIBIT B

FEDERAL EMPLOYEES

HEALTH BENEFITS PROGRAM

STANDARD CONTRACT

FOR

FEE-FOR-SERVICE CARRIERS

2022

CONTRACT FOR FEDERAL EMPLOYEES' HEALTH BENEFITS

CONTRACT NO: CS 1039
EFFECTIVE: January 1, 2022

AMENDMENT NO: 2022A
EFFECTIVE: January 1, 2022

BETWEEN: The United States Office of Personnel Management
hereinafter called OPM or the Government

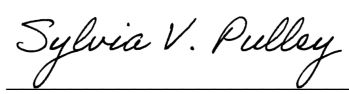
Address: 1900 E Street, NW
Washington, DC 20415-3610

AND

CONTRACTOR: Blue Cross and Blue Shield Association
hereafter also called the Carrier

Address: 1310 G Street, NW
Washington, DC 20005

In consideration of payment by OPM of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract, including Appendix A.

FOR THE CARRIER	FOR THE GOVERNMENT
William A. Breskin	Sylvia V. Pulley
Name of person authorized to execute contract (*type or print*)	Name of Contracting Officer *(type or print)*
Title: Senior Vice President Government Program	Title: Contracting Officer
Signature:	Signature: 
Date signed: December 21, 2021	Date signed: December 30, 2021

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PART I - GENERAL PROVISIONS

SECTION 1.1
DEFINITIONS OF FEHB TERMS (JAN 2012)

For purpose of this contract, the following definitions apply:

Act: The Federal Employees Health Benefits Act, as amended; chapter 89 of title 5, United States Code.

Benefits: Covered services or payment for covered services set forth in Appendix A, to which Members are entitled to the extent provided by this contract.

Carrier: As defined by chapter 89 of title 5, United States Code, and may be used interchangeably with the term Contractor.

Enrollee: The Federal employee, Tribal Employee, annuitant, former spouse, temporarily-covered former Federal employee or family member enrolled under this contract.

FEHBP: Federal Employees Health Benefits Program.

Letter of Credit: The method by which certain Carriers, and their underwriters if authorized, receive recurring premium payments and contingency reserve payments by drawing against a commitment (certified by a responsible OPM official) which specifies a dollar amount available. For each Carrier participating in the Letter of Credit arrangement for payment under FEHBAR 1632.170(b), the terms "Carrier reserves" and "special reserves" include any balance in the Carrier's Letter of Credit account.

Member: The Enrollee and/or an eligible family member for benefit purposes, and sometimes referred to as subscriber.

Regulations: (1) The Federal Employees Health Benefits Regulations; part 890, title 5, Code of Federal Regulations, and (2) Chapters 1 and 16 of title 48, Code of Federal Regulations.

Subcontractor: Any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime contractor, or another subcontractor, except for providers of direct medical services or supplies pursuant to the Carrier's health benefits plan.

Tribal Employee: A full-time or part-time common law employee of a tribal employer.

Tribal Employer: A Tribal Employer is an Indian tribe or tribal organization, as those terms are defined in 25 U.S.C. Chapter 18, carrying out at least one program under the Indian Self-Determination and Education Assistance Act or an urban Indian organization as that term is defined in 25 U.S.C. Chapter 18 carrying out at least one program under the title V of the Indian Health Care Improvement Act, provided that OPM accepts the tribe, tribal organization, or urban Indian organization's agreement to offer FEHB.

SECTION 1.2
ENTIRE CONTRACT (JAN 2009)

(a) This document as described in the *Table of Contents* constitutes the entire contract between the parties. No oral statement of any person shall modify or otherwise affect the terms, conditions, or specifications stated in this contract. Requests for modifications of this contract must be submitted to the authorized Contracting Officer. Only the Contracting Officer acting within the scope of his or her authority may execute a contract modification on behalf of the government.

(b) All statements concerning coverage or benefits made by OPM, the Carrier or by any individual covered under this contract shall be deemed representations and not warranties. No such statement shall convey or void any coverage, increase or reduce any benefits under this contract or be used in the prosecution of or defense of a claim under this contract unless it is contained in writing and a copy of the instrument containing the statement is or has been furnished to the Member or to the person making the claim.

SECTION 1.3
ORDER OF PRECEDENCE (JAN 1996)

Any inconsistency in this contract shall be resolved by giving precedence in the following descending order: The Act, the regulations in part 890, title 5, Code of Federal Regulations, the regulations in chapters 1 and 16, title 48, Code of Federal Regulations, and this contract.

SECTION 1.4
INCORPORATION OF LAWS AND REGULATIONS (JAN 2002)

(a) The applicable provisions of (1) chapter 89 of title 5, United States Code; (2) OPM's regulations as contained in part 890 of title 5, Code of Federal Regulations; and (3) chapters 1 and 16 of title 48, Code of Federal Regulations constitute a part of this contract as if fully set forth herein, and the other provisions of this contract shall be construed so as to comply therewith.

(b) If the Regulations are changed in a manner which would increase the Carrier's liability under this contract, the Contracting Officer will make an equitable adjustment in accordance with the changes clause, Section 5.38 -- Changes--Negotiated Benefits Contracts.

SECTION 1.5
RECORDS AND INFORMATION TO BE FURNISHED BY OPM (JAN 2012)

(a) OPM shall maintain or cause to be maintained records from which the Carrier may determine the names and social security numbers of all Enrollees. OPM, other agencies of the Federal Government, Tribal Employer, or the FEHB Clearinghouse shall furnish the information to the Carrier at such times and in such form and detail as will enable the Carrier to maintain a currently accurate record of all Enrollees.

(b) The Carrier is entitled to rely on information furnished to it under paragraph (a). OPM agrees that any liabilities incurred under this contract in reliance upon such information shall be a valid charge against the contract. Errors or delays in keeping or reporting data relating to coverage shall not invalidate coverage that would otherwise be validly in force and shall not continue coverage that would otherwise be terminated**.** OPM shall make an equitable adjustment of premiums upon discovery of errors or delays under this Section.

(c) Clerical error (whether by OPM, any other agency, Tribal Employer, the FEHB Clearinghouse, or the Carrier) in keeping records pertaining to coverage under this contract, delays in making entries thereon, or failure to make or account for any deduction of enrollment charges, shall not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. OPM shall make an equitable adjustment of premiums when an error, delay, or failure is discovered. If any person finds relevant facts pertaining to a person covered under this contract to be misstated, and if the misstatement affects the existence, amount, or extent of coverage, the actual facts shall determine whether coverage is in force under the terms of this contract and in what amount or to what extent. Any claim payments the Carrier makes before an adjustment or determination shall be a valid charge against this contract.

(d) The OPM shall direct the agencies and Tribal Employers to provide the Carrier or the FEHB Clearinghouse, not less often than quarterly, the names of Enrollees enrolled under the contract by payroll office and the premium paid for those Enrollees for the current pay cycle. The Carrier shall at least quarterly reconcile its enrollment records with those provided by the Government, the Tribal Employer, or the FEHB Clearinghouse.

(e) In instances of erroneous enrollments where benefit payments have been made in error, the Carrier must inform Enrollees within forty-five days of when the Carrier receives notification from the agency or the Tribal Employer that the Carrier will collect for these benefit payments. The Carrier shall provide notice to the Enrollees that they have the right to contest their enrollment change with their agency, Tribal Employer, or their retirement system.

SECTION 1.6
CONFIDENTIALITY OF RECORDS
(JAN 1991) (FEHBAR 1652.224-70)

(a) The Carrier shall use the personal data on employees and annuitants that is provided by agencies and OPM, including social security numbers, for only those routine uses stipulated for the data and published annually in the Federal Register as part of OPM's notice of systems of records.

(b) The Carrier shall also hold all medical records, and information relating thereto, of Federal subscribers confidential except as follows:

(1) As may be reasonably necessary for the administration of this contract;

(2) As authorized by the patient or his or her guardian;

(3) As disclosure is necessary to permit Government officials having authority to investigate and prosecute alleged civil or criminal actions;

(4) As necessary to audit the contract;

(5) As necessary to carry out the coordination of benefit provisions of this contract; and

(6) For bona fide medical research or educational purposes. Release of information for medical research or educational purposes shall be limited to aggregated information of a

statistical nature that does not identify any individual by name, social security number, or any other identifier unique to an individual.

(c) If the Carrier uses medical records for the administration of the contract, or for bona fide research or educational purposes, it shall so state in the Plan's brochure.

SECTION 1.7
STATISTICS AND SPECIAL STUDIES (JAN 2022)

(a) The Carrier shall maintain or cause to be maintained statistical records of its operations under the contract and shall furnish to OPM, in the form prescribed by the Contracting Officer, the statistical reports reasonably necessary for the OPM to carry out its functions under Chapter 89 of title 5, United States Code.

(b) The Carrier shall furnish such other reasonable statistical data and reports of special studies as the Contracting Officer may from time to time request for the purpose of carrying out its functions under Chapter 89 of title 5, United States Code.

(c) The Carrier shall furnish the routine reports in the required number of copies in a format to be determined by the Contracting Officer as instructed by OPM.

(d) The Carrier shall notify the OPM Health Insurance Specialist (Contracts) immediately upon a change in the name or address of the Carrier's contracting official(s).

(e) If a third party requests FEHB Program data, including FEHB members' medical records and information relating thereto, and the Carrier determines that the data request is not reasonably necessary for administration or performance of the FEHB contract, the Carrier shall determine whether it intends to release the data. If the Carrier intends to release the data, it must notify the OPM Health Insurance Specialist within three (3) business days from the date the Carrier makes the determination. The Carrier must not distribute the data unless it receives prior approval from the Contracting Officer. If the Carrier determines the data is reasonably necessary for administration or performance of the FEHB contract, the Carrier must be able to support that determination. Examples include, but are not limited to:

Example 1: A PBM requests data from the Carrier about the FEHB group's utilization relevant to the PBM's performance of its contract. The release of relevant utilization data is reasonably necessary.

Example 2: A PBM requests data from the Carrier about the FEHB group's utilization for its own marketing purposes. This release is not reasonably necessary.

Example 3: A PBM marketing consultant requests data from the Carrier about the FEHB group's utilization demographics for its own business marketing purposes. This release is not reasonably necessary.

Example 4: A state All Payer Claims Database requests the FEHB group's claims information pursuant to state law. The state uses this data to inform its state insurance regulatory policy. This release is not reasonably necessary.

Example 5: A Federal agency seeks the FEHB group's cost information to inform its benefits policy. This release is not reasonably necessary.

SECTION 1.8
NOTICE (JAN 2003)

Where the contract requires that notice be given to the other party, such notice must be given in writing to the address shown on this contract's signature page. To notify OPM, the Carrier must write to the Contracting Officer, unless otherwise specified.

SECTION 1.9
PLAN PERFORMANCE--EXPERIENCE-RATED FFS CONTRACTS (JAN 2021)

(a) Detection of Fraud, Waste, and Abuse (FWA). The Carrier shall conduct a program to assess its vulnerability to FWA to include but not limited to performing post-payment reviews and audits of providers identified either proactively or reactively. The Carrier shall operate a system designed to detect and eliminate FWA internally by Carrier employees and Subcontractors, by providers providing goods or services to FEHB Members, and by individual FEHB Members. In addition, FEHBP Carriers must demonstrate they have submitted written notification to OPM-OIG within 30 business days of identifying potential FWA issues impacting the FEHB Program regardless of dollar value. The program must specify provisions in place for cost avoidance, not just fraud detection, along with criteria for follow-up actions. The Carrier must submit to OPM an annual analysis of the costs and benefits of its FWA program. The Carrier must submit annual reports to OPM by March 31 addressing the following:

1) Number of Allegations/Complaints Opened/Received;
2) Number of Allegations/Complaints where there is FEHBP Program Exposure;
3) Number of Cases Developed Through Proactive Fraud Prevention/Detection Software;
4) Number of Cases Referred to Local, State, or Federal Law Enforcement/Oversight Agencies;
5) Number of Case Notifications/Referrals Sent to OPM-OIG;
6) Number of Cases Resolved Administratively;
7) Dollars Identified as Loss;
8) Estimated Financial Losses;
9) Non-Recoverable Loss;
10) Dollars Recovered by SIU;
11) Vendor Recoveries;
12) Actual Savings;
13) Prevented Loss;
14) Number of Criminal Convictions;
15) Prepayment Review;
16) Fraudulent Schemes;
17) Fraudulent Geographic Areas;
18) FWA Program Costs;
19) Other Associated Costs of the FWA Program;
20) Return on Investment; and
21) Best Practices

The report will also include the industry standards checklist.

(b) Clinical Care Measures. The Carrier shall measure and/or collect data on the quality of the

health care services it provides to its members as requested by OPM. Measurement/data collection efforts may include performance measurement systems such as Healthcare Effectiveness Data and Information Set (HEDIS), measures developed by the Pharmacy Quality Alliance (PQA), and similar measures developed by accrediting organizations such as, but not limited to, the Association for Ambulatory Health Care (AAAHC), the National Committee for Quality Assurance (NCQA), and URAC or endorsed by the National Quality Forum. Costs incurred by the Carrier for collecting or contracting with a vendor to collect quality measures/data are allowable administrative expenses, subject to the administrative cost limitation.

(c) Patient Safety. The Carrier shall implement a patient safety improvement program. At a minimum, the Carrier shall --

(1) Report to OPM on its current patient safety initiatives;

(2) Report to OPM on how it will strengthen its patient safety program for the future;

(3) Assist OPM in providing its Members with consumer information and education regarding patient safety; and

(4) Work with its providers, independent accrediting organizations, and others to implement patient safety improvement programs.

(d) Accreditation. To demonstrate its commitment to providing quality health care, the Carrier shall continue to pursue and maintain accreditation according to the steps and timeframes outlined by OPM. The Carrier shall submit accreditation changes and updates to its OPM contract representative.

(e) Consumer Assessments of Healthcare Providers and Systems (CAHPS). In addition to any other means of surveying Plan members that the Carrier may develop, the Carrier shall participate in the Consumer Assessments of Healthcare Providers and Systems (CAHPS) 5.0 Survey to provide feedback to Enrollees on Enrollee experience with the various FEHBP plans. The Carrier shall take into account the published results of the survey, or other results as directed by OPM, in identifying areas for improvement as part of the Carrier's quality assurance program. Payment of survey charges will be in accordance with Section 3.11.

(f) Contract Quality Assurance. The Carrier shall develop and apply a quality assurance program specifying procedures for assuring contract quality over the contract period. The Carrier shall meet the required standards provided in this section. No later than July 1 of the subsequent year, the Carrier shall submit to OPM an annual report of metrics on each specification provided in this section, using data for the contract period:

(1) *Claims Processing Accuracy*

SPECIFICATION: the number of FEHB claims processed accurately divided by the total number of FEHB claims processed.

REQUIRED STANDARD: The Carrier shall accurately process at least 95 percent of FEHB claims.

(2) *Claims Coding Accuracy*

SPECIFICATION: the number of FEHB claims coded accurately divided by the total number of FEHB claims coded.

REQUIRED STANDARD: The Carrier shall accurately code at least 98 percent of FEHB claims.

(3) *Recovery of Erroneous Payments*

SPECIFICATION: the average number of working days it takes for the Carrier to begin collection action against an FEHB provider or member following identification of an erroneous payment, including overpayments.

REQUIRED STANDARD: The Carrier shall average no more than 30 working days from the date it identifies an FEHB erroneous payment to the date it begins the collection action.

(4) *Claims Timeliness*

SPECIFICATION: the number of FEHB claims adjudicated (paid, denied, or a request for further information is sent out) within 30 working days from the date the Carrier received the claim, divided by the total number of FEHB claims received.

REQUIRED STANDARD: The Carrier shall adjudicate at least 95 percent of claims within 30 working days.

(5) *Processing ID cards on change of plan or option*

SPECIFICATION: the number of calendar days from the date the Carrier receives the enrollment from the Enrollee's agency, Tribal Employer, or retirement system to the date it issues the ID card.

REQUIRED STANDARD: The Carrier shall issue all ID cards within 15 calendar days after receiving the enrollment from the Enrollee's agency, Tribal Employer, or retirement system except that the Carrier shall issue ID cards resulting from an open season election within 15 calendar days or by December 15, whichever is later.

(6) *Member Inquiries*

SPECIFICATION: the number of written inquiries responded to within 15 working days divided by the total number of written inquiries received.

REQUIRED STANDARD: The Carrier shall respond to at least 90 percent of inquiries within 15 working days.

(7) *Written Inquiries Accuracy*

SPECIFICATION: the number of FEHB written inquiries answered accurately divided by the total number of FEHB written inquiries received.

REQUIRED STANDARD: the Carrier shall accurately answer at least 97 percent of FEHB written inquiries.

(8) *Telephone Inquiries Accuracy*

SPECIFICATION: the number of FEHB telephone inquiries answered accurately divided by the total number of FEHB telephone inquiries received.

REQUIRED STANDARD: The Carrier shall accurately answer at least 97 percent of FEHB telephone inquiries.

(9) *Internet Inquiries Accuracy*

SPECIFICATION: the number of FEHB Internet inquiries answered accurately divided by the total number of FEHB Internet inquiries received.

REQUIRED STANDARD: The Carrier shall accurately answer at least 97 percent of FEHB Internet inquiries.

(10) *Telephone Access*

SPECIFICATION: the Carrier shall report on the following statistics concerning telephone access to the member services department (or its equivalent) for the given time period. Except that, if the Carrier does not have a computerized phone system, report results of periodic surveys on telephone access.

(i) Call Answer Timeliness

SPECIFICATION: the percentage of calls answered by a live voice (during operating hours) within 30 seconds.

REQUIRED STANDARD: The Carrier shall answer 80% of telephone calls by a live voice (during operating hours) within 30 seconds.

(ii) Telephone Blockage Rate

SPECIFICATION: the number of calls receiving a busy signal when calling the Carrier divided by the total number of calls received.

REQUIRED STANDARD: The Carrier shall ensure that no more than 5 percent of calls receive a busy signal.

(iii) Telephone Abandonment Rate

SPECIFICATION: the number of calls attempted but not connected to a live voice divided by the total number of calls attempted.

REQUIRED STANDARD: The Carrier shall ensure that no more than 5 percent of calls are abandoned before connection to a live voice.

(*iv*) *Initial Call Resolution*

SPECIFICATION: the number of initial calls that result in a resolution of the issue divided by the total number of initial calls for an issue.

REQUIRED STANDARD: The Carrier shall resolve the issue during the initial call at least 80 percent of the time.

(11) *Responsiveness to FEHB Member Requests for Reconsideration*

SPECIFICATION: the number of times the Carrier responds (affirms the denial in writing to the FEHB member, pays the claim, provides or authorizes coverage of the service, or requests additional information reasonably necessary to make a determination) within 30 days to a request for reconsideration of a disputed claim divided by the total number of requests for reconsideration of disputed claims received.

REQUIRED STANDARD: The Carrier shall respond to 100 percent of written FEHB disputed claim requests within 30 days after receipt by the Carrier.

(g) Quality Assurance Plan. The Carrier must demonstrate that a statistically valid sampling technique is routinely used prior to or after processing to randomly sample FEHB claims against Carrier quality assurance/fraud and abuse prevention standards.

(h) Reporting Compliance. The Carrier shall keep complete records of its quality assurance procedures and fraud prevention program and the results of their implementation and make them available to the Government as determined by OPM.

(i) FEHB Clearinghouse (CLER). The Carrier shall not have any CLER records with a 160 error code and a fail count of four or higher. A '160' error is when a Carrier reports an enrollment but no agency or Tribal Employer reports that enrollment.

(j) The Carrier must demonstrate that it uses and shall use a statistically valid sampling technique to identify FEHB claims prior to or after processing that requires coordination of benefits with a third party payer or the Carrier shall pursue and provide evidence that it pursues all claims for coordination of benefits.

(k) Correction of Deficiencies. The Contracting Officer may order the correction of a deficiency in the Carrier's quality assurance program or fraud prevention program. The Carrier shall take the necessary action promptly to implement the Contracting Officer's order. If the Contracting Officer orders a modification of the Carrier's quality assurance program or fraud prevention program pursuant to this paragraph after the contract year has begun, the costs incurred to correct the deficiency may be excluded from the administrative expenses -- for the

contract year -- that are subject to the administrative expenses limitation specified at Appendix B; provided the Carrier demonstrates that the correction of the deficiency significantly increases the Carrier's liability under this contract.
(l) In order to allow sufficient implementation time, the Contracting Officer will notify the Carrier reasonably in advance of any new requirement(s) under paragraphs (a) through (k).

SECTION 1.10
NOTICE OF SIGNIFICANT EVENTS (JUL 2005) (FEHBAR 1652.222-70)

(a) The Carrier agrees to notify the Contracting Officer of any Significant Event within ten (10) working days after the Carrier becomes aware of it. As used in this section, a Significant Event is any occurrence or anticipated occurrence that might reasonably be expected to have a material effect upon the Carrier's ability to meet its obligations under this contract, including, but not limited to, any of the following:

(1) Disposal of major assets;

(2) Loss of 15 percent or more of the Carrier's overall membership;

(3) Termination or modification of any contract or subcontract if such termination or modification might have a material effect on the Carrier's obligations under this contract;

(4) Addition or termination of provider agreements;

(5) Any changes in underwriters, reinsurers or participating plans;

(6) The imposition of, or notice of the intent to impose, a receivership, conservatorship, or special regulatory monitoring;

(7) The withdrawal of, or notice of intent to withdraw State licensing, HHS qualification, or any other status under Federal or State law;

(8) Default on a loan or other financial obligation;

(9) Any actual or potential labor dispute that delays or threatens to delay timely performance or substantially impairs the functioning of the Carrier's facilities or facilities used by the Carrier in the performance of the contract;

(10) Any change in its charter, constitution, or by-laws which affects any provision of this contract or the Carrier's participation in the Federal Employees Health Benefits Program;

(11) Any significant changes in policies and procedures or interpretations of the contract or brochure which would affect the benefits available under the contract or the costs charged to the contract;

(12) Any fraud, embezzlement or misappropriation of FEHB funds; or

(13) Any written exceptions, reservations or qualifications expressed by the independent accounting firm (which ascribes to the standards of the American Institute of Certified Public Accountants) contracted with by the Carrier to provide an opinion on its annual financial statements.

(b) Upon learning of a Significant Event OPM may institute action, in proportion to the seriousness of the event, to protect the interest of Members, including, but not limited to--

(1) Directing the Carrier to take corrective action;

(2) Suspending new enrollments under this contract;

(3) Advising Enrollees of the Significant Event and providing them an opportunity to transfer to another plan;

(4) Withholding payment of subscription income or restricting access to the Carrier's Letter of Credit account;

(5) Terminating the enrollment of those Enrollees who, in the judgment of OPM, would be adversely affected by the Significant Event; or

(6) Terminating this contract pursuant to Section 1.15, Renewal and Withdrawal of Approval.

(c) Prior to taking action as described in paragraph (b) of this clause, the OPM will notify the Carrier and offer an opportunity to respond.

(d) The Carrier will insert this clause in any subcontract or subcontract modification if the amount of the subcontract or modification charged to the FEHB Program (or in the case of a community-rated Carrier, applicable to the FEHB Program) equals or exceeds $550,000 and is at least 25 percent of the total subcontract cost. The amount of the dollar charge to the FEHB Program shall be adjusted by the same amount and at the same time as any change to the threshold for application of the Truth in Negotiations Act pursuant to 41 U.S.C. 254b(a)(7). [1]

SECTION 1.11
FEHB INSPECTION (JUL 2005) (FEHBAR 1652.246-70)

(a) The Contracting Officer, or an authorized representative of the Contracting Officer, has the right to inspect or evaluate the work performed or being performed under the contract, and the premises where the work is being performed, at all reasonable times and in a manner that will not unreasonably delay the work.

(b) The Contractor shall maintain and the Contracting Officer, or an authorized representative of the Contracting Officer, shall have the right to examine and audit all books and records relating to the contract for purposes of the Contracting Officer's determination of the Carrier's subcontractor or Large Provider's compliance with the terms of the contract, including its payment (including rebate and other financial arrangements) and performance provisions. The Contractor shall make available at its office at all reasonable times those books and records for examination and audit for the record retention period specified in the Federal Employees Health Benefits Acquisition Regulation (FEHBAR), 48 CFR 1652.204-70. This subsection is applicable to subcontract and Large Provider Agreements with the exception of those that are subject to the "Audits and Records – Negotiation" clause, 48 CFR 52.215-2.

(c) If the Contracting Officer, or an authorized representative of the Contracting Officer, performs inspection, audit or evaluation on the premises of the Carrier, the subcontractor, or the Large Provider, the Carrier shall furnish or require the subcontractor or Large Provider to furnish all reasonable facilities for the safe and convenient performance of these duties.

(d) The Carrier shall insert this clause, including this subsection (d), in all subcontracts for underwriting and claim payments and administrative services and in all Large Provider Agreements and shall substitute "contractor", "Large Provider," or other appropriate reference for the term "Carrier."

[1] Section 811 of the National Defense Authorization Act for Fiscal Year 2018 (Pub. L. No. 115-91) increased the threshold for the application of the Truth in Negotiations Act from $750,000 to $2,000,000 for all contracts entered into after June 30, 2018. Based on this change in law, this contract subsection should be read to replace "$550,000" with "$2,000,000" and to replace "41 U.S.C. 254b(a)(7)" with "41 U.S.C. 3502(g)."

SECTION 1.12
CORRECTION OF DEFICIENCIES (JAN 1997)

(a) The Carrier shall maintain sufficient financial resources, facilities, providers, staff and other necessary resources to meet its obligations under this contract. If the OPM determines that the Carrier does not demonstrate the ability to meet its obligations under this contract, the OPM shall notify the Carrier of the asserted deficiencies. The Carrier agrees that, within ten (10) working days following notification, it shall present detailed plans for correcting the deficiencies. These plans shall be presented in a form prescribed by the OPM. Pending submission or implementation of plans required under this Section, the OPM may institute action as it deems necessary to protect the interests of Members, including, but not limited to:

(1) Suspending new enrollments under this contract;

(2) Advising Enrollees of the asserted deficiencies and providing them an opportunity to transfer to another plan;

(3) Withholding payment of subscription income or restricting access to the Carrier's Letter of Credit account; or

(4) Terminating the enrollment of those Enrollees who, in the judgment of OPM, would be adversely affected by the deficiency.

(b) The Carrier agrees that failure to submit or to diligently implement plans which are required under this Section shall constitute sufficient grounds for termination of this contract pursuant to Section 1.15*, Renewal and Withdrawal of Approval.*

(c) Prior to taking action as described in paragraph (a) the OPM shall notify the Carrier and offer an opportunity to respond.

(d) The Carrier shall include the substance of this clause in the contract with its underwriter and substitute an appropriate term for "Carrier."

SECTION 1.13
INFORMATION AND MARKETING MATERIALS (JAN 2014)

(a) OPM and the Carrier shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The Carrier bears full responsibility for the accuracy of its FEHB brochure. OPM in its sole discretion, may order the Carrier to produce and distribute the agreed upon brochure text in a format and quantity approved by OPM, including an electronic 508 compliant brochure version, Section 508 of the Rehabilitation Act of 1973, as amended 29 U.S.C. 794d, for OPM's website. This formatted document is referred to as the FEHB brochure. The Carrier shall distribute the FEHB brochure on a timely basis to new Enrollees and to other Enrollees upon their request. The Carrier shall also distribute the document(s) to Federal agencies and Tribal Employers to be made available to such individuals who are eligible to enroll under this contract. At the direction of OPM, the Carrier shall produce and distribute an audio cassette version, CD, or other electronic media of the approved language. The Carrier may print additional FEHB brochures for distribution for its own use, but only in the approved format and at its own expense.

(b) Supplemental material. Only marketing materials or other supplemental literature prepared in accordance with FEHBAR 1652.203-70 (Section 1.14 of this contract) may be distributed or displayed at or through Federal facilities.

(c) The Carrier shall reflect the statement of benefits in the agreed upon brochure text included at Appendix A of this contract, verbatim, in the FEHB brochure.

(d) OPM may order the Carrier to prepare an addendum or reissue the FEHB brochure or any piece(s) of supplemental marketing material at no expense to the Government if it is found to not conform to the agreed upon brochure text and/or supplemental marketing materials preparations described in paragraphs (a), (b) and (c) of this section.

(e) The Carrier shall produce and make available an FEHB Summary of Benefits and Coverage (SBC).

SECTION 1.14
MISLEADING, DECEPTIVE OR UNFAIR ADVERTISING (JAN 1991) (FEHBAR 1652.203-70)

(a) The Carrier agrees that any advertising material, including that labeled promotional material, marketing material, or supplemental literature, shall be truthful and not misleading.

(b) Criteria to assess compliance with paragraph (a) of this clause are available in the *FEHB Supplemental Literature Guidelines* which are developed by OPM and should be used, along with the additional guidelines set forth in FEHBAR 1603.7002, as the primary guide in preparing material; further guidance is provided in the NAIC *Advertisements of Accident and Sickness Insurance Model Regulation.* The guidelines are periodically updated and provided to the Carrier by OPM.

(c) Failure to conform to paragraph (a) of this clause may result in a reduction in the service charge, if appropriate, and corrective action to protect the interest of Federal Members. Corrective action will be appropriate to the circumstances and may include, but is not limited to the following actions by OPM:

(1) Directing the Carrier to cease and desist distribution, publication, or broadcast of the material;

(2) Directing the Carrier to issue corrections at the Carrier's expense and in the same manner and media as the original material was made; and

(3) Directing the Carrier to provide, at the Carrier's expense, the correction in writing by certified mail to all Enrollees of the Plan(s) that had been the subject of the original material.

(d) Egregious or repeated offenses may result in the following action by OPM:

(1) Suspending new enrollments in the Carrier's Plan(s);

(2) Providing Enrollees an opportunity to transfer to another plan; and

(3) Terminating the contract in accordance with Section 1.15, *Renewal and Withdrawal of Approval.*

(e) Prior to taking action as described in paragraphs (c) and (d) of this clause, the OPM will notify the Carrier and offer an opportunity to respond.

(f) The Carrier shall incorporate this clause in subcontracts with its underwriter, if any, and other subcontractors directly involved in the preparation or distribution of such advertising material and shall substitute "Contractor" or other appropriate reference for the term "Carrier."

SECTION 1.15
RENEWAL AND WITHDRAWAL OF APPROVAL (JAN 1991) (FEHBAR 1652.249-70)

(a) The contract renews automatically for a term of one (1) year each January first, unless written notice of non-renewal is given either by OPM or the Carrier not less than 60 calendar days before the renewal date, or unless modified by mutual agreement.

(b) This contract also may be terminated at other times by order of OPM pursuant to 5 U.S.C. 8902(e). After OPM notifies the Carrier of its intent to terminate the contract, OPM may take action as it deems necessary to protect the interests of Members, including but not limited to--

(1) Suspending new enrollments under the contract;

(2) Advising Enrollees of the asserted deficiencies; and

(3) Providing Enrollees an opportunity to transfer to another plan.

(c) OPM may, after proper notice, terminate the contract at the end of the contract term if it finds that the Carrier did not have at least 300 Enrollees enrolled in its Plan at any time during the two preceding contract terms.

SECTION 1.16
SUBCONTRACTS (JUL 2005) (FEHBAR 1652.244-70)

(a) The Carrier will notify the Contracting Officer in writing at least 30 days in advance of entering into any subcontract or subcontract modification, or as otherwise specified by this contract, if the amount of the subcontract or modification charged to the FEHB Program equals or exceeds $550,000 and is at least 25 percent of the total subcontract cost. The amount of the dollar charge to the FEHB Program shall be adjusted by the same amount and at the same time as any change to the threshold for application of the Truth in Negotiations Act pursuant to 41 U.S.C. 254b(a)(7). Failure to provide advance notice may result in a Contracting Officer's disallowance of subcontract costs or a penalty in the performance aspect of the Carrier's service charge. In determining whether the amount chargeable to the FEHB Program contract for a given subcontract or modification equals or exceeds the $550,000 threshold, the following rules apply:

(1) For initial advance notification, the Carrier shall add the total cost/price for the base year and all options, including quantity or service options and option periods.

(2) For contract modifications, options and/or renewals (e.g. evergreen contracts) not accounted for in paragraph (a)(1) of this clause, the Carrier shall provide advance notification if they cause the total price to equal or exceed the threshold. OPM's review will be of the modification(s), itself, but documentation for the original subcontract will be required to perform the review. The $550,000 threshold will be adjusted by the same amount and at the same time as any change to the threshold for application of the Truth in Negotiations Act. All subcontracts or subcontract modifications that equal or exceed the threshold are subject to audit under FAR 52.215-2 "Audit and Records-Negotiations" if based on cost analysis or 48 CFR 1646.301 and 1652.246-70 "FEHB Inspection" if based on price analysis. [2]

(b) The advance notification required by paragraph (a) of this clause shall include the information specified below:

[2] Section 811 of the National Defense Authorization Act for Fiscal Year 2018 (Pub. L. No. 115-91) increased the threshold for the application of the Truth in Negotiations Act from $750,000 to $2,000,000 for all contracts entered into after June 30, 2018. Based on this change in law, this contract subsection should be read to replace "$550,000" with "$2,000,000" and to replace "41 U.S.C. 254b(a)(7)" with "41 U.S.C. 3502(g)."

(1) A description of the supplies or services to be subcontracted;

(2) Identification of the type of subcontract to be used;

(3) Identification of the proposed subcontractor and an explanation of why and how the proposed subcontractor was selected, including the competition obtained;

(4) The proposed subcontract price and the Carrier's cost or price analysis;

(5) The subcontractor's current, complete, and accurate cost or pricing data and Certificate of Current Cost or Pricing Data, must be submitted to the Contracting Officer if required by law, regulation, or other contract provisions.

(6) (Reserved)

(7) A negotiation memorandum reflecting--

(i) The principal elements of the subcontract price negotiations;

(ii) The most significant consideration controlling establishment of initial or revised prices;

(iii) An explanation of the reason cost or pricing data are not required, if the Carrier believes that cost or pricing data are not required.

(iv) The extent, if any, to which the Carrier did not rely on the subcontractor's cost or pricing data in determining the price objective and in negotiating the final price;

(v) The extent, if any, to which it was recognized in the negotiation that the subcontractor's cost or pricing data were not accurate, complete, or current; the action taken by the Carrier and the subcontractor; and the effect of any such defective data on the total price negotiated;

(vi)The reasons for any significant difference between the Carrier's price objective and the price negotiated; and

(vii) A complete explanation of the incentive fee or profit plan when incentives are used. The explanation will identify each critical performance element, management decisions used to quantify each incentive element, reasons for the incentives, and a summary of all trade-off possibilities considered.

(c) The Carrier will obtain the Contracting Officer's written consent before placing any subcontract for which advance notification is required under paragraph (a) of this clause. However, the Contracting Officer may ratify in writing any such subcontract for which written consent was not obtained. Ratification will constitute the consent of the Contracting Officer.

(d) The Contracting Officer may waive the requirement for advance notification and consent required by paragraphs (a), (b) and (c) of this clause where the Carrier and subcontractor submit an application or renewal as a contractor team arrangement as defined in FAR Subpart 9.6 and--

(1) The Contracting Officer evaluated the arrangement during negotiation of the contract or contract renewal; and

(2) The subcontractor's price and/or costs were included in the Plan's rates that were reviewed and approved by the Contracting Officer during negotiation of the contract or contract renewal.

(e) If the Carrier follows the notification and consent requirements of paragraphs (a), (b) and (c) of this clause and subsequently obtains the Contracting Officer’s consent or ratification, then the reasonableness of the subcontract’s costs will be inferred as provided for in 1631.205-81. However, consent or ratification by the Contracting Officer will not constitute a determination:

(1) Of the acceptability of any subcontract terms or conditions;

(2) Of the allowability of any cost under this contract; or

(3) That the Carrier should be relieved of any responsibility for performing this contract.

(f) No subcontract placed under this contract will provide for payment on a cost-plus-a-percentage-of-cost basis. Any fee payable under cost reimbursement type subcontracts will not exceed the fee limitations in FAR 15.404-4(c)(4)(i). Any profit or fee payable under a subcontract will be in accordance with the provision of Section 3.7, *Service Charge*.

(g) The Carrier will give the Contracting Officer immediate written notice of any action or suit filed and prompt notice of any claim made against the Carrier by any subcontractor or vendor that, in the opinion of the Carrier, may result in litigation related in any way to this contract with respect to which the Carrier may be entitled to reimbursement from the Government.

SECTION 1.17
NOVATION AGREEMENT (JAN 1996)

The agreement at FEHBAR 1642.1204 shall be submitted for approval to OPM when the Carrier's assets or the entire portion of the assets pertinent to the performance of this contract, as determined by the Government, are transferred.

SECTION 1.18
AGREEMENT TO RECOGNIZE CARRIER'S CHANGE OF NAME (JAN 1996)

The agreement at FEHBAR 1642.1205 shall be submitted for approval to OPM when the Carrier changes its name and the Government's and Contractor's rights and obligations remain unaffected.

SECTION 1.19
UNDERWRITER (JAN 2009)

(a) If this Plan is underwritten, the Carrier shall not modify (except as allowed in Section 2.3, *Payment of Benefits and Provision of Services and Supplies*) or terminate the policy issued by the Underwriter of the Plan or give notice of termination or intent not to renew the policy without prior express approval of the Contracting Officer. The Carrier shall notify the Contracting Officer in writing of its decision to change Underwriters as soon as is reasonable after the decision is made but no later than at the time the Carrier submits its benefit and rate proposal to OPM for the succeeding contract term.

(b) In the event of any inconsistency between the terms of this contract between OPM and the Carrier and the terms of the policy issued by the Underwriter to the Carrier, the terms of this contract shall prevail.

(c) If this Plan is underwritten, the policy issued to the Carrier by its Underwriter is a part of this contract and is incorporated therein by reference. The Carrier shall include paragraph (b) in the contract with its Underwriter.

SECTION 1.20
[RESERVED]

SECTION 1.21
PATIENTS' BILL OF RIGHTS (JAN 1999)

(a) The Carrier shall implement the recommendations in the Health Care Consumer Bill of Rights and Responsibilities ("Patients' Bill of Rights") in accordance with OPM guidance.

(b) During the Carrier's provider contract renewal process, the Carrier shall make any necessary modifications to such provider contracts to comply with the recommendations of the Patients' Bill of Rights in accordance with OPM guidance. All new provider contracts with the Carrier shall comply with the recommendations of the Patients' Bill of Rights in accordance with OPM guidance.

SECTION 1.22
ADMINISTRATIVE SIMPLIFICATION-HIPAA (JAN 2008)

(a) The Carrier shall implement and be in compliance with the Department of Health and Human Services (DHHS) regulations regarding the standards for electronic transactions, code sets and unique identifiers on the date DHHS specifies. Subject to paragraph (c) of this section, the regulations at 45 CFR parts 160 and 162 are incorporated by reference in this contract.

(b) The Carrier shall implement and be in compliance with the DHHS regulations regarding the standards for privacy and security of individually identifiable health information on the date DHHS specifies. Subject to paragraph (c) of this section, the regulations at 45 CFR parts 160 and 164 are incorporated by reference in this contract.

(c) Because OPM has determined that the DHHS administrative simplification regulations should serve as a uniform nationwide standard for the FEHB Program, and because of the preemption provision at 5 U.S.C. 8902(m)(1), the provisions of 45 CFR part 160, subpart B are inapplicable to the Carrier with respect to the Plan.

(d) If the Carrier is an employee organization that retains an underwriter, then these requirements also apply to the underwriter with respect to the Plan. If the Carrier for the plan authorized under 5 U.S.C. 8903(l), qualifies for limited application of the HHS Privacy Rule as a business associate, then the HHS Privacy Rule requirements apply to the underwriting participating affiliates.

SECTION 1.23
HIPAA COMPLIANCE (JAN 1998)

(a) The Carrier shall comply with and shall take all steps reasonably necessary to ensure that its affiliates, subcontractors, and agents comply with the guaranteed availability provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations. "Guaranteed availability" means the Carrier, affiliates, subcontractors, and agents do not engage in practices that: 1) decline to offer health insurance coverage (as defined in section 2791(b)(1) of the Public Health Service Act "the Act") to, or deny enrollment of an eligible individual (as defined in section 2741(b) of the Act); or, 2) impose any preexisting condition exclusion (as defined in section 2701(b)(1)(A) of the Act), with respect to such coverage.

(b) A State or Federal enforcement action as the result of noncompliance with the requirements of HIPAA is a significant event under Section 1.10 of this contract, Notice of Significant Events. If the Carrier, or any affiliate, subcontractor, or agent, is notified of any enforcement action by any Federal or State authority with regard to HIPAA compliance, the Carrier must notify OPM within ten working days of learning of the action.

SECTION 1.24
NOTICE ON TERMINATION OF FEHBP OR PROVIDER CONTRACT (JAN 2003)

(a) Members who are undergoing treatment for a chronic or disabling condition or who are in the second or third trimester of pregnancy at the time a Carrier terminates (1) its FEHBP contract, (2) the members' specialty provider contract, or (3) a Preferred Provider Organization (PPO) or Point of Service (POS) network contract, for reasons other than cause, may be able to continue to see their specialty provider for up to 90 days or through their postpartum care.

(b) The Carrier shall notify its members in writing of its intent to terminate its FEHBP contract, the members' specialty provider contract, or a PPO or POS network contract, for reasons other than cause, in order to allow sufficient time for the members to arrange for continued care after the 90-day period or their postpartum care, whichever applies. The Carrier shall send the required notice to the member if the Carrier has in its records an address for the member different from the Enrollee's address; otherwise, the Carrier may send the notice to the Enrollee. The Carrier shall send the notice in time to ensure it is received by the members no less than 90 days prior to the date it terminates the contract, unless the Carrier demonstrates it was prevented from doing so for reasons beyond its control. The Carrier's prompt notice will ensure that the notification period and the transitional care period run concurrently.

SECTION 1.25
TRANSITIONAL CARE (JAN 2003)

(a) "Transitional care" is specialized care provided for up to 90 days or through the postpartum period, whichever is later, to a member who is undergoing treatment for a chronic or disabling condition or who is in the second or third trimester of pregnancy when the Carrier terminates (1) its FEHBP contract, (2) the member's specialty provider contract, or (3) a Preferred Provider Organization (PPO) or Point of Service (POS) network contract for reasons other than cause. The 90-day period begins the earlier of the date the member receives the notice required under Section 1.24, Notice on Termination of FEHBP or Provider Contract, or the date the Carrier's or the provider's contract ends.

(b) The Carrier shall ensure the following:

(1) If it terminates a specialty provider contract or a PPO or POS network contract other than for cause, it allows members who are undergoing treatment for a chronic or disabling condition or who are in the second or third trimester of pregnancy to continue treatment under the specialty provider for up to 90 days, or through their postpartum period, whichever is later, under the same terms and conditions that existed at the beginning of the transitional care period; and

(2) If it enrolls a new member who voluntarily changed Carriers because the member's former Carrier was no longer available in the FEHB Program, it provides transitional care for the member if he or she is undergoing treatment for a chronic or disabling condition or is in the

second or third trimester of pregnancy for up to 90 days, or through the postpartum period, whichever is later, under the same terms and conditions the member had under the prior Carrier.

(c) In addition, the Carrier shall (1) pay for or provide the transitional care required under this clause at no additional cost to members;

(2) require the specialty provider or network to promptly transfer all medical records to the designated new provider during or upon completion of the transition period, as authorized by the patient; and,

(3) require the specialty provider or network to give all necessary information to the Carrier for quality assurance purposes.

SECTION 1.26
STANDARDS FOR ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS (JAN 2022)

The Carrier will ensure and report that the following standards are included in new, renewing or amended contracts with Pharmacy Benefit Managers (PBMs) providing services to Enrollees and family members effective on or after January 1, 2022. Notwithstanding the foregoing, the revisions to Section 1.26 shall not take effect before the expiration of the Carrier's current contract (including the exercise of an existing option to extend the term by not more than one year at a time) but not later than January 2025. The PBM includes all entities that have a majority ownership interest in or majority control over the PBM. The PBM also includes any other subsidiary of the entity that has majority ownership or control over the PBM.

All PBMs must adhere to the provisions of this Section 1.26.

If the Carrier's PBM arrangement is with an Underwriter rather than with the Carrier, then all references to the Carrier and Plan appearing in this Section 1.26 shall be deemed to be references to the Underwriter.

(a) Definitions. Under this section

(1) "Expedited request" means a request initiated by the Prescriber, member, or member's representative when the time limit for standard utilization management review for the prescribed medication could seriously jeopardize the patient's life, health, or ability to regain maximum function.

(2) "Licensed pharmacist" means an individual currently licensed by the appropriate jurisdiction to engage in the practice of pharmacy consistent with that jurisdiction's laws and regulations.

(3) "Manufacturer payment" means any and all compensation, financial benefits, or remuneration the PBM or any Third Party receives from a pharmaceutical manufacturer for any dispensing or distribution channel, including but not limited to, discounts, credits, rebates (regardless of how categorized), market share incentives, chargebacks, commissions, administrative or management fees, patient assistance and any fees received for sales of utilization data to a pharmaceutical manufacturer.

(4) "Network pharmacy," means any retail, mail order, specialty, or licensed pharmacy provider that contracts with the PBM.

(5) "Pass-Through Transparent Pricing" means drug pricing in which the Carrier receives the full value of all discounts, rebates, credits or other financial guarantees or adjustments including any true up or reconciliation.

(6) "Pharmacy Benefit Manager" or "PBM" means the combination of

(i) a business or other entity that, pursuant to a contract with the Carrier, either directly or through an intermediary, manages the prescription drug benefit provided by the Carrier including, but not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with Network pharmacies, and controlling the cost of covered prescription drugs; and

(ii) all entities that have a majority ownership interest in, or majority control over, the business or other entity that is in contract with the Carrier referenced in (i).

(7) "Prescriber" means any licensed, certified or otherwise legally authorized health care professional authorized by law to prescribe a prescription drug.

(8) "Third Party" means any consultant, partner, administrator, intermediary or other entity outside the scope of the relationships between or among the PBM and the FEHB enrollee, Carrier, and/or OPM. It does not include wholesalers, distributors, or pharmacies.

(9) "Total Product Revenue" means the total dollar sales of prescription drugs at the prescription price negotiated with clients and associated administrative fees, either through retail Networks or PBM-owned or controlled mail order pharmacies, with respect to the PBM's entire client base, for the reporting period.

(10) "Mid-year formulary change" means any change that occurs to the formulary effective on a date in a plan year later than the first day of the plan year. Positive mid-year formulary changes enhance formularies by adding drugs or placing a drug on a lower cost~~s~~-sharing tier or removing or relaxing utilization management (UM) requirements for drugs. Restrictive mid-year formulary changes negatively impact formularies by removing drugs, moving drugs to higher tiers, or tightening UM requirements for drugs.

(11) "Impacted Member" means any member who is on a prescription drug that undergoes a mid-year formulary change.

(12) "Written notice" means notification to each Impacted Member by U.S. mail, secure e-mail or text message (if approved by the member).

(b) Transparency Standards

(1) The PBM shall not be majority-owned or majority-controlled by a pharmaceutical manufacturing company. The PBM must disclose to the Carrier and OPM the name of any entity that has a majority ownership interest in or majority control over the PBM.

(2) The PBM shall agree to provide Pass-Through Transparent Pricing as defined above for the following categories:

(i) Retail Pharmacies: The PBM shall charge the Carrier no more than the amount as determined by Pass-Through Transparent Pricing paid to the pharmacy for each drug plus a dispensing fee.

(ii) Mail Order or Specialty Pharmacies not owned or affiliated with the PBM: The PBM shall charge the Carrier no more than the amount as determined by Pass-Through Transparent Pricing paid to the pharmacy for each drug plus a dispensing fee.

(iii) Mail Order or Specialty Pharmacies owned or affiliated with the PBM: The PBM shall charge the Carrier the cost of the drugs based on the pharmacy's actual acquisition cost, plus a dispensing fee. Costs shall not be based on industry benchmarks or set pricing including, but not limited to, Average Acquisition Cost (AAC), Maximum Allowable Charge (MAC), Average Wholesale Price (AWP), and Wholesale Acquisition Cost (WAC).

(3) The PBM or any other Third Party that negotiates or collects Manufacturer Payments allocable to the Carrier agrees to credit to the Carrier either as a price reduction or by cash refund the value of all Manufacturer Payments properly allocable to the Carrier. Patient assistance that is used to reduce member cost shares are not allocable to the Carrier.

(4) The PBM must identify sources of profit to the Carrier and OPM as it relates to the FEHB contract.

(5) All of the PBM's fees, including, but not limited to, administrative or dispensing fees, must be clearly identified to retail claims, mail claims, specialty claims, and clinical or other programs, if applicable. The PBM must agree to disclose each fee to the Carrier and OPM.

(6) The PBM, or any Third Party that negotiates or collects Manufacturer Payments allocable to the Plan, will provide the Carrier with quarterly and annual Manufacturer Payment Reports identifying the following information. This information shall be presented for both the total of all prescription drugs dispensed through the PBM, acting as a specialty and/or a mail order pharmacy, and its retail Network and in the aggregate for the 25 brand name drugs that represent the greatest cost to the Carrier or such number of brand name drugs that together represent 75 percent of the total cost to the Carrier, whichever is the greater number:

(i) the dollar amount of Total Product Revenue;

(ii) the dollar amount of total drug expenditures for the Plan;

(iii)the dollar amount of all Manufacturer Payments earned by the PBM for the reporting period;

(iv) the Manufacturer Payments that have been (1) earned but not billed (2) billed and (3) paid to the PBM based on the drugs dispensed to the Plan members during the past year.

(v) the percentage of all Manufacturer Payments earned by the PBM for the reporting period that were Manufacturer Formulary Payments, which are payments the PBM receives from a manufacturer in return for formulary placement and/or access, or payments that are characterized as "formulary" or "base" rebates or payments pursuant to the PBM's agreements with pharmaceutical manufacturers;

(vi)the percentage of all Manufacturer Payments received by the PBM during the reporting period that were Manufacturer Additional Payments, which are all Manufacturer Payments other than Manufacturer Formulary Payments.

(7) The PBM agrees to provide the Carrier, at least annually, with all financial and utilization information requested by the Carrier relating to the provision of benefits to eligible Enrollees through the PBM and all financial and utilization information relating to services provided to the Carrier, including but not limited to, a reasonable sample of retail pharmacy remittance advices, as selected by the Carrier.

(8) The Carrier shall provide any information it receives from the PBM, including a copy of its contract with the PBM to OPM. At OPM's request, the Carrier must obtain from the PBM any reasonable information or reports and provide it to OPM. A PBM providing information to a

Carrier under this subsection may mark that information as confidential commercial information. The Carrier, in its contract with the PBM shall effectuate the PBM's consent to the disclosure of this information to OPM. OPM shall handle the information in accordance with 5 CFR Part 294.

(9) The Carrier will require that its PBM:

(i) Provide information to physicians, pharmacists, other health care professionals, consumers, and payers about the factors that affect formulary system decisions, including: cost containment measures; the procedures for obtaining non-formulary drugs; and the importance of formulary compliance to improving quality of care and restraining health care costs;

(ii) Provide consumer education that explains how formulary decisions are made and the roles and responsibilities of the consumer; and

(iii) Disclose the existence of formularies and have copies of the current formulary readily available and publicly accessible.

(10) In accordance with FEHBAR 1652.204-74, FAR 52.215-2 and FEHBAR 1652.246-70, all contracts and other documentation that support amounts charged and credited to the Carrier contract are fully disclosed to and auditable by the OPM Office of Inspector General (OPM OIG). The PBM must provide the OPM OIG upon request complete copies of all PBM records including, but not limited to:

(i) All PBM contracts with Participating Pharmacies, including invoices, receipts and credits;

(ii) All PBM contracts with Pharmaceutical Manufacturers, including invoices, receipts, and credits;

(iii)All PBM contracts with Third Parties purchasing or using claims data;

(iv) All PBM transmittals in connection with sales of claims data to Third Parties or other entities;

(v) All PBM Maximum Allowable Cost (MAC) price lists.

(vi) All PBM records relating to patient assistance maximizer programs, optimizer programs, or similar arrangements with Third Parties; and

(vii)All PBM records pertaining to arrangements with Third Parties, including Group Purchasing Organizations (GPOs).

(11) The Carrier at the minimum must perform an annual check of the PBM's adherence to the pricing standards outlined in (b)(2)(i), (ii), and (iii).

(c) Integrity Standards

(1) The Carrier will require that its PBM agree to adopt and adhere to a code of ethics promulgated by a national professional association, such as the Code of Ethics of the American Pharmacists Association, for their employed pharmacists.

(2) The Carrier will require that its PBM be licensed as required by the appropriate jurisdiction's laws and regulations.

(3) The Carrier will require that its PBM only employ or contract with licensed pharmacists for roles that require such a license under the appropriate jurisdiction's laws and regulations.

(4) The PBM shall perform its duties with care, skill, prudence, diligence, and professionalism.

(5) A PBM shall notify the Carrier in writing of any activity, policy, or practice of the PBM that directly or indirectly presents any conflict of interest with the duties imposed in this subsection.

(6) A PBM, or Carrier, shall not enter into a contract with a pharmacy or pharmacist that prohibits or penalizes a pharmacy or pharmacist for disclosure of information to a member regarding:

(i) The cost of a prescription medication to the member; or

(ii) The availability of any therapeutically-equivalent alternative medications or alternative methods of purchasing the prescription medication, including but not limited to, paying a cash price that is less expensive to the member than the cost of the prescription under the Plan.

(d) Performance Standards

The Carrier will require that its PBM contractors develop and apply a quality assurance program specifying procedures for ensuring contract quality on the following standards at a minimum and submit reports to the Carrier on their performance. PBMs must meet, at minimum, the member inquiry, customer service, claims processing, and other applicable standards set for Carriers at Section 1.9(f). All other standards discussed below will have specific target goals the PBM is expected to achieve. Carriers may permit PBMs to measure compliance using statistically valid samples for the PBMs book of business. Agreed to standards shall be provided to OPM for its review and comment. If OPM has concerns about a particular standard, the Carrier agrees to present OPM's concerns to the PBM and either revise the standard as requested by OPM or revise the standard to the extent feasible and present to OPM information demonstrating the problems associated with making the requested revisions in full.

(1) Point of Service (POS) system response time. The PBM's network electronic transaction system provides rapid response to Network pharmacies.

(2) POS system availability. The PBM's network electronic transaction system generally is available to, and accessible by, Network pharmacies.

(3) Licensing. The PBM verifies the appropriate licensing of its Network pharmacies. This includes DEA registration for U.S. pharmacies, and the equivalent, if one exists, for pharmacies outside of the U.S.

(4) Dispensing accuracy – The PBM dispenses its prescriptions to the correct patient and for the correct drug, drug strength and dosage in accordance with the prescription not less than 99.9 percent of the time.

(5) Mail service pharmacy turnaround time – The PBM promptly dispenses and ships at least 98 percent on average of all prescriptions not requiring intervention or clarification within 3 business days or meets an equivalent measure approved by OPM.

(6) Specialty pharmacy shipment stability. The Carrier or PBM's specialty pharmacy must have policies and procedures in place to promote effective shipping practices and monitor cold chain packaging. Specific areas to be addressed include achievement of internal and external metrics and the identification and appropriate use of best practices.

(7) Quality of Drug Therapy. The quality assurance program implemented by a Carrier's PBM contractor must include a process to measure the quality of its drug therapy provided to enrollees. Specific areas to be addressed include achievement of quality targets measured by both internal and external metrics; identification and appropriate use of best practices; and application of evidence-based medicine, as appropriate.

(e) Mid-Year Formulary Changes may not become effective until an itemized list is provided to OPMPharmacy@OPM.gov, and to your Health Insurance Specialist with a copy to the Contracting Officer.

(1) Positive formulary changes may be effective at any time after the itemized list of Mid-year formulary changes is provided as set forth above.
(2) FEHB Carriers must notify their Contracting Officer at least 70 days prior to making any Restrictive Formulary Change effective during the plan year that results in any Impacted Member.
(3) EHB Carriers must provide Impacted Members with written notice of a Restrictive mid-year formulary change at least 60 days prior to the date the formulary change becomes effective.
(4) FEHB Carriers have the option to grandfather Impacted Members of a restrictive formulary change for coverage and cost-sharing for the remainder of the plan year. In such cases, Impacted Member notification is not required. However, FEHB Carriers must notify OPMPharmacy@OPM.gov and their Contracting Officer at least 10 days prior to making any restrictive mid-year formulary change that has no member impact.
(5) Carriers may immediately remove from their formulary drugs deemed unsafe based on new information on a drug's safety or efficacy or removed from the market by their manufacturer or due to long-term drug shortages without meeting the advance notice requirement specified above. In such cases, FEHB Carriers must provide retrospective written notice of any such formulary changes to Impacted Members and OPM as soon as possible.
(6) When long-term drug shortages result in disruption to the formulary, FEHB Carriers must review their formularies and ensure that alternative drug(s) are available at the same tier or at a lower tier.

(f) Alternative Drug Options

The Carrier will require that its PBM contractors, at a minimum, utilize the following protocols for PBM initiated drug interchanges (any change from the original prescription) other than generic substitutions:

(1) The PBM must treat the Prescriber, and not itself, as the ultimate decision-maker. Furthermore, to the extent appropriate under the circumstances, the PBM must allow the patient input into that decision-making process. At a minimum, the PBM must provide the patient with a written notice in the package sent to the patient that the drug interchange has occurred with the approval of the Prescriber.
(2) The PBM will obtain authorization for a drug interchange only with the express, verifiable authorization from the Prescriber as communicated directly by the Prescriber, in writing or verbally, or by a licensed medical professional or other office staff member as authorized by the Prescriber.
(3) The PBM must memorialize in appropriate detail all conversations with patients and Prescribers in connection with drug interchanging requests, including the identity of the contact person at the Prescriber's office and the basis for his or her authority.
(4) The PBM will only interchange a patient's drug from a lower priced drug to a drug with a higher cost to the patient or Plan when authorized by the Carrier or the Plan.

(5) The PBM will permit pharmacists to express their professional judgment to both the PBM and Prescribers on the impact of drug interchanges and to answer Prescribers' questions. PBMs will not require pharmacists to, and will not penalize pharmacists for refusing to, initiate calls to Prescribers for drug interchanges that in their professional judgment should not be made.
(6) The PBM will offer to disclose, and if requested, will disclose to Prescribers, the Carrier, and patients (i) the reason(s) why it is suggesting a drug interchange and (ii) how the interchange will affect the PBM, the Plan, and the patients financially.

(g) Utilization Management Timeframe –
(1) The PBM must promptly review and respond to requests for prior approval for specific drugs and any other utilization management edits following receipt of all required information.
(i) For Expedited requests, the PBM must review and respond within 24 hours.
(ii) For other, non-expedited requests, the PBM must review and respond within 72 hours.
(2) For expiring prescription prior authorizations (PAs), the PBM must:
(i) have in place a process to review all expiring PAs; and
(ii) must notify members at least 45 days before the expiration of a PA for a maintenance medication.

(h) Patient Safety Standard - The Carrier will require that its PBM establish drug utilization management, formulary process and procedures that have distinct systems for identifying and rectifying consumer safety issues including:

(i) A system for identifying and communicating drug and consumer safety issues at point-of-service;
(ii) A system of drug utilization management tools, such as prospective and concurrent drug utilization management that identifies situations which may compromise the safety of the consumer.
(iii) A system/process for error reporting; and
(iv) A system/process for identifying/managing risk

(i) Safety and Accessibility for Consumers - The Carrier will require that its PBM meets the following standards related to pharmacy Network management and consumer access to medications.

(1) The Carrier will require that its PBM define the scope of its services with respect to:
(i) The distribution channels offered (e.g. pharmacy Network, mail order pharmacies, or specialty pharmacies);
(ii) The types of pharmacy services offered within each distribution channel; and
(iii) The geographic area served by each distribution channel.

(2) The Carrier will require that for each distribution channel provided by its PBM, the PBM:
(i) Establishes criteria and measures actual performance in comparison to those criteria: and
(ii) Makes improvements where necessary to maintain the pharmacy network and meet contractual requirements.

(3) The Carrier will require that its PBM contractor establish a quality and safety mechanism for each distribution channel in order to identify and address concerns related to:

(i) Quality and safety of drug distribution; and
(ii) Quality of service

(j) Fraud, Waste, and Abuse

(1) The PBM must establish fraud, waste and abuse detection processes and procedures, with distinct systems for identifying and rectifying FWA issues including:
  (i) A system designed to detect and eliminate FWA
  (ii) A system that assesses its vulnerability to FWA to include, but not limited to, performing post-payment reviews and audits of providers identified either proactively or reactively;
  (iii) A system/process for FWA reporting; and
  (iv) A system/process for identifying/managing risk

(2) Any third party or entity providing services or supplies related to the administration of payments or benefits must certify to the PBM that it has established fraud, waste and abuse detection processes and procedures, with distinct systems for identifying and rectifying FWA issues including:
  (i) A system designed to detect and eliminate FWA;
  (ii) A system that assesses its vulnerability to FWA to include, but not limited to, performing post-payment reviews and audits of providers identified either proactively or reactively;
  (iii) A system/process for FWA reporting; and
  (iv) A system/process for identifying/managing risk.

(k) Contract Terms - The contract between the PBM and the Carrier must not exceed 3 years without re-competition unless the Contracting Officer approves an exception. The Carrier's PBM contract must allow for termination based on a material breach of any terms and conditions stated in the Carrier's PBM contract. The Carrier must provide sufficient written notice of the material breach to the PBM and the PBM must be given adequate time to respond and cure the material breach.

SECTION 1.27
DISCLOSURE NOTICE UNDER P.L. 108-173 (MEDICARE MODERNIZATION ACT OF 2003) (JAN 2006)

The Carrier will issue, as part of its FEHB benefits brochure, a disclosure notice concerning creditable prescription drug coverage in accordance with the regulation at 42 CFR 423.56 issued by the Department of Health and Human Services.

SECTION 1.28
CARRIER DISASTER RECOVERY PLAN (JAN 2007)

The Carrier must implement a disaster recovery plan that addresses flexibility for the following:

(a) Medical and pharmacy procedures and requirements;
(b) Barriers to accessing needed health care;
(c) Requests for out-of-network medical services;
(d) Alternatives for medical pre-certification, referrals, medical necessity review and notification of hospital admissions;
(e) Accessing other PCPs or specialists;
(f) Pharmacy restrictions, refills, additional supplies of medications as backup;
(g) Mail-order pharmacy;
(h) Adhering to recommendations for vaccinations from the Center for Disease Control;
(i) Claims payments;
(j) Crisis toll free hotline;
(k) Ability to identify current members;
(l) Recovery procedures for critical business functions (i.e., system, network, communication, work area recovery); and
(m) Secure backup site (hot/cold). A "hot work site" is a designated location to be used in the event of a disaster that is fully prepared for continuation of work to which the employees can go. A "cold work site" is a designated location to use in the event of a disaster that is not fully prepared for continuation of work to which the employees can go.

The Carrier must provide OPM with the following information:
(a) description of its disaster recovery plan;
(b) the Carrier's current state of readiness and the frequency of evaluations;
(c) the Carrier's work with its subcontractor on this issue;
(d) a timeline; and
(e) any potential problem areas.

The Carrier may implement its own additional measures.

Carriers must submit this information by January 1, 2007. Carriers who enter the FEHBP subsequent to 2007, must submit this information by January 1st of their first FEHBP contract year. Any material changes to the disaster recovery plan, such as a prime disaster recovery subcontract change or a hot site change, should be reported to OPM.

SECTION 1.29
HEALTH INFORMATION TECHNOLOGY REQUIREMENTS (JAN 2011)

(a) The Carrier agrees that as it implements, acquires, or upgrades health information technology systems, it shall utilize, where available, certified health information technology systems and products that meet interoperability standards recognized by the Secretary of Health and Human Services, as existing on the date of the implementation, acquisition, or upgrade of health information technology systems ("Interoperability Standards"). Interoperability Standards include those standards adopted by the Secretary to promote meaningful use of health information technology in accordance with Public Law 111-5, The Health Information Technology for Economic and Clinical Health Act (HITECH Act).

(b) The Carrier agrees that such health information technology systems will have already been pilot tested in a variety of live settings and refined, if needed, before the Carrier will consider them for implementation.

(c) The Carrier agrees that as its provider agreements are established or renewed, it will encourage contracted providers to comply with applicable Interoperability Standards and to demonstrate meaningful use of health information technology in accordance with the HITECH ACT.

SECTION 1.30
HEALTH INFORMATION TECHNOLOGY PRIVACY AND SECURITY (JAN 2019)

(a) Any Carrier subcontractor, large provider, or vendor, that administers a personal health record or quality and cost or price transparency software applications for Members that collect, create, receive, store or transmit individually identifiable protected health information of Members that does not qualify as a covered entity or business associate under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or regulations will be required by the Carrier to, at a minimum, comply with equivalent privacy and security policies as are required of a "covered entity" under the HIPAA Privacy and Security regulations.

(b) The Carrier will provide for consumer transparency including, but not limited to, the posting of the subcontractor's, large provider's, or vendor's notice of privacy practices prominently at the point where the Member enters the subcontractor's, large provider's, vendor's or other entity's website or web portal.

(c) Notices of privacy practices disclosures must describe the uses of individually identifiable protected health information and any potential disclosure to other entities as described in the HIPAA Privacy Rule.

(d) The Carrier must allow the Contracting Officer or an authorized representative of the Contracting Officer to independently perform credentialed vulnerability scans and configuration compliance audits (using administrator accounts) against the Carrier's information systems and environments described in this subsection to determine whether the Carrier has controls in place to ensure its information systems are securely configured and patches are timely applied and up to date based on the level of risk in the environment.

(1) NIST SP 800-53 (or its current equivalent) may be used as a benchmark for conducting audits of Carrier information systems. The Contracting Officer or an authorized representative of the Contracting Officer may recommend that the Carrier adopt a best practice drawn from NIST SP 800-53 (or its current equivalent) to the following Carrier information systems:

(i) Information systems that directly process FEHBP data for contract purposes; and

(ii) All other information systems operating in the same general information technology control environment(i.e. any resources in the same physical or logical environment) as the information systems in subparagraph as the information systems in (i) above.

(2) In a written response to such a recommendation, the Carrier shall do one of the following:

(i) Agree to adopt the recommendation,

(ii) Explain that it is already in compliance with the recommendation, or

(iii) Explain why maintaining its current practice is compliant with Section 1.22, captioned Administrative Simplification -- HIPAA and is equally, if not more, appropriate for its business purposes than the recommended best practice from (1) above.

(3) Upon request of the Contracting Officer or an authorized representative of the Contracting Officer, the Carrier agrees to demonstrate to the requestor its compliance with either a recommended best practice from (1) or an alternative current practice from subparagraph (2)(iii) that the Carrier has adopted. Evidence submitted pursuant to (2) that the Carrier and Contracting Officer agree is extremely sensitive may, at the Carrier's request and the Contracting Officer's concurrence, be reviewed on the Carrier's premises.
(4) If the Carrier agrees to adopt a best practice recommendation made pursuant to (1) above, the Contracting Officer will allow reasonable time for the Carrier to implement the best practice before making any request under (3) above.

SECTION 1.31
DEFINITION AND SCOPE OF INFORMATION SECURITY (JAN 2012)

(a) As indicated in FAR Subpart 2.1, information security means protecting OPM information and information systems from unauthorized access, use, disclosure, disruption, modification, or destruction in order to provide —

1. Integrity, which means guarding against improper information modification or destruction, and includes ensuring information nonrepudiation and authenticity; or destruction.

2. Confidentiality, which means preserving authorized restrictions on access and disclosure, including means for protecting personal privacy and proprietary information; and

3. Availability, which means ensuring timely and reliable access to, and use of, information.

(b) This Contract grants the Carrier access to OPM's Letter of Credit (LOC) System. The Carrier recognizes its responsibility to help maintain the information security of OPM's LOC System. Section 1.31 through 1.35 inclusive and Section 5.67 and 5.68 pertain exclusively to such limited access to OPM's LOC System.

SECTION 1.32
CARRIER PERSONNEL ACCESS DETERMINATION REQUIREMENTS (JAN 2021)

(a) Carrier personnel who receive a user identification and password to access OPM's LOC System shall comply with the U.S. Office of Management and Budget (OMB) Memorandum M-05-24, referenced in paragraph (a) of FAR 52.204-9, Personal Identity Verification of Contractor Personnel, which is available on-line at https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/memoranda/2005/m05-24.pdf.

(b) Homeland Security Presidential Directive (HSPD) 12 requires the Government to institute standards for secure and reliable identification of employees and contractors accessing Federal facilities. OPM has determined that a National Agency Check with Written Inquiries (NACI) is required for Carrier employees with access to OPM's LOC System. The Carrier must obtain these access determinations for its employees with access to OPM's LOC System using the e-QIP system. The NACI will be requested on a Standard Form (SF) 85, "Questionnaire for Non-Sensitive Positions." OPM will not allow Carrier employees who have not completed the NACI process in any of its facilities, pursuant to applicable security policies.

(c) Carriers must meet facility and access clearance requirements.

(d) Carriers are responsible for the security, integrity and appropriate authorized use of their systems interfacing with OPM's LOC System. OPM, through its Contracting Officer, may

require the use or modification of security and/or secure communications technologies related to Government systems access and use.

(e) OPM, at its discretion, may suspend or terminate the Carrier's access to and/or use of OPM's LOC System when a security or other electronic access, use or misuse issue gives cause for such action. The suspension or termination may last until such time as the Government determines that the situation has been corrected or no longer exists.

SECTION 1.33
INFORMATION TECHNOLOGY SYSTEMS SECURITY (JULY 2011)

Carriers must comply with OPM IT Security and Privacy, NIST and OMB requirements for system users. System users are Carrier employees with a user identification and password to access OPM's LOCS. Based upon the Federal Information Processing Standards Publication 199 (FIPS PUB 199), the Government has determined that a minimum level, applies to the sensitivity of the data contained in OPM's LOC System and a minimum level, applies to the operational criticality of the data processing capabilities of OPM's LOC System. (Note: FIPS PUB 199 is accessible on line at: http://csrc.nist.gov/publications/fips/fips199/FIPS-PUB-199-final.pdf.)

In order to access the OPM LOC System, the Carriers must demonstrate that they comply with the end-user security requirements in the Federal Information Security Management Act of 2002 (FISMA, Public Law 107-347, 44 U.S.C. 3531-3536); Office of Management and Budget (OMB) Circular A-130, Appendix III, "Security of Federal Automated Information Systems" and an acknowledgement of their understanding of the security requirements in the contract. (Note: OMB Circular A-130, Appendix III is accessible on line at: http://www.whitehouse.gov/omb/circulars/a130/appendix_iii.pdf.)

SECTION 1.34
CARRIER ACCESS TO OPM IT SYSTEMS (JAN 2011)

Each Carrier employee is required to utilize individual identification and authorization to access the OPM LOC System. Using shared accounts to access the OPM LOC System is strictly prohibited. OPM will disable accounts and access to the OPM LOC System will be revoked and denied if Carriers share accounts. Users of the OPM LOC System will be subject to periodic auditing to ensure compliance to OPM Security and Privacy Policy. In addition, Carriers are required to comply with the following NIST 800-53 security controls to include at a minimum: Access Control (AC) - Controls falling under the AC category ensure that proper restrictions are in place to limit access to authorized users with a need to know.

The Carrier must:

(1) Provide to the OPM Letter of Credit (LOC) System Security Officer listed in OPM's "Letter of Credit Drawdown System User Manual For Experience Rated Carriers" - Contacts for Questions and Problem Resolution, an initial and complete list of employees' names that require access to OPM's LOC System;

(2) By the fifth day of each month thereafter, send a staffing change report to the Contracting Officer's Representative, contract administrator and LOC Security Officer. The report must contain the listing of all staff members with an LOC System user identification and password who left employment or were hired under this contract in the past 60 days. This form

must be submitted even if no separation has occurred during this period. Failure to submit a 'Contractor Staffing Change Report' each month will result in the suspensions of all user IDs associated with this contract; and

(3) Anyone who accesses the OPM LOC System must complete OPM's IT Security and Privacy Awareness Training (ITPSA) annually and upon the initial access. This requirement applies to all Carriers.

SECTION 1.35
PROCEDURES FOR REPORTING A LETTER OF CREDIT SYSTEM SECURITY BREACH (JAN 2013)

(a) A breach of data, system access, etc. includes loss of control, compromise, unauthorized disclosure, unauthorized acquisition, or unauthorized access of information whether physical or electronic. As an agency, OPM is required to immediately report all potential security and data breaches -- whether they involve paper documents or electronic information. In order to meet this responsibility, OPM has established a new internal procedure for reporting the loss or possible compromise of any data, and this clause conforms to that procedure.

(b) OPM Carriers must report any breach or potential breach to the OPM Situation Room and the Contracting Officer within 30 minutes of becoming aware of the risk – regardless of the time or day of the week. Breaches should be reported, even if it is believed the breach is limited, small, or insignificant. OPM's IT security experts, who will determine when a breach needs additional focus and attention. The OPM Situation Room is available 24 hours per day, 365 days per year. Report the breach to the OPM Situation Room and the Contracting Officer either by phone or by e-mail; however, be sure NOT to include PII in the e-mail.

(1) OPM Carriers must report a breach or potential security breach to the OPM Situation Room at: sitroom@opm.gov, (202) 418-0111, Fax (202) 606-0624.

(2) When notifying the Situation Room, please copy the Contracting Officer.

(3) To get help with WinZip, please contact the OPM Help Desk at: helpdesk@opm.gov, (202) 606-4927, TTY (202) 606-1295.

(4) If you have questions regarding these procedures, contact the Contracting Officer.

SECTION 1.36
FEDERAL FLEXIBLE SPENDING ACCOUNT PROGRAM (FSAFEDS) PAPERLESS REIMBURSEMENT (JAN 2013)

(a) If the Carrier participates in the FSAFEDS paperless reimbursement process, the Carrier must notify OPM following the discovery of a triggering event, as defined herein. Unless OPM and the Carrier mutually agree upon a different triggering event, the triggering event for notice shall be when the paid or denied claims included in a weekly electronic feed to FSAFEDS contain systemic errors attributable to a single claims processing system programming error, including but not limited to, a programming error in setting a co-payment or deductible amount. OPM and the Carrier recognize and agree that medical, dental, or prescription drug claim payment adjustments and voids made in the regular course of business including but not limited to,

network pricing changes or restocking unclaimed prescription drugs, are not claims processing system programming errors for purposes of this provision.
(b) The Carrier shall provide notice to OPM as set forth in subsection (a) above within one business day after discovering the triggering event.
(c) The Carrier's notice to OPM shall explain in writing the nature of the triggering event.
(d) After giving such notice, the Carrier shall take the following steps:

(1) Explain in writing, the steps that the Carrier has taken or will take to correct the error within five (5) business days after discovering the triggering event;

(2) Collaborate with FSAFEDS to confirm the number of impacted Enrollees or the number of claims affected by the error;

(3) Assist FSAFEDS when requested to develop an action plan that assists Enrollees to avoid a situation in which Enrollees would forfeit a portion of their annual salary reduction contributed toward FSAFEDS;

(4) Draft in consultation with OPM and FSAFEDS a notice to all affected Enrollees that explains the nature of the error and how the Carrier anticipates solving the problem; and

(5) Timely inform OPM about issues raised by Enrollees that result from recovery efforts and cooperate with OPM's efforts to resolve those issues.

SECTION 1.37
PROCEDURES FOR INFORMATION SECURITY INCIDENT AND DATA BREACH REPORTING (JAN 2022)

(a) The specific terms listed below are defined as stated for purposes of this Section.
  (1) Incident is defined by 44 U.S.C. 3552(b)(2) and applicable OMB guidance.
  (2) Breach is defined in HHS regulations 45 CFR Part 164 Subpart D.
  (3) Compromise is defined in the current revisions of the glossary of NIST SP 800-32.
(b) A Carrier must report to OPM incidents and breaches where the confidentiality, integrity, or availability of FEHB member protected health information (PHI) is compromised or if a Carrier notifies law enforcement of an incident or breach that: (1) compromises its systems that contain or process FEHB Program data or (2) compromises its systems operating in the same general information technology control environment as the information systems that process FEHB Program data.
(c) The Carrier must report to OPM before any other external notifications are made (excluding notification to necessary parties for incident response), and in no case later than 24 hours after its incident response team determines the confidentiality, integrity, or availability of FEHB member PHI is compromised, or it has notified law enforcement of an incident or breach that meets the requirements stated in paragraph (b) of this Section.
(d) The Carrier must submit reports to OPM via email to Cybersolutions@opm.gov or via phone to (844) 377-6109. The Carrier must also notify their Health Insurance Specialist on its security incident and data breach reporting.
  (1) Any data shared with OPM that relates to an incident or breach must be transmitted in a secure manner.
  (2) The report should include the following:
    i. A brief description of the nature of the incident or breach.

ii. An estimate of the number of affected FEHB members, if feasible.
iii. A brief description of the remedial steps that the Carrier has already taken and those they plan to take.

(3) The Carrier is responsible for providing additional detailed information as soon as it becomes available.

(e) For a breach of PHI, the notice to FEHB enrollees will comport with 45 CFR 164.404 for breaches as defined in this Section or OPM guidance and must be coordinated with OPM before any communication with FEHB enrollees. All other notices must also be coordinated with OPM and the Carrier must follow OPM guidance to the extent practicable.

(f) In case of a subcontractor breach or incident the following applies.
(1) A subcontractor breach or incident must be reported to OPM by the Carrier no later than the calendar day following notice to the Carrier.
(2) Either the Carrier or its subcontractor may provide a notice of the breach to FEHB enrollees.
(3) If the subcontractor provides the notice, it must be in a form that allows the enrollee to easily identify the Carrier and FEHB plan. If specific identification is not practical under the circumstances, Carrier and FEHB plan identification shall be otherwise accomplished in a manner agreed upon with OPM.
(4) The Contracting Officer may direct the Carrier to issue a separate notice in order to avoid enrollee confusion.

SECTION 1.38
INCREASING TRANSPARENCY BY PROHIBITING GAG CLAUSES ON PRICE AND QUALITY INFORMATION (JAN 2022)

A Carrier shall not enter into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict a Carrier from—

(a) Providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, OPM, enrollees, or individuals eligible to become enrollees of the Carrier's FEHB Plans;

(b) Electronically accessing de-identified claims and encounter information or data for each covered individual in the Carrier's FEHB Plans, upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990, including, on a per claim basis—
(1) Financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract;
(2) Provider information, including name and clinical designation;
(3) Service codes; or
(4) Any other data element included in claim or encounter transactions; or

(c) Sharing information or data described in paragraph (a) or (b), or directing that such data be shared, with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated

pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

PART II – BENEFITS

SECTION 2.1
ENROLLMENT ELIGIBILITY AND EVIDENCE OF ENROLLMENT (JAN 2015)

(a) Enrollment.

(1) Each eligible individual who wishes to be enrolled in the plan offered by this Carrier shall, as a prerequisite to such enrollment, complete a Health Benefits Election Form, or use an electronic or telephonic method approved by OPM, within the time and under the conditions specified in 5 CFR Part 890. The personnel office having cognizance over the Enrollee shall promptly furnish notification of such election to the Carrier.

(2) A person's eligibility for coverage, effective date of enrollment, the level of benefits (option), the effective date of termination or cancellation of a person's coverage, the date any extension of a person's coverage ceases, and any continuance of benefits beyond a period of enrollment and the date any such continuance ceases, shall all be determined in accordance with regulations or directions of OPM given pursuant to chapter 89, title 5, United States Code.

(b) Special Limitations With Regard To Employee Organizations.

(1) A plan sponsored by an employee organization as defined by the Act, is available only to eligible employees, Tribal Employees, annuitants, former spouses, and former employees and eligible members of their families who must be or must become members of the sponsoring organization to enroll in the Plan.

(2) Employees with membership status in an employee organization at the time they become annuitants may retain their membership in the organization and, if eligible, continue their enrollment in the Plan. Survivor annuitants of Enrollees in the Plan may continue their enrollment in the Plan without becoming members of the sponsoring employee organization.

(c) The Carrier shall issue evidence of the Enrollee's coverage and furnish to the Enrollee copies of any forms necessary to make claim for benefits.

SECTION 2.2
BENEFITS PROVIDED (JAN 2020)

(a) The Carrier shall provide the benefits as described in the agreed upon brochure text found in Appendix A.

(b) In addition to providing benefits in accordance with (a) above, the Carrier shall be authorized to modify them as follows:

(1) To permit methods of treatment not expressly provided for, but not prohibited by law, rule or Federal policy, if otherwise contractually appropriate, and if such treatment is medically necessary and is as cost effective as providing benefits to which the Member may otherwise be entitled.

(2) To pay for or provide a health service or supply in an individual case which does not come within the specific benefit provisions of the contract, if the Carrier determines the benefit is within the intent of the contract, and the Carrier determines that the provision of such benefit is in the best interests of the Federal Employees Health Benefits Program.

(3) To offer in individual cases, after consultation with and concurrence by the Member and provider(s), a benefit alternative not ordinarily covered under this contract which will result in equally effective medical treatment at no greater benefit cost. An alternative benefit will be

made available for a limited time period and is subject to the Carrier's ongoing review. Members must cooperate with the Carrier's review process.

(c)The decision to offer, deny, or withdraw coverage for a modified benefit provided in accordance with (b) above is solely within the Carrier's discretion (unless the Carrier and Member have entered into an alternative benefits agreement that expressly modifies this authority), and is not subject to OPM review under the disputed claims process.

(d) In each case when the Carrier provides a non-covered benefit in accordance with the authority of (b) above, the Carrier shall document in writing prior to the provision of such benefit the reasons and justification for its determination. The writing may be in the form of an alternative benefit agreement with the Member. Such payment or provision of services or supplies while a valid charge under the contract shall not be considered to be a precedent in the disposition of similar cases or extensions in the same case beyond the approved period.

(e) Except as provided for in (b) above, the Carrier shall provide benefits for services or supplies in accordance with Appendix A.

(f) The Carrier, subject to (g) below, shall determine whether in its judgment a service or supply is medically necessary or payable under this contract.

(g) The Carrier agrees to pay for or provide a health service or supply in an individual case if OPM finds that the Member is entitled thereto under the terms of the contract.

(h) (1) Notwithstanding (b) and (e) above, in accordance with the Rehabilitation Act of 1973, in the case of a Member who is a qualified individual with a disability, the Carrier shall pay for or provide a covered health service or supply as an alternative benefit appropriate to the Member's needs, when required by OPM following OPM consultation with the Carrier, pursuant to paragraph 2.2(g), above.

(2)(i) An OPM requirement under (h)(1) is subject to ongoing review by OPM and the Carrier. Members must cooperate with the review process. If, in the Carrier's judgment, the conditions for the OPM requirement are no longer satisfied, the Carrier may request that OPM modify or terminate the requirement. OPM's decision to modify or terminate a requirement shall be subject to judicial review.

(ii) The Carrier agrees that its benefits as described in the brochure found at Appendix A, are reasonably and in good faith expected to result in coverage that satisfies Mental Health Parity and Addiction Equity Act requirements as defined in 45 C.F.R.146.136.

(i) In accordance with Section 2706(a) of the Public Health Service Act as added by the Affordable Care Act, the Carrier shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require the Carrier to contract with any health care provider willing to abide by the terms and conditions for participation established by the carrier. Nothing in this section shall be construed as preventing a Carrier from establishing varying reimbursement rates based on quality or performance measures.

SECTION 2.3
PAYMENT OF BENEFITS AND PROVISION OF SERVICES AND SUPPLIES (JAN 2016)

(a) By enrolling or accepting services under this contract, Members are obligated to all terms, conditions, and provisions of this contract. The Carrier may request Members to complete reasonable forms or provide information which the Carrier may reasonably request, provided, however, that the Carrier shall not require Members to complete any form as a precondition of

receiving benefits unless the form has first been approved for use by OPM. Notwithstanding Section 2.9*, Claims Processing*, forms requiring specific approval do not include claim forms and other forms necessary to receive payment of individual claims.

(b) All benefits shall be paid (with appropriate documentation of payment) within a reasonable time after receipt of reasonable proof covering the occurrence, character, and extent of the event for which the claim is made. The claimant shall furnish satisfactory evidence that all services or supplies for which expenses are claimed are covered services or supplies within the meaning of the contract.

(c) The procedures and time period for filing claims shall be as specified in the agreed upon brochure text (*Appendix A*). However, failure to file a claim within the time required shall not in itself invalidate or reduce any claim where timely filing was prevented by administrative operations of Government or legal incapacitation, provided the claim was submitted as soon as reasonably possible.

(d) The Carrier may request a Member to submit to one or more medical examinations to determine whether benefits applied for are for services and supplies necessary for the diagnosis or treatment of an illness or injury or covered condition of the Member and may withhold payment of such benefits pending completion of the examinations. The examinations shall be made at the expense of the Carrier by a physician selected by the Member from a panel of at least three physicians whose names are furnished by the Carrier, and the results of the examinations shall be made available to the Carrier and the Member.

(e) As a condition precedent to the provision of benefits hereunder, the Carrier, to the extent reasonable and necessary and consistent with Federal law, shall be entitled to obtain from any person, Tribal Employer, organization or agency, including the Office of Personnel Management, all information and records relating to visits or examination of, or treatment rendered or supplies furnished to, a Member as the Carrier requires in the administration of such benefits. The Carrier may obtain from any insurance company or other organization or person any information, with respect to any Member, which it has determined is reasonably necessary to:

(1) identify enrollment in a plan,

(2) verify eligibility for payment of a claim for health benefits, and

(3) carry out the provisions of the contract, such as subrogation, recovery of payments made in error, workers' compensation, and coordination of benefits.

(f) Benefits are payable to the Enrollee in the Plan or his or her assignees. However, under the following circumstances different payment arrangements are allowed:

(1) Reimbursement Payments for the Enrollee. If benefits become payable to the estate of an Enrollee or an Enrollee is a minor, or an Enrollee is physically or mentally not competent to give a valid release, the Carrier may either pay such benefits directly to a hospital or other provider of services or pay such benefits to any relative by blood or connection by marriage of the Enrollee determined by the Carrier to be equitably entitled thereto.

(2) Reimbursement Payments for a minor child. If a child is covered as a family member under the Enrollee's Self Plus One or Self and Family enrollment and is in the custody of a person other than the Enrollee, and if that other person certifies to the Carrier that he or she has custody of and financial responsibility for the child, then the Carrier may issue an identification card for the child(ren) to that person and may reimburse that person for any covered medical service or supply.

(3) Reimbursement Payments to family members covered under the Enrollee's Self Plus One or Self and Family enrollment. If a covered child is legally responsible, or if a covered

spouse is legally separated, and if the covered person does not reside with the Enrollee and certifies such conditions to the Carrier, then the Carrier may issue an identification card to the person and may reimburse that person for any covered medical service or supply. In the case of a legally separated spouse, the Carrier may also furnish the explanation of benefits to the spouse when determined by the Carrier to be required.

(4) Reimbursement payments to Government programs, such as Medicaid. If Federal law provides that reimbursement is payable to a Government program under coordination of benefits or similar rules, in lieu of being payable to the Enrollee or other covered person, the Carrier may reimburse the other Government program for any covered medical service or supply. To the degree that the Carrier is able to identify Medicaid beneficiaries, the Carrier will process claims directly to the provider of service or reimburse the Medicaid agency if the Medicaid agency has already paid the provider and is seeking reimbursement. When this situation is identified, the Carrier will update the member's records to ensure proper adjudication of claims.

(5) Compliance with the HIPAA Privacy Rule. The Carrier may pay benefits to a covered person other than the Enrollee when in the exercise of its discretion the Carrier decides that such action is necessary to comply with the HIPAA Privacy Rule, 45 C.F.R. 164.500 et seq.

(6) Any payments made in good faith in accordance with paragraphs (f)(1) through (f)(5) shall fully discharge the Carrier to the extent of such payment.

(g) *Erroneous Payments*. It is the Carrier's responsibility to proactively identify overpayments through comprehensive, statistically valid reviews and a robust internal control program. If the Carrier determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider. In the case of fraud or abuse, the Carrier must coordinate with OPM OIG as required by Section 1.9 and OPM's Fraud, Waste and Abuse guidance. The recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment under 48 C.F.R. 1631.201-70(h) regardless of any time period limitations in the written agreement with the provider. The Carrier shall follow general business practices and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall--

(1) Send a written notice of erroneous payment to the member or provider that provides: (A) an explanation of when and how the erroneous payment occurred, (B) when applicable, cite the appropriate contractual benefit provision, (C) the exact identifying information (i.e., dollar amount paid erroneously, date paid, check number, date of service and provider name), (D) a request for payment of the debt in full, and (E) an explanation of what may occur should the debt not be paid, including possible offset to future benefits. The notice may also offer an installment option. In addition, the Carrier shall provide the debtor with an opportunity to dispute the existence and amount of the debt before proceeding with collection activities;

(2) After confirming that the debt does exist and in the appropriate amount, send follow-up notices to the member or the provider at 30, 60 and 90 day intervals, if the debt remains unpaid and undisputed;

(3)(i) The Carrier may off-set future Benefits payable to the Member or to a provider on behalf of the Member to satisfy a debt due under the FEHBP if the debt remains unpaid and undisputed for 120 days after the first notice.

(ii) Notwithstanding section 2.3(g)(3)(i), a Carrier may set up benefit off-sets to a provider less than 120 days after the first notice as long as the Carrier electing this option

continues to comply with any remaining applicable steps enumerated in this subsection 2.3(g) as part of the Carrier's effort to recover erroneous benefit payments.

(4) After applying the first three steps, refer cases when it is cost effective to do so to a collection attorney or a collection agency if the debt is not recovered; provided, however, that the Carrier may not commence an overpayment recovery lawsuit later than December 31 of the third year after the year in which the overpayment was discovered by the Carrier (except in cases where the False Claims Act, 31 U.S.C 3729, or another federal limitations period applies);

(5) Make prompt and diligent effort to recover erroneous payments until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost effective to pursue further collection efforts or it would be against equity and good conscience to continue collection efforts;

(6) Additional prompt and diligent effort is required for significant claim overpayments that exceed $10,000 per each claim. Examples of such efforts include copies of dated notices, offset attempt(s) made, certified letter communication(s), and third party collection efforts to the extent required under (g)(4) above. The Carrier should maintain and provide to OPM upon request, documentation of those efforts.

(7) Suspend recovery efforts for a debt which is based upon a retroactive disenrollment that has been appealed under 5 C.F.R. 890.104 or a claim that has been appealed as a disputed claim under Section 2.8, until the appeal has been resolved;

(8)(i) The Carrier may charge the contract for benefit payments made erroneously but in good faith provided that it can document that it made a prompt and diligent effort to recover erroneous payments as described above.

(ii) Notwithstanding (g)(8)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that caused erroneous benefit payments) when the errors are egregious or repeated. These costs are deemed to be unreasonable and unallowable under section 3.2(b)(2)(ii);

(9) Maintain records that document individual unrecovered erroneous payment collection activities for audit or future reference.

(10) If OPM determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the Member, from the Member or, if to the provider, from the provider as specified in (g)(1) through (9).

(11) At the request of OPM, the Carrier shall provide evidence that it has taken the steps enumerated above in this subsection to promptly recover erroneous payments, including but not limited to overpayments related to Medicare coordination of benefits. OPM will review the Carrier's claims payments and procedures to validate the Carrier's prompt and diligent effort. The Contracting Officer may require the Carrier to establish and submit to the Contracting Officer a written corrective action plan.

(12) In compliance with the provisions of the Contract Disputes Act, the Carrier shall return to the Program an amount equal to the uncollected erroneous payment where the Contracting Officer determines that (a) the Carrier's failure to appropriately apply its operating procedure caused the erroneous payment and (b) that the Carrier failed to make a prompt and diligent effort to recover an erroneous payment.

(h) Erroneous payment recoveries may be reduced by any legal or collection agency fees expended to obtain the recoveries and which are not otherwise payable under this experience-rated

contract. The amount credited to the contract shall be the net amount remaining after deducting the related legal or collection agency fees.

(i) All health benefit refunds and recoveries, including erroneous payment recoveries, must be deposited into the working capital or investment account within 30 days and returned to or accounted for in the FEHBP letter of credit account within 60 days after receipt by the Carrier.

(j) Notwithstanding subsection (f), the Carrier reserves the right to pay the Member directly for all covered services described in the agreed upon brochure text attached as Appendix A.

SECTION 2.4
TERMINATION OF COVERAGE AND CONVERSION PRIVILEGES (JAN 2017)

(a) A Member's coverage is terminated as specified in regulations issued by the OPM. Benefits after termination of coverage are as specified in the regulations.

(b) A Member is entitled to a temporary continuation of coverage under the conditions and to the extent specified in the regulations or an extension of coverage under the conditions and to the extent specified below.

(c) A Member whose coverage hereunder has terminated is entitled, upon application within the times and under the conditions specified in regulations, to obtain assistance from the Carrier for enrollment in a guaranteed issue non-group contract available in the Carrier's service area. In the event this 31-day temporary extension period provides insufficient opportunity for the Member to obtain non-group coverage with an effective date commencing before or immediately upon termination of group coverage, the Carrier may, on a case-by-case basis, provide an additional 29 days extension of coverage (not to exceed a total of 60 days) as appropriate to avoid an interruption in coverage. The Member must explain in writing the circumstances for seeking additional extension, and the Carrier must notify the Contracting Officer of any extension granted, or obtain prior approval of any request for an extension that the Carrier intends to deny.

(d) Costs associated with the additional extension of coverage not to exceed 60 days are allowable costs under the contract. Costs associated with writing or providing benefits under conversion contracts shall not be an allowable cost of this contract.

SECTION 2.5
SUBROGATION AND REIMBURSEMENT (JAN 2016)

(a) The Carrier must condition the extension of benefits and benefit payments to covered individuals on its rights to subrogation and reimbursement under 5 CFR 890.106.

(b) The Carrier shall subrogate and pursue reimbursement of FEHB claims if doing so would be in the best interests of the FEHBP.

(c) The Carrier may recover directly from any party that may be liable, or from the covered individual, or from any applicable insurance policy, or a workers' compensation program or insurance policy, all amounts available to or received by or on behalf of the covered individual by judgment, settlement, or other recovery, to the extent of the amount of benefits that have been paid or provided by the Carrier. The Carrier has the right to file suit in federal court in order to enforce its rights to subrogation and reimbursement.

(d) The Carrier's subrogation and reimbursement policies for payments with respect to benefits shall be explained in the plan brochure.

(e) Subrogation recoveries and reimbursements may be reduced by any legal or subrogation and reimbursement vendor fees expended to obtain the recoveries and which are not otherwise payable under this experience-rated contract. The amount credited to the contract shall be the net amount remaining after deducting the related legal or subrogation and reimbursement vendor fees.

SECTION 2.6
COORDINATION OF BENEFITS (JAN 2001) (FEHBAR 1652.204-71)

(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare, other group health benefits coverages, and the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault.

(b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary Carrier or unless permitted to do so by the Contracting Officer.

(c) In coordinating benefits between plans, the Carrier shall follow the order of precedence established by the NAIC Group Coordination of Benefits Model Regulation, Rules for Coordination of Benefits, as specified by OPM.

(d) Where (1) the Carrier makes payments under this contract which are subject to COB provisions; (2) the payments are erroneous, not in accordance with the terms of the contract, or in excess of the limitations applicable under this contract; and (3) the Carrier is unable to recover such COB overpayments from the Member or the providers of services or supplies, the Contracting Officer may allow such amounts to be charged to the contract; the Carrier must be prepared to demonstrate that it has made a diligent effort to recover such COB overpayments.

(e) COB savings shall be reported by experience-rated Carriers each year along with the Carrier's annual accounting statement in a form specified by OPM.

(f) Changes in the order of precedence established by the NAIC Group Coordination of Benefits Model Regulation, Rules for Coordination of Benefits, implemented after January 1 of any given year shall be required no earlier than the beginning of the following contract term.

[NOTE: In the event that benefits are payable to the Member under no-fault automobile insurance, the no-fault automobile insurer shall be the Primary Carrier if it is obligated legally to pay benefits for health care expenses without regard to other health benefits coverage that the Member may have. The term "no-fault automobile insurance" includes any automobile insurance policy under which the insurer pays benefits for health care expenses resulting from the accident without regard to whether the insured's conduct contributed to the accident.]

SECTION 2.7
DEBARMENT AND OTHER SANCTIONS (JAN 2022)

(a) Notwithstanding 5 U.S.C. 8902(j) or any other provision of the law and regulations, if, under 5 U.S.C. 8902a or , 5 CFR Part 919, a provider is barred from participating in the Program under 5 U.S.C. or the provider's services under 5 U.S.C. are excluded, the Carrier agrees that no payment shall be made by the Carrier pursuant to any contract under 5 U.S.C. (either to such provider or by reimbursement) for any service or supply furnished by such provider during the period of the debarment, except as provided in 5 CFR Part 919.

(b) The OPM shall notify the Carrier when a provider is barred from the FEHBP.

SECTION 2.8
FILING HEALTH BENEFIT CLAIMS/COURT REVIEW OF DISPUTED CLAIMS (MAR 1995) (FEHBAR 1652.204-72)

(a) General. (1) The Carrier resolves claims filed under the Plan. All health benefit claims must be submitted initially to the Carrier. If the Carrier denies a claim (or a portion of a claim), the covered individual may ask the Carrier to reconsider its denial. If the Carrier affirms its denial or fails to respond as required by paragraph (b) of this clause, the covered individual may ask OPM to review the claim. A covered individual must exhaust both the Carrier and OPM review processes specified in this clause before seeking judicial review of the denied claim.

(2) This clause applies to covered individuals and to other individuals or entities who are acting on the behalf of a covered individual and who have the covered individual's specific written consent to pursue payment of the disputed claim.

(b) Time limits for reconsidering a claim. (1) The covered individual has 6 months from the date of the notice to the covered individual that a claim (or a portion of a claim) was denied by the Carrier in which to submit a written request for reconsideration to the Carrier. The time limit for requesting reconsideration may be extended when the covered individual shows that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(2) The Carrier has 30 days after the date of receipt of a timely-filed request for reconsideration to:

(i) Affirm the denial in writing to the covered individual;

(ii) Pay the bill or provide the service; or

(iii) Request from the covered individual or provider additional information needed to make a decision on the claim. The Carrier must simultaneously notify the covered individual of the information requested if it requests additional information from a provider. The Carrier has 30 days after the date the information is received to affirm the denial in writing to the covered individual or pay the bill or provide the service. The Carrier must make its decision based on the evidence it has if the covered individual or provider does not respond within 60 days after the date of the Carrier's notice requesting additional information. The Carrier must then send written notice to the covered individual of its decision on the claim. The covered individual may request OPM review as provided in paragraph (b)(3) of this clause if the Carrier fails to act within the time limit set forth in this paragraph.

(3) The covered individual may write to OPM and request that OPM review the Carrier's decision if the Carrier either affirms its denial of a claim or fails to respond to a covered individual's written request for reconsideration within the time limit set forth in paragraph (b)(2) of this clause. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this clause.

(4) The Carrier may extend the time limit for a covered individual's submission of additional information to the Carrier when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the additional information.

(c) Information required to process requests for reconsideration. (1) The covered individual must put the request to the Carrier to reconsider a claim in writing and give the reasons, in terms of applicable brochure provisions, that the denied claim should have been approved.

(2) If the Carrier needs additional information from the covered individual to make a decision, it must:

(i) Specifically identify the information needed;

(ii) State the reason the information is required to make a decision on the claim;

(iii) Specify the time limit (60 days after the date of the Carrier's request) for submitting the information; and

(iv) State the consequences of failure to respond within the time limit specified, as set out in paragraph (b)(2) of this section.

(d) Carrier determinations. The Carrier must provide written notice to the covered individual of its determination. If the Carrier affirms the initial denial, the notice must inform the covered individual of:

(1) The specific and detailed reasons for the denial;

(2) The covered individual's right to request a review by OPM; and

(3) The requirement that requests for OPM review must be received within 90 days after the date of the Carrier's denial notice and include a copy of the denial notice as well as documents to support the covered individual's position.

(e) OPM review. (1) If the covered individual seeks further review of the denied claim, the covered individual must make a request to OPM to review the Carrier's decision. Such a request to OPM must be made:

(i) Within 90 days after the date of the Carrier's notice to the covered individual that the denial was affirmed; or

(ii) If the Carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this clause, within 120 days after the date of the covered individual's timely request for reconsideration by the Carrier; or

(iii) Within 120 days after the date the Carrier requests additional information from the covered individual, or the date the covered individual is notified that the Carrier is requesting additional information from a provider. OPM may extend the time limit for a covered individual's request for OPM review when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by the Carrier, OPM may

(i) Request that the covered individual submit additional information;

(ii) Obtain an advisory opinion from an independent physician;

(iii) Obtain any other information as may in its judgment be required to make a determination; or

(iv) Make its decision based solely on the information the covered individual provided with his or her request for review.

(3) When OPM requests information from the Carrier, the Carrier must release the information within 30 days after the date of OPM's written request unless a different time limit is specified by OPM in its request.

(4) Within 90 days after receipt of the request for review, OPM will either:

(i) Give a written notice of its decision to the covered individual and the Carrier; or

(ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph (e)(3) of this clause, OPM may make its decision based solely on information available to it at that time and give a written notice of its decision to the covered individual and to the Carrier.

(f) OPM, upon its own motion, may reopen its review if it receives evidence that was unavailable at the time of its original decision.

(g) Court review. (1) A suit to compel enrollment under 890.102 of Title 5, Code of Federal Regulations, must be brought against the employing office that made the enrollment decision.

(2) A suit to review the legality of OPM's regulations under this part must be brought against the Office of Personnel Management.

(3) Federal Employees Health Benefits (FEHB) Carriers resolve FEHB claims under authority of Federal statute (chapter 89, title 5, United States Code). A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the Carrier or the Carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the Carrier to pay the amount of benefits in dispute.

(4) An action under paragraph (3) of this clause to recover on a claim for health benefits:

(i) May not be brought prior to exhaustion of the administrative remedies provided in paragraphs (a) through (f) of this clause;

(ii) May not be brought later than December 31 of the 3rd year after the year in which the care or service was provided; and

(iii) Will be limited to the record that was before OPM when it rendered its decision affirming the Carrier's denial of benefits.

SECTION 2.9
CLAIMS PROCESSING (JAN 2011)

A standardized claims filing process shall be used by all FEHB Carriers. The Carrier shall apply procedures for using the standard claims process. At a minimum the Carrier's program must achieve the following objectives:

(1) The majority of provider claims should be submitted electronically;

(2) All providers shall be notified that future claims must be submitted electronically, or on the Centers for Medicare and Medicaid Services 1500 form or the UB-04 form;

(3) The Carrier shall not use any unique provider claim form(s) for such FEHB member claims;

(4) The Carrier should reject all such claims submitted on forms other than the CMS 1500 form or the UB-04 form and shall explain the reason on the Explanation of Benefits form; and

(5) The Carrier shall advise OPM of its progress in implementing this policy as directed by the Contracting Officer.

SECTION 2.10
CALCULATION OF COST SHARING PROVISIONS (JAN 1996)

When the Member is required to pay a specified percentage of the cost of covered services, the Member's obligation for covered services shall be based on the amount the provider has agreed to accept as full payment, including future discounts that are known and that can be accurately calculated at the time the claim is processed. This includes for example, prompt pay discounts as well as other discounts granted for various business reasons. Any discount not determined at the time of the actual adjudication shall be placed in the Special Reserve upon its determination.

SECTION 2.11
BENEFITS PAYMENTS WHEN MEDICARE IS PRIMARY (JAN 2015)

When a Member who is covered by Medicare Part A, Part B, or Parts A and B on a fee-for-service basis (a) receives services that generally are eligible for coverage by Medicare (regardless of whether or not benefits are paid by Medicare) and are covered by the Carrier, and (b) Medicare is the primary payer and the Carrier is the secondary payer for the Member under the order of benefit determination rules stated in Appendix A and Appendix D of this contract, then the Carrier shall limit its payment to an amount that supplements the benefits payable by Medicare (regardless of whether or not Medicare benefits are paid). When emergency services have been provided by a Medicare nonparticipating institutional provider and the provider is not reimbursed by Medicare, the Carrier shall pay its primary benefits. Payments that supplement Medicare include amounts necessary to reimburse the Member for Medicare deductibles, coinsurance, copayments, and the balance between the Medicare approved amount and the Medicare limiting charge made by non-participating providers.

Carriers may use the Department of Veterans Affairs (VA) Medicare-equivalent remittance advice (MRA) when the form is submitted to determine the Plan's benefits payment for covered services provided to members who have Medicare as their primary payer, when Medicare does not pay the VA facility.

SECTION 2.12
CONTINUING REQUIREMENTS AFTER TERMINATION OF THE CARRIER
(JAN 2004)

(a) The Carrier shall fulfill all of the requirements agreed to under the contract that continue after termination. The order of precedence for the applicable laws, regulations, and the contract are listed in Section 1.3.

(b) Contract requirements extend beyond the date of the Carrier's termination until the effective date of the new enrollment including processing and paying claims incurred prior to the effective date of the new enrollment.

(c) When the prior Carrier is discontinued in whole or in part, the gaining Carrier assumes full coverage on the effective date of the new enrollment.

SECTION 2.13
LARGE PROVIDER AGREEMENTS (OCT 2005) (FEHBAR 1652.204-74)

(a) Notification and Information Requirements. (1) The experience-rated Carrier must provide notice to the Contracting Officer of its intent to enter into or to make a significant modification of a Large Provider Agreement:

(i) Not less than 60 days before entering into any Large Provider Agreement; and

(ii) Not less than 60 days before exercising a renewal or other option, or significant modification to a Large Provider Agreement, when such action would result in total costs to the FEHB Program of an additional 20 percent or more above the existing contract. However, if a Carrier is exercising a simple renewal or other option contemplated by a Large Provider Agreement that OPM previously reviewed, and there are no significant changes, then a statement

to the effect that the renewal or other option is being exercised along with the dollar amount is sufficient notice.

(2) The Carrier's notification to the Contracting Officer must be in writing and must, at a minimum:

(i) Describe the supplies and/or services the proposed provider agreement will require;

(ii) Identify the proposed basis for reimbursement;

(iii) Identify the proposed provider agreement, explain why the Carrier selected the proposed provider, and what contracting method it used, where applicable, including the kind of competition obtained;

(iv) Describe the methodology the Carrier used to compute the provider's profit; and,

(v) Describe provider risk provisions.

(3) The Contracting Officer may request from the Carrier any additional information on a proposed provider agreement and its terms and conditions prior to a provider award and during the performance of the agreement. The Carrier may mark any information it deems confidential commercial information, and OPM will handle information so designated in accordance with relevant procedures set forth at 5 CFR Part 294.

(4) Within 30 days of receiving the Carrier's notification, the Contracting Officer will give the Carrier either written comments or written notice that there will be no comments. If the Contracting Officer comments, the Carrier must respond in writing within 10 calendar days, and explain how it intends to address any concerns.

(5) When computing the Carrier's service charge, the Contracting Officer will consider how well the Carrier complies with the provisions of this section, including the advance notification requirements, as an aspect of the Carrier's performance factor.

(6) The Contracting Officer's review of any Large Provider Agreement, option, renewal, or modification will not constitute a determination of the acceptability of the terms and conditions of any provider agreement or of the allowability of any costs under the Carrier's contract, nor will it relieve the Carrier of any responsibility for performing the contract.

(b) Records and Inspection. The Carrier must insert in all Large Provider Agreements the requirement that the provider will retain and make available to the Government all records relating to the agreement that support the annual statement of operations and Enrollee records--Retain for 6 years after the agreement term ends.

(c) Audit and Records - Negotiation. The provisions of FAR 52.215-2, "Audit and Records--Negotiation," when required, or FEHBAR 1652.246-70, "FEHB Inspection" apply to all experience-rated Carriers' Large Provider Agreements. The Carrier will insert the clauses at FAR 52.215-2, when applicable, or FEHBAR 1652.246-70 in all Large Provider Agreements. In FAR 52.215-2 the Carrier will substitute

(1) The term "Large Provider" for the term "Contractor" throughout the clause, and

(2) The term "Large Provider Agreement" for the term "Subcontracts" in paragraph (g) of FAR 52.215-2. The term "Contracting Officer" will mean the FEHB Program Contracting Officer at OPM. The Carrier will be responsible for ensuring the Large Provider complies with the provisions set forth in the clause.

(d) Prohibited Agreements. No provider agreement made under this contract will provide for payment on a cost-plus-a-percentage-of-cost basis.

(e) The Carrier will insert this clause, 1652.204-74, in all Large Provider Agreements.

SECTION 2.14
COORDINATION OF PRESCRIPTION DRUG BENEFITS WITH MEDICARE (JAN 2015)

(a) The Carrier shall comply with the Center for Medicare and Medicaid Services' (CMS) Part D Coordination of Benefits Guidance when the mechanisms and systems indicated in this guidance are in place and functioning properly. This guidance provides the requirements and procedures for coordination of benefits between Part D plans and other providers of prescription drug coverage.
(b) For Medicare Part B covered prescription drugs, the Carrier will coordinate benefits with Medicare except when such prescription drugs are purchased from retail or mail order pharmacies. The Carrier may pay its benefits on retail pharmacy or mail order drugs eligible for Medicare Part B coverage or may coordinate benefits subject to Contracting Officer approval.

SECTION 2.15
[RESERVED]

SECTION 2.16
[RESERVED]

SECTION 2.17
PART D CREDITABLE COVERAGE (JAN 2022)

The Carrier shall offer prescription drug coverage that is considered creditable prescription drug coverage under 42 CFR 423.56.

SECTION 2.18
SURPRISE BILLING (JAN 2022)

(a) The Carrier shall comply with requirements described in the provisions of sections 2799A–1, 2799A-2, 2799A-3, 2799A-4, 2799A-5, and 2799A-7 and 2799A-8 of the Public Health Service Act, sections 716, 717, 718, 719, 720, 722, and 723 of the Employee Retirement Income Security Act of 1974, and sections 9816, 9817, 9818, 9819, 9820, 9822, and 9823 of the Internal Revenue Code of 1986 (as applicable) in the same manner as such provisions apply to a group health plan or health insurance issuer offering group or individual health insurance coverage, as described in such sections.
(b) The Carrier's compliance with paragraph (a) will be concurrent and consistent with implementing regulations issued by the Departments of Health and Human Services, Labor, and the Treasury, subject to OPM regulation and FEHB contract terms.
(c) The Carrier's provider contracts must extend the provisions of sections 2799B–6, 2799B–8, and 2799B–9 of the Public Health Service Act to covered individuals in the same manner as such provisions apply to an enrollee in a group health plan or group or individual health insurance coverage offered by a health insurance issuer.
(d) Consistent with the preemption provision at 5 U.S.C. 8902(m)(1), the provisions of Public Health Service Act section 2723 as well as 45 CFR Part 150 are inapplicable to the Carrier and Underwriter with respect to the Plan.

PART III - PAYMENTS, CHARGES AND ACCOUNTING

SECTION 3.1
PAYMENTS—EXPERIENCE-RATED CONTRACTS (JAN 2003) (FEHBAR 1652.232-71)

(a) OPM will pay to the Carrier, in full settlement of its obligations under this contract, subject to adjustment for error or fraud, the subscription charges received for the Plan by the Employees Health Benefits Fund (hereinafter called the Fund) less the amounts set aside by OPM for the Contingency Reserve and for the administrative expenses of OPM and amounts for obligations due pursuant to paragraph (b) of this clause, plus any payments made by OPM from the Contingency Reserve.

(b) OPM will notify the Carrier of amounts due for outstanding obligations under the contract. Not later than 60 days after the date of written notice from OPM, the Carrier shall reimburse OPM. If payment is not received within the prescribed time frame, OPM shall withhold the amount due from the subscription charges owed the Carrier under paragraph (a) of this clause.

(c) The specific subscription rates, charges, allowances and limitations applicable to the contract are set forth in Appendix B.

(d) Recurring payments from premiums shall be made available for Carrier drawdown not later than thirty days after receipt by the Fund. The Contracting Officer may authorize special non-recurring payments from the Contingency Reserve in accordance with OPM's regulations.

(e) In the event this contract between the Carrier and OPM is terminated or not renewed in accordance with General Provision 1.15, *Renewal and Withdrawal of Approval*, the Contingency Reserve of the Carrier held by OPM shall be available to the Carrier to pay the necessary and proper charges against this contract to the extent that the Carrier reserves are insufficient for that purpose.

SECTION 3.2
ACCOUNTING AND ALLOWABLE COST (JAN 2003) (FEHBAR 1652.216-71)

(a) Annual Accounting Statements.

(1) The Carrier shall furnish to OPM an accounting of its operations under the contract. In preparing the accounting, the Carrier shall follow the reporting requirements and statement formats prescribed by OPM in the OPM Annual and Fiscal Year Financial Reporting Instructions.

(2) The Carrier shall have its Annual Accounting Statements and that of its underwriter, if any, audited in accordance with the FEHBP Experienced-Rated Carrier and Service Organization Audit Guide (Guide). The Carrier shall submit the audit report and the Annual Accounting Statements to OPM in accordance with the requirements of the Guide.

(3) Based on the results of either the independent audit prescribed by the Guide or a Government audit, OPM may require the Carrier to adjust its annual accounting statements (i) by amounts found not to constitute actual, allowable, allocable and reasonable costs; or (ii) to reflect prior overpayments or underpayments.

(4) The Carrier shall develop corrective action plans to resolve audit findings identified in audits that were performed in accordance with the Guide. The corrective action plans will be prepared in accordance with and as defined by the Guide.

(b) Definition of costs. (1) The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable. In addition, the Carrier must:

(i) on request, document and make available accounting support for the cost to justify that the cost is actual, reasonable and necessary; and

(ii) determine the cost in accordance with: (A) the terms of this contract, and (B) Subpart 31.2 of the Federal Acquisition Regulation (FAR) and Subpart 1631.2 of the Federal Employees Health Benefits Program Acquisition Regulation (FEHBAR) applicable on the first day of the contract period.

(2) In the absence of specific contract terms to the contrary, the Carrier shall classify contract costs in accordance with the following criteria:

(i) Benefits. Benefit costs consist of payments made and liabilities incurred for covered health care services on behalf of FEHBP subscribers less any refunds, rebates, allowances or other credits received.

(ii) Administrative expenses. Administrative expenses consist of all actual, allowable, allocable and reasonable expenses incurred in the adjudication of subscriber benefit claims or incurred in the Carrier's overall operation of the business. Unless otherwise stated in the contract, administrative expenses include, in part: all taxes (excluding premium taxes, as provided in section 1631.205-41), insurance and reinsurance premiums, medical and dental consultants used in the adjudication process, concurrent or managed care review when not billed by a health care provider and other forms of utilization review, the cost of maintaining eligibility files, legal expenses incurred in the litigation of benefit payments and bank charges for letters of credit. Administrative expenses exclude the cost of Carrier personnel, equipment, and facilities directly used in the delivery of health care services, which are benefit costs, and the expense of managing the FEHBP investment program which is a reduction of investment income earned.

(iii) Investment income. While compliance with the checks presented letter of credit methodology will minimize funds on hand, the Carrier shall invest and reinvest all funds on hand, including any in the Special Reserve or any attributable to the reserve for incurred but unpaid claims, which are in excess of the funds needed to discharge promptly the obligations incurred under the contract. Investment income represents the net amount earned by the Carrier after deducting investment expenses. Investment expenses are those actual, allowable, allocable, and reasonable contract costs that are attributable to the investment of funds, such as consultant or management fees.

(iv) Other charges.

(A) Mandatory statutory reserve. Charges for mandatory statutory reserves are not allowable unless specifically provided for in the contract. When the term "mandatory statutory reserve" is specifically identified as an allowable contract charge without further definition or explanation, it means a requirement imposed by State law upon the Carrier to set aside a specific amount or rate of funds into a restricted reserve that is accounted for separately from all other reserves and surpluses of the Carrier and which may be used only with the specific approval of the State official designated by law to make such approvals. The amount chargeable to the contract may not exceed an allocable portion of the amount actually set aside. If the statutory reserve is no longer required for the purpose for which it was created, and these funds become available for the general use of the Carrier, the Carrier shall return to the FEHBP a pro rata share based upon FEHBP's contribution to the total Carrier's set aside shall be returned to the FEHBP in accordance with FAR 31.201-5.

(B) Premium taxes. (1) When the term “premium taxes” is used in this contract without further definition or explanation, it means a tax, fee, or other monetary payment directly or indirectly imposed on FEHB premiums by any State, the District of Columbia, or the Commonwealth of Puerto Rico or by any political subdivision or other governmental authority of

those entities, with the sole exception of a tax on net income or profit, if that tax, fee, or payment is applicable to a broad range of business activity.

(2) For purposes of this paragraph (B), OPM has determined that the term "State" as used in 5 U.S.C. 8909(f) includes, but is not limited to, a territory or possession of the United States.

(c) Certification of Accounting Statement Accuracy. (1) The Carrier shall certify the annual and fiscal year accounting statements in the form set forth in paragraph (c)(3) of this clause. The Carrier's chief executive officer and the chief financial officer shall sign the certificate.

(2) The Carrier shall require an authorized agent of its underwriter, if any, also to certify the annual accounting statement.

(3) The certificate required shall be in the following form:

CERTIFICATION OF ACCOUNTING
STATEMENT ACCURACY

This is to certify that I have reviewed this accounting statement and to the best of my knowledge and belief:

1. The statement was prepared in conformity with the guidelines issued by the Office of Personnel Management and fairly presents the financial results of this reporting period in conformity with those guidelines.

2. The costs included in the statement are actual, allowable, allocable, and reasonable in accordance with the terms of the contract and with the cost principles of the Federal Employees Health Benefits Acquisition Regulation and the Federal Acquisition Regulation;

3. Income, rebates, allowances, refunds and other credits made or owed in accordance with the terms of the contract and applicable cost principles have been included in the statement;

4. If applicable, the letter of credit account was managed in accordance with 5 CFR part 890, 48 CFR chapter 16, and OPM guidelines.

Carrier Name: _____

Name of Chief Executive Officer:
(Type or Print)

_____
Name of Chief Financial Officer:

_____
Signature of Chief Executive Officer:

_____
Signature of Chief Financial Officer:

_____
Date Signed:

_____
Date Signed: _____
Underwriter:

_____
Name and Title of Responsible Corporate Official:
(Type or Print:)

_____
Signature of Responsible Corporate Official:

_____
Date Signed:_____

(End of Certificate)

(FFS-2022)

SECTION 3.3
SPECIAL RESERVE (JAN 2003)

(a) This contract is experience rated. The Special Reserve represents the cumulative difference between income to the plan (subscription income plus interest on investments [item (b)(2)(iii) in Section 3.2, *Accounting and Allowable Cost*, which also includes income gain or loss]) and plan expenses (benefit costs plus allowable administrative expenses and retentions). The Special Reserve held by or on behalf of the Carrier is to be used only for payment of charges against this contract.

(b) If this contract is terminated or not renewed and there is a positive balance remaining in the Special Reserve after all allowable costs chargeable to the contract in accordance with Section 3.2 plus an agreed-upon amount of administrative expenses for contract liquidation have been paid, the balance of any funds held by the Carrier, including current income on its investment, shall be paid to OPM for credit to the Carrier's Contingency Reserve maintained by OPM when the Carrier submits its annual accounting statement for the final contract year.

(c) The Carrier shall incorporate this clause in all agreements with underwriters of the Carrier's FEHB Plans.

SECTION 3.4
INVESTMENT INCOME (JAN 1998) (FEHBAR 1652.215-71)

(a) The Carrier shall invest and reinvest all FEHB funds on hand that are in excess of the funds needed to promptly discharge the obligations incurred under this contract. The Carrier shall seek to maximize investment income with prudent consideration to the safety and liquidity of investments.

(b) All investment income earned on FEHB funds shall be credited to the Special Reserve on behalf of the FEHBP.

(c) When the Contracting Officer concludes that the Carrier failed to comply with paragraphs (a) or (b) of this clause, the Carrier shall credit the Special Reserve with investment income that would have been earned, at the rate(s) specified in paragraph (f) of this clause, had it not been for the Carrier's noncompliance. "Failed to comply with paragraphs (a) or (b)" means: (1) making any charges against the contract which are not allowable, allocable, or reasonable; or (2) failing to credit any income due the contract and/or failing to place excess funds, including subscription income and payments from OPM not needed to discharge promptly the obligations incurred under the contract, refunds, credits, payments, deposits, investment income earned, uncashed checks, or other amounts owed the Special Reserve, in income producing investments and accounts.

(d) Investment income lost as a result of unallowable, unallocable, or unreasonable charges against the contract shall be paid from the first day of the contract term following the contract term in which the unallowable charge was made and shall end on the earlier of: (1) the date the amounts are returned to the Special Reserve (or the Office of Personnel Management); (2) the date specified by the Contracting Officer; or (3) the date of the Contracting Officer's Final Decision.

(e) Investment income lost as a result of failure to credit income due the contract or failure to place excess funds in income producing investments and accounts shall be paid from the date the funds should have been invested or appropriate income was not credited and shall end on the earlier of: (1) the date the amounts are returned to the Special Reserve (or the Office of

Personnel Management); (2) the date specified by the Contracting Officer; or (3) the date of the Contracting Officer's Final Decision.

(f) The Carrier shall credit the Special Reserve for income due in accordance with this clause. All lost investment income payable shall bear simple interest at the quarterly rate determined by the Secretary of the Treasury under the authority of 26 U.S.C. 6621(a)(2) applicable to the periods in which the amount becomes due, as provided in paragraphs (d) and (e) of this clause.

(g) The Carrier shall incorporate this clause into agreements with underwriters of the Carrier's FEHB plans and shall substitute "underwriter" or other appropriate reference for the term "Carrier".

SECTION 3.5
NON-COMMINGLING OF FUNDS (JAN 1991) (FEHBAR 1652.232-72)

(a) The Carrier and/or its underwriter shall keep all FEHBP funds for this contract (cash and investments) physically separate from funds obtained from other sources. Accounting for such FEHBP funds shall not be based on allocations or other sharing mechanisms and shall agree with the Carrier's accounting records.

(b) In certain instances the physical separation of FEHBP funds may not be practical or desirable. In such cases, the Carrier may request a waiver from this requirement from the Contracting Officer. The waiver shall be requested in advance and the Carrier shall demonstrate that accounting techniques have been established that will clearly measure FEHBP cash and investment income (*i.e.*, subsidiary ledgers). Reconciliations between amounts reported and actual amounts shown in accounting records shall be provided as supporting schedules to the Annual Accounting Statements.

(c) The Carrier shall incorporate this clause in all subcontracts that exceed $25,000 and shall substitute "contractor" or other appropriate reference for "Carrier and/or its underwriter".

SECTION 3.6
UNCASHED CHECKS (JAN 1996)

Payment of checks issued pursuant to this contract shall be voided if the checks have been outstanding for two (2) years. The amounts represented by these checks shall be credited to the Special Reserve of this contract no later than the 25th month after issuance. The term "Check" shall include any written instrument issued to pay or reimburse the payment of benefits, or any services, supplies or subcontracts hereunder.

SECTION 3.7
SERVICE CHARGE (JAN 1996)

(a) Any service charge negotiated shall be set forth in Appendix B and shall be the total profit that can be charged to the contract. The amount set forth in Appendix B shall encompass all profit (whether entitled service charge, profit, fee, contribution to reserves or surpluses or any other title) that may be included in major subcontracts in accordance with the provisions of FEHBAR 1631.205-80, Major Subcontractor Service Charges.

(b) One-twelfth of the service charge for the contract term accrues on the last day of each month during the contract term. The Carrier shall withdraw the service charge from the Special Reserve when it accrues.

(c) If this contract is renewed by operation of section 1.15(a), the amount of the service charge accrued under (b) shall be "one-twenty-fourth" rather than "one-twelfth." The remainder of the service charge not otherwise accrued during the contract term shall accrue on the last day of the contract term.

SECTION 3.8
CONTRACTOR RECORDS RETENTION (JUL 2005) (FEHBAR 1652.204-70)

Notwithstanding the provisions of Section 5.7 (FAR 52.215-2(f*)), Audit and Records - Negotiation* the Carrier will retain and make available all records applicable to a contract term that support the annual statement of operations and, for contracts that equal or exceed the threshold at FAR 15.403-4(a)(1), the rate submission for that contract term for a period of six years after the end of the contract term to which the records relate. This includes all records of Large Provider Agreements and subcontracts that equal or exceed the threshold requirements. In addition, individual Enrollee and/or patient claim records will be maintained for six years after the end of the contract term to which the claim records relate. This clause is effective prospectively as of the 2005 contract year.

SECTION 3.9
APPROVAL FOR ASSIGNMENT OF CLAIMS (JAN 1991) (FEHBAR 1652.232-73)

(a) Notwithstanding the provisions of Section 5.35 [FAR 52.232-23], *Assignment of Claims*, the Carrier shall not make any assignment under the Assignment of Claims Act without the prior written approval of the Contracting Officer.
(b) Unless a different period is specified in the Contracting Officer's written approval, an assignment shall be in force only for a period of one year from the date of the Contracting Officer's approval. However, assignments may be renewed upon their expiration.

SECTION 3.10
AUDIT, FINANCIAL, AND OTHER INFORMATION (JAN 2001)

The Carrier shall furnish to OPM audit, financial, and other information in the format and within the time frames specified in the Audit Guide for Financial Statement Audits, Reporting on Internal Controls and Compliance with Laws and Regulations, Attestation Reports, Agreed-Upon Procedures, and Reporting on Internal Controls of Third Party Servicing Organizations. Information and reports shall be furnished in the required number of copies to the addresses specified by OPM.

SECTION 3.11
SURVEY CHARGES (JAN 2002)

(a) If the Carrier participates in an FEHB annual consumer assessment survey, it shall pay OPM's contractor a pro rata share of the total cost of consolidating and reporting the survey results to OPM. The Carrier shall pay a separate fee for each plan option and /or rating area. The Carrier agrees to pay the contractor's invoice within 30 days of the billing date. If the Carrier does not remit payment to the contractor within 60 days of the billing date, OPM shall withhold

the amount due from the Carrier's subscription charges according to FEHBAR 1652.232-71, Payments–experience-rated contracts, and forward payment to the contractor.

(b) Costs incurred by the Carrier for contracting with a vendor to conduct the survey shall be the Carrier's responsibility and constitute allowable administrative charges.

SECTION 3.12
FEHB CLEARINGHOUSE (JAN 2012)

(a) The FEHB Clearinghouse will facilitate the reconciliation of enrollments between Carriers and Federal agencies, and between Carriers and Tribal Employers. The Carrier shall pay a pro rata share based on its proportion of FEHB premiums as determined by OPM for the cost of developing and operating the Clearinghouse.

(b) OPM shall withhold the amount due from the Carrier's subscription charges under the authority of FEHBAR 1652.232-71, Payments--Experience-Rated Contracts, and shall forward payment to the FEHB Clearinghouse.

SECTION 3.13
TAXPAYER IDENTIFICATION NUMBER (JAN 2000) (FEHBAR 1652.204-73)

(a) Definitions.

Common parent, as used in this provision, means that corporate entity that owns or controls an affiliated group of corporations that files its Federal income tax returns on a consolidated basis, and of which the Carrier is a member.

Taxpayer Identification Number (TIN), as used in this provision, means the number required by the Internal Revenue Service (IRS) to be used by the Carrier in reporting income tax and other returns.

(b) The Carrier must submit the information required in paragraphs (d) through (f) of this clause to comply with debt collection requirements of 31 U.S.C. 7701(c) and 3325(d), reporting requirements of 26 U.S.C. 6041, 6041A, and 6050M, and implementing regulations issued by the IRS. The Carrier is subject to the payment reporting requirements described in Federal Acquisition Regulation (FAR) 4.904. The Carrier's failure or refusal to furnish the information will result in payment being withheld until the TIN number is provided.

(c) The Government may use the TIN to collect and report on any delinquent amounts arising out of the Carrier's relationship with the Government (31 U.S.C. 7701(c)(3)). The TIN provided hereunder may be matched with IRS records to verify its accuracy.

(d) Taxpayer Identification Number (TIN).

TIN: _____

(e) Type of organization.

☐ Sole proprietorship;
☐ Partnership;
☐ Corporate entity (not tax-exempt);
☐ Corporate entity (tax-exempt);
☐ Other_____.

(f) Common parent.

☐ Carrier is not owned or controlled by a common parent as defined in paragraph (a) of this clause.
☐ Name and TIN of common parent:

Name_____
TIN_____

SECTION 3.14
REPORTABLE OVERPAYMENTS (JAN 2011)

(a) If the Carrier becomes aware of either a duplicate letter of credit payment or a significant letter of credit overpayment made by OPM, the Carrier shall notify the Contracting Officer within a maximum of ten days and request instructions for disposition of the overpayment. See FAR 3.1003(a)(3) for penalties applicable to the failure to timely report credible evidence of significant overpayments which shall mean letter of credit payments that are 25 percent or a percentage determined by the Contracting Officer above the total checks presented amount for the day(s) in question and are reoccurring with no corrective action plan in place.

SECTION 3.15
AUDIT RESOLUTION (JAN 2015)

(a) When OIG issues a Draft Report of findings to the Carrier, the Carrier must respond with all available, accurate and relevant documentation to validate or invalidate the findings. This must be done within the timeframe specified in the OIG Draft Report transmittal letter. The Carriers shall promptly begin reconciling findings and not wait until the receipt of the Final Report to address disagreement with any findings previously communicated in the Draft Report.

OPM expects to fully resolve audits within 180 days of issuance of the final report. To enable this, Carriers must expeditiously tender all documentation necessary for resolution of the audit not later than 120 days from the date of the final audit report. This includes overpayment recoveries via check or certification, full documentation of the Carrier's position for findings being contested, evidence supporting due diligence assertions, and support for all other pertinent issues which OPM must consider, as appropriate. Fully supported requests for an extension will be evaluated by the Contracting Officer on a case-by-case basis.

(b) Notwithstanding Section 3.8, *Contractor Records Retention*, the Carrier will retain records related to open audits being conducted by the Office of Inspector General, provided the Carriers were notified of the audit within the records retention timeframes in Section 3.8. Specific records identified in the scope of these open audits will need to be maintained by the Carrier until the audits are resolved by OPM. This clause is effective prospectively as of the 2015 contract year.

SECTION 3.16 REPORTABLE FINDINGS (JAN 2013)

(a) Audit findings (except for claim payment findings) in the scope of an OIG audit are reportable as questioned charges unless the Carrier provides documentation supporting that the findings were already identified and corrected (i.e., administrative expense overcharges and untimely health benefit refunds were already processed and returned to the FEHBP) prior to audit notification.

(b) Claim payment findings (i.e., claim overpayments) in the scope of an OIG audit are reportable as questioned charges unless the Carrier provides documentation supporting that these findings were already identified (i.e., documentation that the plan initiated recovery efforts) prior to audit notification and corrected (i.e., claims were adjusted and/or voided and overpayments were recovered and returned to the FEHBP) by the original due date of the draft report response.

SECTION 3.17 FEHB FAMILY MEMBER VERIFICATION AUDIT (JAN 2015)

OPM may conduct a family member verification audit. If OPM conducts the audit, the Carrier shall pay a pro rata share for conducting the audit based on its proportion of FEHB premiums as determined by OPM. The Carrier's payment hereunder is an allowable cost that can be charged outside the annual allowable expense limitation.

Part IV-SPECIAL PROVISIONS is deleted and replaced with the following:

SECTION 4.1
ALTERATIONS IN CONTRACT (JAN 2019) (FAR 52.252-4)

Portions of this contract are altered as follows:

(a) Section 1.6 Confidentiality of Records. The following subsection is added:

(d) Local Blue Cross and/or Blue Shield Plans may combine the personal data and medical records of Federal subscribers, and information relating thereto, with the same information of other individuals who have health benefits coverage under the Local Blue Cross and/or Blue Shield Plan. This combined data may only be used and disclosed for the Plan's health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501). Such activities include, but are not limited to: care management; prevention, detection, and recovery of funds subject to fraud and abuse; and negotiation of provider contracts.

(e) As used in subsection (b)(1) of this section, "administration of this contract" means health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501).

(b) Section 1.9 Plan Performance - Experience-Rated FFS Contracts.

The Carrier may use the appropriate systems for measurement and/or collection of data on the quality of the health care services as described in subparagraph 1.9(b).

(c) Section 1.14, Misleading, Deceptive, or Unfair Advertising, is amended by removing the reference to the NAIC Advertisements of Accident and Sickness Insurance Model Regulation (Appendix D-b). Carrier should continue to use the FEHB Supplemental Literature Guidelines (now at the renumbered Appendix C) along with FEHBAR 1603.7002.

(d) Section 1.15 Renewal and Withdrawal of Approval (FEHBAR). The following subsections are added:

(d) If the agency suspends payment of the subscription charges for any reason, the Carrier may (1) suspend making benefit payments until payment of all subscription charges due is fully restored; or (2) terminate the contract without prior notice.

(e) Section 1.21 Patient Bill of Rights. For the purpose of compliance with this Section, the Carrier will conduct the following minimum activities: (1) the Carrier will provide subscribers with a Fact Sheet that includes information about the disenrollment rate in the Blue Cross and Blue Shield Service Benefit Plan, as well as Local Plan-specific information including compliance with Federal and State financial requirements, public corporate information, years in existence, and accreditation status; (2) Provider

Directories will include language advising subscribers to contact their providers directly to obtain information about the providers, including but not limited to board certifications, languages spoken, availability of interpreters, facility accessibility, and whether the provider is accepting new patients.

(f) Section 1.30 Health Information Technology Privacy and Security. Subsections (b), (c) and the introductory paragraph of Subsection (d) of Section 1.30 are amended to read as follows:

(b) The Carrier will promote consumer transparency by ensuring that at the point where the Federal member enters the subcontractor's, large provider's, or vendor's website or web portal the link to the subcontractor's, large provider's, or vendor's notice of privacy practices and/or privacy policies is displayed on the bottom, or prominently displayed elsewhere, on the website or web portal.

(c) Notice of privacy practices and/or privacy policies disclosures must describe the uses of individually identifiable protected health information and any potential disclosure to other entities as described in the HIPAA Privacy Rule.

(d) The Carrier will participate with the Contracting Officer or an authorized representative of the Contracting Officer in credential vulnerability scans and configuration compliance audits conducted in accordance with rules of engagement agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The rules of engagement will include the software and hardware used for vulnerability scanning; the specific process used to conduct vulnerability scanning; precautions taken to prevent negative disruption on the systems being scanned; restrictions on the release of documents and artifacts; and how the results of the scanning will be reviewed and reported.

(g) Section 2.2 Benefits Provided. The following paragraph is added to subsection 2.2(a):

(4) The Carrier may pay the Preferred Provider Organization level of benefits under this contract to ease the hardship of members affected by natural disasters such as earthquakes, floods, etc., when because of the natural disaster members have difficulty gaining access to Preferred network providers. The Carrier may pay the Preferred level of benefits without regard to the provider's contractual relationship with the Carrier and will determine an appropriate time frame based on local conditions during which the provision of this paragraph will apply. Benefits provided under this paragraph will be made available to all members similarly affected by the natural disaster.

(h) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Notwithstanding subsection (f) of Section 2.3, benefits provided under the contract are not assignable by the Member to any person without express written approval of the carrier, and in the absence of such approval, any such assignment shall be void. Notwithstanding such approval, no assignment of benefits may be made in any case prior to the time that a valid claim for benefits arises.

(i) Section 2.3 Payment of Benefits and Provision of Services and Supplies. The introductory paragraph of Subsection 2.3(g) is amended to read as follows:

(g) *Erroneous Payments*.

(i) If the Carrier or OPM determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider; the recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment under 48 C.F.R. 1631.201-70(h) regardless of any time period limitations in the written agreement with the provider.

(ii) The Carrier shall be deemed to have satisfied the requirements of Subsection (g) (i) above by complying with Subsections (ii), (iii), and (iv). Local Blue Cross and Blue Shield Plans which have time period limitations in their provider contracts which prevent the Plan from recovering erroneous benefit payments made to providers will participate in an action plan. The action plan shall be developed by the Blue Cross and Blue Shield Association by December 31, 2008 and agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield Association and the Contracting Officer shall utilize standards of commercial reasonableness and neither shall unreasonably withhold agreement. The action plan shall be designed to reduce the occurrence of erroneous benefit payments, to identify and recover erroneous benefit payments within the time limits stipulated in their provider contracts, and to demonstrate due diligence in making an attempt to identify and recover within that provider contract timeframe such erroneous benefit payments.

(iii) The Blue Cross and Blue Shield Association shall be responsible for monitoring and determining whether each Blue Cross and Blue Shield Plan participating in the action plan is complying with its obligations under the action plan.

(iv) A Blue Cross and Blue Shield Plan which is in compliance with its obligations under the action plan shall be found to be in compliance with its obligation under this Section 2.3(g) to make a prompt and diligent effort to recover erroneous benefit payments. In the event that any Plan with such time period limitations is determined to be not in substantial compliance with the action plan, and that Plan is determined not to have pursued material benefit payments with promptness and diligence, then the Plan shall return the erroneous benefit payments to the Program.

(v) The Carrier shall follow general business practices and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall—

(j) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(7)(ii) of Section 2.3 is amended to read as follows:

Notwithstanding (g)(7)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that

caused erroneous benefit payments) when the errors are egregious and repeated. These costs are deemed to be unreasonable and unallowable under Section 3.2(b). The term "repeated" in the previous sentence does not apply to situations in which a claims processing system error causes multiple erroneous payments or to situations that involve audit findings on errors that are endemic to the provision of insurance and claims processing.

(k) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(10) of Section 2.3 is amended to read as follows:

(10) In compliance with the Contracts Disputes Act, the Carrier shall return to the Program an amount equal to the uncollected erroneous benefit payment where the Contracting Officer determines that the Carrier failed to make a prompt and diligent effort, as that term is described above, to recover the erroneous benefit payment. This provision applies to benefit payments which have been paid in error for any reason (except in the case of fraud or abuse).

(l) Section 2.4 Termination of Coverage and Conversion Privileges. The conversion contract set forth in Section 2.4(c) may be a contract that is regularly offered by the local Blue Cross and/or Blue Shield Plan.

(m) Section 2.5 Subrogation. The following subsections are added:

(c) To the extent that a Member has received benefits for covered services under this contract for an injury or illness caused by a third party, the Carrier shall have the right to be subrogated and succeed to any rights of recovery against any person or organization from whom the Member is legally entitled to receive all or part of those same benefits, including insurers of individuals (non-group) policies of liability insurance that are issued to and in the name of the Member. The obligation of the Carrier to recover amounts through subrogation is limited to making a reasonable effort to seek recovery of amounts to which it is entitled to recover in cases which are brought to its attention. The Carrier shall not be required to recover any amounts from any person or organization who causes an injury or illness for which the Member makes claims for benefits.

(d) The Carrier may also recover directly from the Member all amounts received by the Member by suit, settlement, or otherwise from any third party or its insurer, or the Member's insurer under an individual policy or liability insurance, for benefits which have also been paid under this contract.

(e) The Member shall take such action, furnish such information and assistance, and execute such papers as the Carrier or its representative believes are necessary to facilitate enforcement of its rights, and shall take no action which would prejudice the interests of the Carrier to subrogation.

(f) Effective January 1, 1997, all Participating Plans shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under the contract.

(n) Section 2.6 Coordination of Benefits (FEHBAR). The following subsections are added:

(g) The benefits payable by this Plan shall be determined, on a claim by claim basis, only for those claims in excess of $100, except where Medicare is the primary payer of benefits, claims in excess of $50.

(h) Whenever payments which should have been made under this contract in accordance with this provision have been made under any other group health coverage, the Carrier shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amount it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this contract and, to the extent of such payments discharged from liability under the contract.

(o) Section 3.1 Payments (FEHBAR). The following sentence is added to the end of Section 3.1(a):

OPM will withhold from the subscription charges amounts for other obligations due under the contract only to the extent that OPM and the Carrier have agreed in writing to specific deductions for such other obligations.

(p) Section 3.1 Payments (FEHBAR). The following subsection is added:

(g) Except as required pursuant to Sections 1.25 and 2.12, in the event this contract is terminated or not renewed, the agency shall be liable for all sums due and unpaid, including subscription charges, for the period up to the last day of the Member's entitlement to benefits.

(q) Section 3.2 Accounting and Allowable Cost (FEHBAR). Section 3.2(b)(2)(ii) of this contract is amended to comply with 5 U.S.C. 8909(f) as follows:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(r) Section 3.2 Accounting and Allowable Cost (FEHBAR). The provision in Section 3.2 (b)(2)(iv)(A) is supplemented as follows:

Charges for mandatory statutory reserves (Section 3.2(b)(2)(iv)(A)) to satisfy mandatory

statutory reserve requirements of Participating Plans are allowable to the extent that such requirements exceed that portion of the service charge at Appendix B, Subscription Rates, Charges, Allowances and Limitations applicable to such Plans.

(s) Section 3.2 Accounting and Allowable Cost (FEHBAR). This section is modified as follows:

The Carrier, as required by the Blue Cross and Blue Shield Service Benefit Plan Workplan, shall furnish OPM an accounting of its operations under the contract not less than 120 days after the end of the calendar year contract period.

(t) Section 3.3 Special Reserve. The provision in Section 3.3(a) is supplemented as follows:

The Special reserve held by or on behalf of the Carrier is to be used only for payment of charges against this contract, including advance payments to Participating Plans and to hospitals.

(u) Section 3.10, Audit, Financial, and Other Information. Compliance by the Carrier and Participating Blue Cross and Blue Shield Plans with the Blue Cross Blue Shield Service Benefit Plan Workplan, as agreed upon between the Carrier and OPM, will constitute compliance with the Audit Guide referred to in Sections 3.2 and 3.10.

SECTION 4.2
HOSPITAL (FACILITY) BENEFIT PAYMENTS AND CONDITIONS (JAN 1991)

(a) Benefits described in the agreed upon brochure text shall be provided to the extent practicable in the form of services rendered by hospitals, freestanding ambulatory facilities, and home health care agencies, and payment, therefore, by or on behalf of the carrier shall constitute a complete discharge of their obligations under this contract to the extent of services rendered in accordance with the terms and conditions of the contract.

(b) Benefits for inpatient hospital care shall be available only to a Member admitted to the hospital on the recommendation, and while under the active medical supervision of a duly licensed physician or alternative provider as described in section 8902(k)(1) of title 5 U.S.C. who is a member of the staff of, or acceptable to, the hospital selected.

(c) Hospital service is subject to all the rules and regulations of the hospital selected including rules governing admissions.

(d) While a Member may elect to be hospitalized in any hospital, the Carrier does not undertake to guarantee the admission of such Member to the hospital, nor the availability of any accommodations or services therein requested by the Member or his physician.

SECTION 4.3
DEFINITION OF CARRIER (JAN 1991)

The Carrier is the Blue Cross and Blue Shield Association, an Illinois not-for-profit corporation, acting on behalf of participating Blue Cross and Blue Shield Plans and

pursuant to authority specified in Exhibit A for and in behalf of the organizations specified in Exhibit A (hereinafter sometimes referred to as "Participating Plans").

SECTION 4.4
AUDIT DISPUTES (JAN 2000)

(a) Any questioned costs or issues documented by or on behalf of OPM's Office of the Inspector General (OIG) in draft or final audit reports examining the Carrier's and Participating Plans' performance under this contract, that are provided to the Carrier and that were initially raised in the timeframe set forth in subsection (c) below, remain open until resolved. Audit issues related to monetary findings for which extensions of the waiver period for the issuance of final decisions and processing of prior period adjustments were obtained in previous contract terms also remain open until resolved.

(b) Resolution of a questioned cost or issue can be the result of a resolution letter or the issuance of a final decision by the Contracting Officer, or by the processing of a prior period adjustment, an adjustment to the Special reserve, or submission of a claim to OPM (as appropriate) by the Carrier or Participating Plan. A prior period adjustment intended to partially or fully resolve an audit finding will not be considered closed until properly reported on the calendar year Annual Accounting Statement.

(c) A claim seeking, as a matter of right, the payment of money, in a sum certain, pursuant to 48 CFR section 52.233-1, shall not be made more than five years following the last day prescribed by the contract for filing the calendar year Annual Accounting Statement for the year with respect to which the claim arises. A claim includes, in the case of the carrier, a charge against the contract.

SECTION 4.5
ASSOCIATION DUES (JAN 2004)

A Participating local Blue Cross and Blue Shield Plan may charge to this contract Association Dues, with the exception of dues related to those lobbying costs and Special Assessments determined to be unallowable. In calculating the unallowable portion of dues related to lobbying costs for a contract year, the Blue Cross and Blue Shield Plan will rely on the percentage of dues, less any special assessments, as determined by the BCBSA for IRS purposes, to be not tax deductible from the previous contract year.

SECTION 4.6
TRAVEL COSTS (JAN 1996)

The Carrier may charge and account for travel expenses related to administration of the contract on a per diem basis, subject to the maximums prescribed by the Federal Travel Regulations. For those travel costs for each contract term that are subject to the Federal per diem rates set forth at 48 CFR section 31.205-46, the Carrier shall charge to the contract an amount equal to the lesser of:

(i) the actual aggregate charges for those costs, or
(ii) the aggregate charges calculated using the per diem rates set forth in the Federal Travel Regulations.

SECTION 4.7
MARKET RESEARCH COSTS (JAN 1996)

(a) Costs of market research surveys or studies are generally allowable if the survey or study is:

1. directed to current Members and Members who left the Blue Cross and Blue Shield Service Benefit Plan in the most recent Open season, or
2. focused on long-range planning, industry state-of-the-art developments, or product development issues for which a direct benefit or potential benefit to the FEHB Program can be identified, or
3. pre-approved by the Contracting Officer.

(b) Costs of market research surveys or studies are generally not allowable if the primary purpose is to survey or study an otherwise unallowable cost item, such as: to determine the effectiveness of advertising or sales strategies; to evaluate image effectiveness or ways to achieve image enhancement; or to perform a competitive analysis with other carriers in the FEHB Program. Such costs are unallowable, regardless of who receives the research surveys or studies.

(c) This provision does not supersede other contract requirements, such as prior approval for subcontracts under Section 1.16 Subcontracts (FEHBAR 1652.244-70).

SECTION 4.8
PRESCRIPTION DRUG BENEFITS WAIVER PROVISIONS (JAN 2009)

(a) For the purposes of applying the special provisions in this section, the Standard Option Mail Service Prescription Drug Program service standards are:

(1) When a prescription order is placed that does not require additional information or clarification (i.e., a clean or non-diverted prescription), the prescription order shall be dispensed within three business days from the date of receipt so the enrollee may expect to receive the medication within 7 calendar days.

(2) When a prescription order is placed that does require additional information, clarification or resolution of payment issues (i.e., a diverted prescription), the prescription order shall be dispensed within seven business days from the date of receipt so the enrollee may expect to receive the medication within 14 calendar days. However the following situations will not be considered a diverted prescription for the purposes of this section:

(i) Prescriptions for refrigerated products that require prior arrangements between the mail order pharmacy and a Member before the Member can receive the Prescription;

(ii) Prescriptions requiring specific counseling obligations imposed by the pharmaceutical manufacturer, distributor or the FDA;

(iii) Prescriptions requiring "registration" with a pharmaceutical manufacturer.

(b) The special provisions described in paragraphs (c)(1), (2), and (3) shall become effective automatically when less than 98 percent of the prescriptions are filled within the

service standards described in either paragraph (a)(1) or (a)(2) for 7 consecutive business days. The special provisions shall terminate when for 7 consecutive business days 98 percent or more of the prescriptions are filled within the service standards described in paragraphs (a)(1) and (a)(2) of this section.

(c) The special provisions are:

(1) The Carrier shall waive during the effective periods in paragraph (b) the coinsurance for a 21 day prescription filled at a Preferred retail pharmacy when the Mail Service Prescription Drug Program vendor is unable to fill the prescription within the service standards. This waiver of the coinsurance shall be in effect for 14 calendar days after notice to the enrollee as described in paragraph (c)(2) below.

(2) The Carrier shall deliver to the enrollee a written or telephone notice no later than 5 days from the date of receipt for clean or non-diverted prescriptions and no later than 12 days from the date of receipt for diverted prescriptions.

This notice shall:

(i) advise the enrollee that the Mail Service Prescription Drug Program may not be able to fill the prescription(s) within the service standard timeframes;

(ii) advise the enrollee that any applicable coinsurance will be waived for a 21 day supply of the medication(s) when filled at a Preferred retail pharmacy;

(iii) provide the enrollee with instructions on how to use the waiver, and

(iv) advise the enrollee when the waiver will expire.

(3) The Carrier may use next day delivery service at no additional cost to the enrollee in order to meet the service standards in (a)(1) and (a)(2).

SECTION 4.9
SMALL BUSINESS SUBCONTRACTING PLAN (JAN 2002) (FAR 52.219-9) (AS AMENDED)

An amended clause 52.219-9, Small Business Subcontracting Plan, is attached to Appendix E.

SECTION 4.10
LETTER OF CREDIT (JAN 1997)

As of January 1, 1997, OPM will administer Letter of Credit drawdowns directly with the local Plans.

SECTION 4.11
PILOTING OF COST CONTAINMENT PROGRAMS (JAN 2001)

Upon approval by the Contracting Officer, the Carrier may design and implement pilot programs in one or more local Plan areas that test the feasibility and examine the impact of various managed care initiatives. The Carrier shall brief the Contracting Officer on a pilot program prior to its implementation, advise the Contracting Officer of the progress of the pilot program and provide a written evaluation at the conclusion of the pilot program. The evaluation of the pilot program shall, at a minimum, assess the cost effectiveness, effect on quality of care and/or quality of life, and customer satisfaction, and recommend whether the pilot program should be continued or expanded.

SECTION 4.12
TRANSITION COSTS FOR PLAN TERMINATIONS (JAN 1999)

In the event a Participating Plan's license to use the Blue Cross and/or Blue Shield service marks is terminated, thereby rendering it ineligible to participate in this Contract, the costs of transitioning the terminated Plan's Service Benefit Plan subscribers to a successor Plan shall be subject to advance approval. The Carrier shall submit to OPM a proposed transition plan, together with a detailed estimate of costs, prior to the incurrence of any significant transition costs. OPM and the Carrier shall negotiate an advance agreement pursuant to FAR 31.109 that covers the extent of allowable transition costs.

SECTION 4.13
PAYMENT BY ELECTRONIC FUNDS TRANSFER-CENTRAL CONTRACTOR REGISTRATION (MAY 1999) (FAR 52.232-33)

The references to the Central Contractor Registration in FAR 52.232-33 are not applicable to this contract.

SECTION 4.14
FEDERAL INCOME TAX RELATED TO HEALTH INSURANCE PROVIDERS' FEE (JANUARY 2015)

(a) Notwithstanding FAR 31.205-41(b)(1) and this Contract Section 3.2(b)(1)(ii), a charge for an incremental amount of Federal income tax liability incurred as the result of compliance with the Health Insurance Providers Fee (HIP Fee) provision of the Affordable Care Act section 9010 (hereafter referred to as the "HIP Tax Cost") by a participating local plan (Local Plan) that administers the Service Benefit Plan on behalf of the Blue Cross and Blue Shield Association (Carrier), and that is a covered entity within the meaning of 26 CFR Part 57, is an allowable cost to the Carrier under this contract under the criteria set forth below.

(1) The allowable cost to the Carrier for a year is the sum of the HIP Tax Cost for each Local Plan. The HIP Tax Cost for each Local Plan equals:
the amount reimbursed by OPM to the Carrier for the HIP Fee attributable to the Local Plan (Local Plan HIP Fee) for the year, divided by one minus the tax rate for the Local Plan specified under section (2) below, (Local Plan Tax Rate), less the Local Plan HIP Fee. In mathematical terms, the allowable charge to the Carrier for the HIP Tax Cost is the sum of each Local Plan's application of the formula below:

$$\left[\frac{\text{Local Plan HIP Fee}}{1 - \text{Local Plan Tax Rate}}\right] - \text{Local Plan HIP Fee}$$

(2) The Local Plan Tax Rate for purposes of the formula specified in section (1) is the lowest of the following:
(a) the rate specified at 26 USC §11 (b) (1) (D),

(b) the rate specified at 26 USC § 55(b)(1)(B)(i), for any year in which the Local Plan is entitled to the special deduction under 26 USC § 833(a)(2), or
(c) zero, for any year in which the Local Plan experiences a Net Operating Loss or other circumstance resulting in no tax liability. For a year in which the Local Plan experiences a Net Operating Loss resulting in no tax liability, the Carrier will charge the HIP Tax Cost attributable to the Local Plan in the first subsequent year in which the Local Plan's tax liability is greater than zero. The Local Plan will calculate the HIP Tax Cost in this circumstance by applying the formula using the HIP Fee for the year of the loss and the Local Plan Tax Rate for the year in which the tax liability is greater than zero. This charge by the Carrier is in addition to the charge allowed by the Carrier for the Local Plan Tax Cost for the year in which the tax liability is greater than zero.

(d) If the Local Plan Tax Rate reflected on the Local Plan's tax return actually filed for the contract year (which normally occurs the following year) differs from the Local Plan Tax Rate that was anticipated when the costs were drawn down by the Carrier for the contract year as allowable administrative expenses, the Carrier will make a commensurate adjustment to its current year drawdown of administrative expenses.

(b) The Contracting Officer or an authorized representative of the Contracting Officer shall have the right to examine and audit all books and records, including tax filings, relating to the calculation of the HIP Tax Cost charge for each Local Plan.

Part IV - Attachment I
SECTION 4.14
FEDERAL INCOME TAX RELATED TO HEALTH INSURER'S PROVIDER FEE

Examples of Allowable 9010 Tax Cost:

C is an experience rated FEHB carrier consisting of participating Local Plans F and G who underwrite and administer C in different geographic areas.

In 2015, F reports $900 on IRS Form 8963 and pays $500 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the $500 HIP Fee, F's Form 8963 reflects that $300 is attributable to F's FEHBP business.

Also in 2015, G reports $950 on IRS Form 8963 and pays $550 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the $550 HIP Fee, G's Form 8963 reflects that $325 is attributable to G's FEHBP business.

In 2015, C draws down a 2015 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2014 health risks, which is calculated as the sum of F and G's HIP Fee, or $300 +325 = $725, which is an allowable cost, from its FEHB letter of credit account (LOCA). C reimburses F for its HIP Fee of 300 and G for its HIP Fee of 325.

F records income of $300 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by $300. F records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, F pays quarterly payments to the IRS for its' 2015 tax liability. F's 2015 tax rate is 35 percent.

G records income of $325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by $325. G records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, G pays quarterly payments to the IRS for its' 2015 tax liability. Because G claims a special deduction under 26 USC § 833(a)(2), G's 2015 tax rate is 20 percent.

In 2015, C also draws down from its LOCA a 2015 HIP Tax Cost reimbursement for the 2015 income tax expense accrued and paid by F & G in 2015. C's 2015 HIP Tax cost reimbursement is calculated as follows:

Local Plan F HIP Tax Cost: ($300/1-.35)-$300 = $162
Local Plan G HIP Tax Cost: ($325/1-.20)-$325 = $81
Sum which is C's allowable HIP Tax Cost for 2015 = $243

In 2016, F & G report the same HIP Fee expense for 2015 health risks.

In 2016, F experiences the same tax rate as for 2015, but G incurs a net operating loss, resulting in a zero percent tax rate for 2016.

In 2016, C draws down a 2016 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2015 health risks of 300 + 325 = $725, which is an allowable cost, from C's FEHB letter of credit account (LOCA). C reimburses F for 300 and G for 325.

In 2016, F proceeds as in 2015 and C may charge 162 as an allowable HIP Tax Cost attributable to F in 2016.

In 2016 G records income of $325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by $325. Because G determines that its 2016 tax liability will be zero as it will have a Net Operating Loss for 2016, C does not incur an allowable 2016 HIP Tax Cost attributable to G. C must refund any such amounts drawn down during 2016.

Local Plan F HIP Tax Cost for 2016 = 162
Local Plan G HIP Tax Cost for 2016 = 0
Reimbursement attributable to G = adjustment for amounts drawn down by C, if any
Sum = C's allowable HIP Tax Cost for 2016 = 162 less adjustment.

In 2017, F proceeds as in 2015. C's allowable 2017 HIP Tax Cost includes $162 attributable to F. In 2017, G has an operating gain and reports the same HIP Fee amount and experiences the same 20% tax rate as in 2015. C's allowable 2017 HIP Tax Cost includes $81 attributable to G.

In addition, in 2017, because G's operating gain results in a tax rate higher than zero, G incurs economic disadvantage. This is because the 2016 HIP Fee reimbursement of $325 has reduced G's otherwise applicable Net Operating Loss carry-forward amount. G calculates the economic disadvantage as the difference between its 2017 tax liability with and without the 2016 HIP Fee reimbursement. This disadvantage is included in the Carrier's 2017 charge as an allowable HIP Tax Cost with respect to 2016. This is calculated as $325 (2016 HIP Fee) divided by 1-20% (application of 2017 Local Plan Tax Rate), less $325.]

Local Plan F HIP Tax Cost for 2017 = 162
Local Plan G HIP Tax Cost for 2017 = 81
Local Plan G HIP Tax Cost for 2017 due to 2016 HIP Fee reimbursement = apply formula using 2016 Fee Reimbursement amount and 2017 tax rate of 20% =81
Sum = C's allowable HIP Tax Cost for 2017 = 162 + 81 + 81 = $324

PART V - REQUIRED CLAUSES

SECTION 5.1
DEFINITIONS (JUN 2020) (FAR 52.202-1)

When a solicitation provision or contract clause uses a word or term that is defined in the Federal Acquisition Regulation (FAR), the word or term has the same meaning as the definition in FAR 2.101 in effect at the time the solicitation was issued, unless—

(a) The solicitation, or amended solicitation, provides a different definition;
(b) The contracting parties agree to a different definition;
(c) The part, subpart, or section of the FAR where the provision or clause is prescribed provides a different meaning;
(d) The word or term is defined in FAR Part 31, for use in the cost principles and procedures; or
(e) The word or term defines an acquisition-related threshold, and if the threshold is adjusted for inflation as set forth in FAR 1.109(a), then the changed threshold applies throughout the remaining term of the contract, unless there is a subsequent threshold adjustment; see FAR 1.109(d).

SECTION 5.2
[RESERVED]

SECTION 5.3
GRATUITIES (APR 1984) (FAR 52.203-3)

(a) The right of the Contractor to proceed may be terminated by written notice if, after notice and hearing, the agency head or a designee determines that the Contractor, its agent, or another representative -

(1) Offered or gave a gratuity (e.g., an entertainment or gift) to an officer, official, or employee of the Government; and

(2) Intended, by the gratuity, to obtain a contract or favorable treatment under a contract.

(b) The facts supporting this determination may be reviewed by any court having lawful jurisdiction.

(c) If this contract is terminated under paragraph (a) above, the Government is entitled -

(1) To pursue the same remedies as in a breach of the contract; and

(2) In addition to any other damages provided by law, to exemplary damages of not less than 3 nor more than 10 times the cost incurred by the Contractor in giving gratuities to the person concerned, as determined by the agency head or a designee. (This subparagraph (c)(2) is applicable only if this contract uses money appropriated to the Department of Defense.)

(d) The rights and remedies of the Government provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this contract.

SECTION 5.4
COVENANT AGAINST CONTINGENT FEES (MAY 2014) (FAR 52.203-5)

(a) The Contractor warrants that no person or agency has been employed or retained to solicit

or obtain this contract upon an agreement or understanding for a contingent fee, except a bona fide employee or agency. For breach or violation of this warranty, the Government shall have the right to annul this contract without liability or to deduct from the contract price or consideration, or otherwise recover, the full amount of the contingent fee.

(b) "Bona fide agency," as used in this clause, means an established commercial or selling agency, maintained by a contractor for the purpose of securing business, that neither exerts nor proposes to exert improper influence to solicit or obtain Government contracts nor holds itself out as being able to obtain any Government contract or contracts through improper influence.

"Bona fide employee," as used in this clause, means a person, employed by a contractor and subject to the contractor's supervision and control as to time, place, and manner of performance, who neither exerts nor proposes to exert improper influence to solicit or obtain Government contracts nor holds out as being able to obtain any Government contract or contracts through improper influence.

"Contingent fee", as used in this clause, means any commission, percentage, brokerage, or other fee that is contingent upon the success that a person or concern has in securing a Government contract.

"Improper influence," as used in this clause, means any influence that induces or tends to induce a Government employee or officer to give consideration or to act regarding a Government contract on any basis other than the merits of the matter.

SECTION 5.5
ANTI-KICKBACK PROCEDURES (JUN 2020) (FAR 52.203-7)

(a) Definitions.

"Kickback," as used in this clause, means any money, fee, commission, credit, gift, gratuity, thing of value, or compensation of any kind which is provided to any prime Contractor, prime Contractor employee, subcontractor, or subcontractor employee for the purpose of improperly obtaining or rewarding favorable treatment in connection with a prime contract or in connection with a subcontract relating to a prime contract.

"Person," as used in this clause, means a corporation, partnership, business association of any kind, trust, joint-stock company, or individual.

"Prime contract," as used in this clause, means a contract or contractual action entered into by the United States for the purpose of obtaining supplies, materials, equipment, or services of any kind.

"Prime Contractor," as used in this clause, means a person who has entered into a prime contract with the United States.

"Prime Contractor employee," as used in this clause, means any officer, partner, employee, or agent of a prime Contractor.

"Subcontract," as used in this clause, means a contract or contractual action entered into by a prime Contractor or subcontractor for the purpose of obtaining supplies, materials, equipment, or services of any kind under a prime contract.

"Subcontractor," as used in this clause, (1) means any person, other than the prime Contractor, who offers to furnish or furnishes any supplies, materials, equipment, or services of any kind under a prime contract or a subcontract entered into in connection with such prime contract, and (2) includes any person who offers to furnish or furnishes general supplies to the prime Contractor or a higher tier subcontractor.

"Subcontractor employee," as used in this clause, means any officer, partner, employee, or agent of a subcontractor.

(b) 41 U.S.C. chapter 87, Kickbacks, prohibits any person from --

(1) Providing or attempting to provide or offering to provide any kickback;

(2) Soliciting, accepting, or attempting to accept any kickback; or

(3) Including, directly or indirectly, the amount of any kickback in the contract price charged by a prime Contractor to the United States or in the contract price charged by a subcontractor to a prime Contractor or higher tier subcontractor.

(c)(1) The Contractor shall have in place and follow reasonable procedures designed to prevent and detect possible violations described in paragraph (b) of this clause in its own operations and direct business relationships.

(2) When the Contractor has reasonable grounds to believe that a violation described in paragraph (b) of this clause may have occurred, the Contractor shall promptly report in writing the possible violation. Such reports shall be made to the inspector general of the contracting agency, the head of the contracting agency if the agency does not have an inspector general, or the Attorney General.

(3) The Contractor shall cooperate fully with any Federal agency investigating a possible violation described in paragraph (b) of this clause.

(4) The Contracting Officer may (i) offset the amount of the kickback against any monies owed by the United States under the prime contract and/or (ii) direct that the Prime Contractor withhold, from sums owed a subcontractor under the prime contract, the amount of the kickback. The Contracting Officer may order that monies withheld under subdivision (c)(4)(ii) of this clause be paid over to the Government unless the Government has already offset those monies under subdivision (c)(4)(i) of this clause. In either case, the Prime Contractor shall notify the Contracting Officer when the monies are withheld.

(5) The Contractor agrees to incorporate the substance of this clause, including this paragraph (c)(5) but excepting paragraph (c)(1) of this clause, in all subcontracts under this contract that exceed the threshold specified in Federal Acquisition Regulation 3.502–2(i) on the date of subcontract award.

SECTION 5.6
[RESERVED]

SECTION 5.7
AUDIT AND RECORDS-NEGOTIATION (JUN 2020) (FAR 52.215-2)

(a) As used in this clause, "records" includes books, documents, accounting procedures and practices, and other data, regardless of type and regardless of whether such items are in written form, in the form of computer data, or in any other form.

(b) *Examination of costs*. If this is a cost- reimbursement, incentive, time-and-materials, labor-hour, or price redeterminable contract, or any combination of these, the Contractor shall maintain and the Contracting Officer, or an authorized representative of the Contracting Officer, shall have the right to examine and audit all records and other evidence sufficient to reflect properly all costs claimed to have been incurred or anticipated to be incurred directly or indirectly in performance of this contract. This right of examination shall include inspection at all reasonable times of the Contractor's plants, or parts of them, engaged in performing the

contract.

(c) *Certified cost or pricing data*. If the Contractor has been required to submit certified cost or pricing data in connection with any pricing action relating to this contract, the Contracting Officer, or an authorized representative of the Contracting Officer, in order to evaluate the accuracy, completeness, and currency of the certified cost or pricing data, shall have the right to examine and audit all of the Contractor's records, including computations and projections, related to--

(1) The proposal for the contract, subcontract, or modification;

(2) The discussions conducted on the proposal(s), including those related to negotiating;

(3) Pricing of the contract, subcontract, or modification; or

(4) Performance of the contract, subcontract or modification.

(d) *Comptroller General* -- (1) The Comptroller General of the United States, or an authorized representative, shall have access to and the right to examine any of the Contractor's directly pertinent records involving transactions related to this contract or a subcontract hereunder and to interview any current employee regarding such transactions.

(2) This paragraph may not be construed to require the Contractor or subcontractor to create or maintain any record that the Contractor or subcontractor does not maintain in the ordinary course of business or pursuant to a provision of law.

(e) *Reports*. If the Contractor is required to furnish cost, funding, or performance reports, the Contracting Officer or an authorized representative of the Contracting Officer shall have the right to examine and audit the supporting records and materials, for the purpose of evaluating--(1) The effectiveness of the Contractor's policies and procedures to produce data compatible with the objectives of these reports and (2) The data reported.

(f) *Availability*. The Contractor shall make available at its office at all reasonable times the records, materials, and other evidence described in paragraphs (a), (b), (c), (d), and (e) of this clause, for examination, audit, or reproduction, until 3 years after final payment under this contract or for any shorter period specified in Subpart 4.7, Contractor Records Retention, of the Federal Acquisition Regulation (FAR), or for any longer period required by statute or by other clauses of this contract. In addition--(1) If this contract is completely or partially terminated, the Contractor shall make available the records relating to the work terminated until 3 years after any resulting final termination settlement; and (2) The Contractor shall make available records relating to appeals under the Disputes clause or to litigation or the settlement of claims arising under or relating to this contract until such appeals, litigation, or claims are finally resolved.

(g) The Contractor shall insert a clause containing all the terms of this clause, including this paragraph (g), in all subcontracts under this contract that exceed the simplified acquisition threshold, as defined in FAR 2.101 on the date of subcontract award, and--

(1) That are cost-reimbursement, incentive, time-and-materials, labor-hour, or price-redeterminable type or any combination of these;

(2) For which certified cost or pricing data are required; or

(3) That require the subcontractor to furnish reports as discussed in paragraph (e) of this clause.

The clause may be altered only as necessary to identify properly the contracting parties and the Contracting Officer under the Government prime contract.

SECTION 5.8
PRICE REDUCTION FOR DEFECTIVE CERTIFIED COST OR PRICING DATA (AUG 2011) (FAR 52.215-10)

(a) If any price, including profit or fee, negotiated in connection with this contract, or any cost reimbursable under this contract, was increased by any significant amount because (1) the Contractor or a subcontractor furnished certified cost or pricing data that were not complete, accurate, and current as certified in its Certificate of Current Cost or Pricing Data, (2) a subcontractor or prospective subcontractor furnished the Contractor certified cost or pricing data that were not complete, accurate, and current as certified in the Contractor's Certificate of Current Cost or Pricing Data, or (3) any of these parties furnished data of any description that were not accurate, the price or cost shall be reduced accordingly and the contract shall be modified to reflect the reduction.

(b) Any reduction in the contract price under paragraph (a) of this clause due to defective data from a prospective subcontractor that was not subsequently awarded the subcontract shall be limited to the amount, plus applicable overhead and profit markup, by which (1) the actual subcontract; or (2) the actual cost to the Contractor, if there was no subcontract, was less than the prospective subcontract cost estimate submitted by the Contractor; provided, that the actual subcontract price was not itself affected by defective certified cost or pricing data.

(c)(1) If the Contracting Officer determines under paragraph (a) of this clause that a price or cost reduction should be made, the Contractor agrees not to raise the following matters as a defense:

(i) The Contractor or subcontractor was a sole source supplier or otherwise was in a superior bargaining position and thus the price of the contract would not have been modified even if accurate, complete, and current certified cost of pricing data had been submitted;

(ii) The Contracting Officer should have known that the certified cost or pricing data in issue were defective even though the Contractor or subcontractor took no affirmative action to bring the character of the data to the attention of the Contracting Officer;

(iii) The contract was based on an agreement about the total cost of the contract and there was no agreement about the cost of each item procured under the contract; or

(iv) The Contractor or subcontractor did not submit a Certificate of Current Cost or Pricing Data.

(2)(i) Except as prohibited by subdivision (c)(2)(ii) of this clause, an offset in an amount determined appropriate by the Contracting Officer based upon the facts shall be allowed against the amount of a contract price reduction if--

(A) The Contractor certifies to the Contracting Officer that, to the best of the Contractor's knowledge and belief, the Contractor is entitled to the offset in the amount requested; and

(B) The Contractor proves that the certified cost or pricing data were available before the “as of” date specified on its Certificate of Current Cost or Pricing Data, and that the data were not submitted before such date.

(ii) An offset shall not be allowed if--

(A) The understated data were known by the Contractor to be understated before the “as of” date specified on its Certificate of Current Cost or Pricing Data; or

(B) The Government proves that the facts demonstrate that the contract price would not have increased in the amount to be offset even if the available data had been submitted before the “as of” date specified on its Certificate of Current Cost or Pricing Data.

(d) If any reduction in the contract price under this clause reduces the price of items for which payment was made prior to the date of the modification reflecting the price reduction, the Contractor shall be liable to and shall pay the United States at the time such overpayment is repaid--

(1) Interest compounded daily, as required by 26 U.S.C. 6622, on the amount of such overpayment to be computed from the date(s) of overpayment to the Contractor to the date the Government is repaid by the Contractor at the applicable underpayment rate effective for each quarter prescribed by the Secretary of the Treasury under 26 U.S.C. 6621(a)(2); and

(2) A penalty equal to the amount of the overpayment, if the Contractor or subcontractor knowingly submitted certified cost or pricing data which were incomplete, inaccurate, or noncurrent.

SECTION 5.9
[RESERVED]

SECTION 5.10
SUBCONTRACTOR CERTIFIED COST OR PRICING DATA (JUN 2020) (FAR 52.215-12)

(a) Before awarding any subcontract expected to exceed the threshold for submission of certified cost or pricing data in Federal Acquisition Regulation (FAR) 15.403-4(a)(1), on the date of agreement on price or the date of award, whichever is later; or before pricing any subcontract modification involving a pricing adjustment expected to exceed the threshold for submission of certified cost or pricing data in FAR 15.403-4(a)(1), the Contractor shall require the subcontractor to submit certified cost or pricing data (actually or by specific identification in writing), in accordance with FAR 15.408, Table 15-2 (to include any information reasonably required to explain the subcontractor's estimating process such as the judgmental factors applied and the mathematical or other methods used in the estimate, including those used in projecting from known data, and the nature and amount of any contingencies included in the price), unless an exception under 15.403-1(b) applies. If the threshold for submission of certified cost or pricing data specified in FAR 15.403-4(a)(1) is adjusted for inflation as set forth in FAR 1.109(a), then pursuant to FAR 1.109(d) the changed threshold applies throughout the remaining term of the contract, unless there is a subsequent threshold adjustment.

(b) The Contractor shall require the subcontractor to certify in substantially the form prescribed in FAR 15.406-2 that, to the best of its knowledge and belief, the data submitted under paragraph (a) of this clause were accurate, complete, and current as of the date of agreement on the negotiated price of the subcontract or subcontract modification.

(c) In each subcontract that, when entered into, exceeds the threshold for submission of certified cost or pricing data in FAR 15.403-4(a)(1), the Contractor shall insert either --

(1) The substance of this clause, including this paragraph (c), if paragraph (a) of this clause requires submission of certified cost or pricing data for the subcontract; or

(2) The substance of the clause at FAR 52.215-13, Subcontractor Certified Cost or Pricing Data - Modifications.

SECTION 5.11
[RESERVED]

SECTION 5.12
[RESERVED]

SECTION 5.13
[RESERVED]

SECTION 5.14
UTILIZATION OF SMALL BUSINESS CONCERNS (OCT 2018) (FAR 52.219-8)

(a) Definitions. As used in this contract --

"HUBZone small business concern" means a small business concern, certified by the Small Business Administration, that appears on the List of Qualified HUBZone Small Business Concerns maintained by the Small Business Administration.

"Service-disabled veteran-owned small business concern"

(1) Means a small business concern—

(i) Not less than 51 percent of which is owned by one or more service-disabled veterans or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more service-disabled veterans; and

(ii) The management and daily business operations of which are controlled by one or more service-disabled veterans or, in the case of a service-disabled veteran with permanent and severe disability, the spouse or permanent caregiver of such veteran.

(2) Service-disabled veteran means a veteran, as defined in 38 U.S.C. 101(2), with a disability that is service-connected, as defined in 38 U.S.C. 101(16).

"Small business concern" means a small business as defined pursuant to Section 3 of the Small Business Act and relevant regulations promulgated pursuant thereto.

"Small disadvantaged business concern", consistent with 13 CFR 124.1002, means a small business concern under the size standard applicable to the acquisition, that--

(1) Is at least 51 percent unconditionally and directly owned (as defined at 13 CFR 124.105) by—

(i) One or more socially disadvantaged (as defined at 13 CFR 124.103) and economically disadvantaged (as defined at 13 CFR 124.104) individuals who are citizens of the United States; and

(ii) Each individual claiming economic disadvantage has a net worth not exceeding $750,000 after taking into account the applicable exclusions set forth at 13 CFR 124.104(c)(2); and

(2) The management and daily business operations of which are controlled (as defined at 13.CFR 124.106) by individuals, who meet the criteria in paragraphs (1)(i) and (ii) of this definition.

"Veteran-owned small business concern" means a small business concern—

(1) Not less than 51 percent of which is owned by one or more veterans (as defined at 38 U.S.C. 101(2)) or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more veterans; and

(2) The management and daily business operations of which are controlled by one or more veterans.

"Women-owned small business concern" means a small business concern—

(1) That is at least 51 percent owned by one or more women, or, in the case of any publicly owned business, at least 51 percent of the stock of which is owned by one or more women; and

(2) Whose management and daily business operations are controlled by one or more women.

(b) It is the policy of the United States that small business concerns, veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns, and women-owned small business concerns shall have the maximum practicable opportunity to participate in performing contracts let by any Federal agency, including contracts and subcontracts for subsystems, assemblies, components, and related services for major systems. It is further the policy of the United States that its prime contractors establish procedures to ensure the timely payment of amounts due pursuant to the terms of their subcontracts with small business concerns, veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns, and women-owned small business concerns.

(c) The Contractor hereby agrees to carry out this policy in the awarding of subcontracts to the fullest extent consistent with efficient contract performance. The Contractor further agrees to cooperate in any studies or surveys as may be conducted by the United States Small Business Administration or the awarding agency of the United States as may be necessary to determine the extent of the Contractor's compliance with this clause.

(d)(1) The Contractor may accept a subcontractor’s written representations of its size and socioeconomic status as a small business, small disadvantaged business, a veteran-owned small business, service-disabled veteran-owned small business or a women-owned small business if the subcontractor represents that the size and socioeconomic status representations with its offer are current, accurate, and complete as of the date of the offer for the subcontract.

(2) The Contractor may accept a subcontractor’s representations of its size and socioeconomic status as a small business, small disadvantaged business, veteran-owned small business, service-disabled veteran-owned small business, or a women-owned small business in the System for Award Management (SAM) if–

(i) The subcontractor is registered in SAM; and

(ii) The subcontractor represents that the size and socioeconomic status representations made in SAM are current, accurate and complete as of the date of the offer for the subcontract.

(3) The Contractor may not require the use of SAM for the purposes of representing size or socioeconomic status in connection with a subcontract.

(4) In accordance with 13 CFR 121.411, 124.1015, 125.29, 126.900, and 127.700, a contractor acting in good faith is not liable for misrepresentations made by its subcontractors regarding the subcontractor’s size or socioeconomic status.

(5) The Contractor shall confirm that a subcontractor representing itself as a HUBZone small business concern is certified by SBA as a HUBZone small business concern by accessing the System for Award Management or by contacting the SBA. Options for contacting the SBA include—

(i) HUBZone small business database search application web page at http://dsbs.sba.gov/dsbs/search/dsp_searchhubzone.cfm; or http://www.sba.gov/hubzone;

(ii) In writing to the Director/HUB, U.S. Small Business Administration, 409 3rd Street, SW., Washington, DC 20416; or

(iii) The SBA HUBZone Help Desk at hubzone@sba.gov.

SECTION 5.15
[RESERVED]

SECTION 5.16
[RESERVED]

SECTION 5.17
CONVICT LABOR (JUN 2003) (FAR 52.222-3)

(a) Except as provided in paragraph (b) of this clause, the Contractor shall not employ in the performance of this contract any person undergoing a sentence of imprisonment imposed by any court of a State, the District of Columbia, Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, or the U.S. Virgin Islands.

(b) The Contractor is not prohibited from employing persons-

(1) On parole or probation to work at paid employment during the term of their sentence;

(2) Who have been pardoned or who have served their terms; or

(3) Confined for violation of the laws of any of the States, the District of Columbia, Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, or the U.S. Virgin Islands who are authorized to work at paid employment in the community under the laws of such jurisdiction, if-

(i) The worker is paid or is in an approved work training program on a voluntary basis;

(ii) Representatives of local union central bodies or similar labor union organizations have been consulted;

(iii) Such paid employment will not result in the displacement of employed workers, or be applied in skills, crafts, or trades in which there is a surplus of available gainful labor in the locality, or impair existing contracts for services;

(iv) The rates of pay and other conditions of employment will not be less than those paid or provided for work of a similar nature in the locality in which the work is being performed; and

(v) The Attorney General of the United States has certified that the work-release laws or regulations of the jurisdiction involved are in conformity with the requirements of Executive Order 11755, as amended by Executive Orders 12608 and 12943.

SECTION 5.18
CONTRACT WORK HOURS AND SAFETY STANDARDS ACT -- OVERTIME COMPENSATION (MAY 2018) (FAR 52.222-4)

(a) *Overtime requirements*. No Contractor or subcontractor employing laborers or mechanics (see Federal Acquisition Regulation 22.300) shall require or permit them to work over 40 hours in any workweek unless they are paid at least 1 and ½ times the basic rate of pay for each hour worked over 40 hours.

(b) *Violation; liability for unpaid wages; liquidated damages*. The responsible Contractor and subcontractor are liable for unpaid wages if they violate the terms in paragraph (a) of this clause. In addition, the Contractor and subcontractor are liable for liquidated damages payable to the Government. The Contracting Officer will assess liquidated damages at the rate specified at

29 CFR 5.5(b)(2) per affected employee for each calendar day on which the employer required or permitted the employee to work in excess of the standard workweek of 40 hours without paying overtime wages required by the Contract Work Hours and Safety Standards statute (found at 40 U.S.C. chapter 37). In accordance with the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 Note), the Department of Labor adjusts this civil monetary penalty for inflation no later than January 15 each year.

(c) *Withholding for unpaid wages and liquidated damages.* The Contracting Officer will withhold from payments due under the contract sufficient funds required to satisfy any Contractor or subcontractor liabilities for unpaid wages and liquidated damages. If amounts withheld under the contract are insufficient to satisfy Contractor or subcontractor liabilities, the Contracting Officer will withhold payments from other Federal or Federally assisted contracts held by the same Contractor that are subject to the Contract Work Hours and Safety Standards statute.

(d) *Payrolls and basic records.* (1) The Contractor and its subcontractors shall maintain payrolls and basic payroll records for all laborers and mechanics working on the contract during the contract and shall make them available to the Government until 3 years after contract completion. The records shall contain the name and address of each employee, social security number, labor classifications, hourly rates of wages paid, daily and weekly number of hours worked, deductions made, and actual wages paid. The records need not duplicate those required for construction work by Department of Labor regulations at 29 CFR 5.5(a)(3) implementing the Construction Wage Rate Requirements statute.

(2) The Contractor and its subcontractors shall allow authorized representatives of the Contracting Officer or the Department of Labor to inspect, copy, or transcribe records maintained under paragraph (d)(1) of this clause. The Contractor or subcontractor also shall allow authorized representatives of the Contracting Officer or Department of Labor to interview employees in the workplace during working hours.

(e) *Subcontracts*. The Contractor shall insert the provisions set forth in paragraphs (a) through (d) of this clause in subcontracts that may require or involve the employment of laborers and mechanics and require subcontractors to include these provisions in any such lower tier subcontracts. The Contractor shall be responsible for compliance by any subcontractor or lower-tier subcontractor with the provisions set forth in paragraphs (a) through (d) of this clause.

SECTION 5.19
EQUAL OPPORTUNITY (SEP 2016) (FAR 52.222-26)

(a) Definition. As used in this clause.

"Compensation" means any payments made to, or on behalf of, an employee or offered to an applicant as remuneration for employment, including but not limited to salary, wages, overtime pay, shift differentials, bonuses, commissions, vacation and holiday pay, allowances, insurance and other benefits, stock options and awards, profit sharing, and retirement.

"Compensation information" means the amount and type of compensation provided to employees or offered to applicants, including, but not limited to, the desire of the Contractor to attract and retain a particular employee for the value the employee is perceived to add to the Contractor's profit or productivity; the availability of employees with like skills in the marketplace; market research about the worth of similar jobs in the relevant marketplace; job analysis, descriptions, and evaluations; salary and pay structures; salary surveys; labor union

agreements; and Contractor decisions, statements and policies related to setting or altering employee compensation.

"Essential job functions" means the fundamental job duties of the employment position an individual holds. A job function may be considered essential if–

(1) The access to compensation information is necessary in order to perform that function or another routinely assigned business task; or

(2) The function or duties of the position include protecting and maintaining the privacy of employee personnel records, including compensation information.

"Gender identity" has the meaning given by the Department of Labor's Office of Federal Contract Compliance Programs, and is found at www.dol.gov/ofccp/LGBT/LGBT_FAQs.html.

"Sexual orientation" has the meaning given by the Department of Labor's Office of Federal Contract Compliance Programs, and is found at www.dol.gov/ofccp/LGBT/LGBT_FAQs.html.

"United States,", means the 50 States, the District of Columbia, Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, the U.S. Virgin Islands, and Wake Island.

(b)(1) If, during any 12-month period (including the 12 months preceding the award of this contract), the Contractor has been or is awarded nonexempt Federal contracts and/or subcontracts that have an aggregate value in excess of $10,000, the Contractor shall comply with this clause, except for work performed outside the United States by employees who were not recruited within the United States. Upon request, the Contractor shall provide information necessary to determine the applicability of this clause.

(2) If the Contractor is a religious corporation, association, educational institution, or society, the requirements of this clause do not apply with respect to the employment of individuals of a particular religion to perform work connected with the carrying on of the Contractor's activities (41 CFR 60-1.5).

(c)(1) The Contractor shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, sexual orientation, gender identity, or national origin. However, it shall not be a violation of this clause for the Contractor to extend a publicly announced preference in employment to Indians living on or near an Indian reservation, in connection with employment opportunities on or near an Indian reservation, as permitted by 41 CFR 60-1.5.

(2) The Contractor shall take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, sexual orientation, gender identity or national origin. This shall include, but not be limited to—

(i) Employment;
(ii) Upgrading;
(iii) Demotion;
(iv) Transfer;
(v) Recruitment or recruitment advertising;
(vi) Layoff or termination;
(vii) Rates of pay or other forms of compensation; and
(viii) Selection for training, including apprenticeship.

(3) The Contractor shall post in conspicuous places available to employees and applicants for employment the notices to be provided by the Contracting Officer that explain this clause.

(4) The Contractor shall, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity or national origin.

(5) (i) The Contractor shall not discharge or in any other manner discriminate against any employee or applicant for employment because such employee or applicant has inquired about, discussed, or disclosed the compensation of the employee or applicant or another employee or applicant. This prohibition against discrimination does not apply to instances in which an employee who has access to the compensation information of other employees or applicants as a part of such employee's essential job functions discloses the compensation of such other employees or applicants to individuals who do not otherwise have access to such information, unless such disclosure is in response to a formal complaint or charge, in furtherance of an investigation, proceeding, hearing, or action, including an investigation conducted by the employer, or is consistent with the Contractor's legal duty to furnish information.

(ii) The Contractor shall disseminate the prohibition on discrimination in paragraph (c)(5)(i) of this clause, using language prescribed by the Director of the Office of Federal Contract Compliance Programs (OFCCP), to employees and applicants by–

(A) Incorporation into existing employee manuals or handbooks; and

(B) Electronic posting or by posting a copy of the provision in conspicuous places available to employees and applicants for employment.

(6) The Contractor shall send, to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, the notice to be provided by the Contracting Officer advising the labor union or workers' representative of the Contractor's commitments under this clause, and post copies of the notice in conspicuous places available to employees and applicants for employment.

(7) The Contractor shall comply with Executive Order 11246, as amended, and the rules, regulations, and orders of the Secretary of Labor.

(8) The Contractor shall furnish to the contracting agency all information required by Executive Order 11246, as amended, and by the rules, regulations, and orders of the Secretary of Labor. The Contractor shall also file Standard Form 100 (EEO-1), or any successor form, as prescribed in 41 CFR Part 60-1. Unless the Contractor has filed within the 12 months preceding the date of contract award, the Contractor shall, within 30 days after contract award, apply to either the regional Office of Federal Contract Compliance Programs (OFCCP) or the local office of the Equal Employment Opportunity Commission for the necessary forms.

(9) The Contractor shall permit access to its premises, during normal business hours, by the contracting agency or the OFCCP for the purpose of conducting on-site compliance evaluations and complaint investigations. The Contractor shall permit the Government to inspect and copy any books, accounts, records (including computerized records), and other material that may be relevant to the matter under investigation and pertinent to compliance with Executive Order 11246, as amended, and rules and regulations that implement the Executive Order.

(10) If the OFCCP determines that the Contractor is not in compliance with this clause or any rule, regulation, or order of the Secretary of Labor, this contract may be canceled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further Government contracts, under the procedures authorized in Executive Order 11246, as amended. In addition, sanctions may be imposed and remedies invoked against the Contractor as

provided in Executive Order 11246, as amended; in the rules, regulations, and orders of the Secretary of Labor; or as otherwise provided by law.

(11) The Contractor shall include the terms and conditions of this clause in every subcontract or purchase order that is not exempted by the rules, regulations, or orders of the Secretary of Labor issued under Executive Order 11246, as amended, so that these terms and conditions will be binding upon each subcontractor or vendor.

(12) The Contractor shall take such action with respect to any subcontract or purchase order as the Contracting Officer may direct as a means of enforcing these terms and conditions, including sanctions for noncompliance, provided, that if the Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of any direction, the Contractor may request the United States to enter into the litigation to protect the interests of the United States.

(d) Notwithstanding any other clause in this contract, disputes relative to this clause will be governed by the procedures in 41 CFR part 60-1.

SECTION 5.20
[RESERVED]

SECTION 5.21
NOTIFICATION OF VISA DENIAL (APR 2015) (FAR 52.222-29)

(a) Definitions. As used in this clause-

"Gender identity" has the meaning given by the Department of Labor's Office of Federal Contract Compliance Programs, and is found at http://www.dol.gov/ofccp/LGBT/LGBT_FAQs.html.

"Sexual orientation" has the meaning given by the Department of Labor's Office of Federal Contract Compliance Programs, and is found at http://www.dol.gov/ofccp/LGBT/LGBT_FAQs.html.

(b) Requirement to notify.

(1) It is a violation of Executive Order 11246 for a Contractor to refuse to employ any applicant or not to assign any person hired in the United States, Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, the U.S. Virgin Islands, or Wake Island on the basis that the individual's race, color, religion, sex, sexual orientation, gender identity or national origin is not compatible with the policies of the country where the work is to be performed or for whom the work will be performed (41 CFR 60-1.10).

(2)The Contractor shall notify the U.S. Department of State, Assistant Secretary, Bureau of Political-Military Affairs (PM), 2201 C Street NW, Room 6212, Washington, DC 20520, and the U.S. Department of Labor, Deputy Assistant Secretary for Federal Contract Compliance, when it has knowledge of any employee or potential employee being denied an entry visa to a country where this contract will be performed, and it believes the denial is attributable to the race, color, religion, sex, sexual orientation, gender identity, or national origin of the employee or potential employee.

SECTION 5.22
EQUAL OPPORTUNITY FOR VETERANS (JUN 2020) (FAR 52.222-35)

(a) *Definitions.* As used in this clause—

"Active duty wartime or campaign badge veteran," "Armed Forces service medal veteran," "disabled veteran," "protected veteran," "qualified disabled veteran," and "recently separated veteran" have the meanings given at Federal Acquisition Regulation (FAR) 22.1301.

(b) *Equal opportunity clause*. The Contractor shall abide by the requirements of the equal opportunity clause at 41 CFR 60-300.5(a), as of March 24, 2014. This clause prohibits discrimination against qualified protected veterans, and requires affirmative action by the Contractor to employ and advance in employment qualified protected veterans.

(c) *Subcontracts.* The Contractor shall insert the terms of this clause in subcontracts valued at or above the threshold specified in FAR 22.1303(a) on the date of subcontract award, unless exempted by rules, regulations, or orders of the Secretary of Labor. The Contractor shall act as specified by the Director, Office of Federal Contract Compliance Programs, to enforce the terms, including action for noncompliance. Such necessary changes in language may be made as shall be appropriate to identify properly the parties and their undertakings.

SECTION 5.23
EQUAL OPPORTUNITY FOR WORKERS WITH DISABILITIES (JUN 2020) (FAR 52.222-36)

(a) *Equal opportunity clause*. The Contractor shall abide by the requirements of the equal opportunity clause at 41 CFR 60-741.5(a), as of March 24, 2014. This clause prohibits discrimination against qualified individuals on the basis of disability, and requires affirmative action by the Contractor to employ and advance in employment qualified individuals with disabilities.

(b) Subcontracts. The Contractor shall include the terms of this clause in every subcontract or purchase order in excess of the threshold specified in Federal Acquisition Regulation (FAR) 22.1408(a) on the date of subcontract award, unless exempted by rules, regulations, or orders of the Secretary, so that such provisions will be binding upon each subcontractor or vendor. The Contractor shall act as specified by the Director, Office of Federal Contract Compliance Programs of the U.S. Department of Labor, to enforce the terms, including action for noncompliance. Such necessary changes in language may be made as shall be appropriate to identify properly the parties and their undertakings.

SECTION 5.24
[RESERVED]

SECTION 5.25
DRUG-FREE WORKPLACE (MAY 2001) (FAR 52.223-6)

(a) Definitions. As used in this clause,

"Controlled substance" means a controlled substance in schedules I through V of section 202 of the Controlled Substances Act (21 U.S.C. 812) and as further defined in regulation at 21 CFR 1308.11-1308.15.

"Conviction" means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes.

"Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, possession or use of any controlled substance.

"Drug-free workplace" means the site(s) for the performance of work done by the Contractor in connection with a specific contract where employees of the Contractor are prohibited from engaging in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance.

"Employee" means an employee of a Contractor directly engaged in the performance of work under a Government contract. Directly engaged is defined to include all direct cost employees and any other Contractor employee who has other than a minimal impact or involvement in contract performance.

"Individual" means an offeror/contractor that has no more than one employee including the offeror/contractor.

(b) The Contractor, if other than an individual, shall - within 30 days after award (unless a longer period is agreed to in writing for contracts of 30 days or more performance duration); or as soon as possible for contracts of less than 30 days performance duration -

(1) Publish a statement notifying its employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition;

(2) Establish an ongoing drug-free awareness program to inform such employees about-

(i) The dangers of drug abuse in the workplace;

(ii) The contractor's policy of maintaining a drug-free workplace;

(iii) Any available drug counseling, rehabilitation, and employee assistance programs; and

(iv) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace.

(3) Provide all employees engaged in performance of the contract with a copy of the statement required by subparagraph (b)(1) of this clause;

(4) Notify such employees in writing in the statement required by subparagraph (b)(1) of this clause that, as a condition of continued employment on this contract, the employee will -

(i) Abide by the terms of the statement; and

(ii) Notify the employer in writing of the employee's conviction under a criminal drug statute for a violation occurring in the workplace no later than 5 days after such conviction.

(5) Notify the Contracting Officer in writing within 10 days after receiving notice under subdivision (b)(4)(ii) of this clause, from an employee or otherwise receiving actual notice of such conviction. The notice shall include the position title of the employee;

(6) Within 30 days after receiving notice under subdivision (b)(4)(ii) of this clause of a conviction, take one of the following actions with respect to any employee who is convicted of a drug abuse violation occurring in the workplace:

(i) Taking appropriate personnel action against such employee, up to and including termination; or

(ii) Require such employee to satisfactorily participate in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and

(7) Make a good faith effort to maintain a drug-free workplace through implementation of subparagraphs (b)(1) through (b)(6) of this clause.

(c) The Contractor, if an individual, agrees by award of the contract or acceptance of a purchase order, not to engage in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance while performing this contract.

(d) In addition to other remedies available to the Government, the Contractor's failure to comply with the requirements of paragraphs (b) or (c) of this clause may, pursuant to FAR 23.506, render the Contractor subject to suspension of contract payments, termination of the contract for default, and suspension or debarment.

SECTION 5.26
[RESERVED]

SECTION 5.27
FEDERAL, STATE, AND LOCAL TAXES (STATE AND LOCAL ADJUSTMENTS) (FEB 2013) (FAR 52.229-4)

(a) As used in this clause-

"After-imposed tax" means any new or increased Federal, State, or local tax or duty, or tax that was excluded on the contract date but whose exclusion was later revoked or amount of exemption reduced during the contract period, other than an excepted tax, on the transactions or property covered by this contract that the Contractor is required to pay or bear as the result of legislative, judicial, or administrative action taking effect after the contract date.

"After-relieved tax" means any amount of Federal, State, or local tax or duty, other than an excepted tax, that would otherwise have been payable on the transactions or property covered by this contract, but which the Contractor is not required to pay or bear, or for which the Contractor obtains a refund or drawback, as the result of legislative, judicial, or administrative action taking effect after the contract date.

"All applicable Federal, State, and local taxes and duties" means all taxes and duties, in effect on the contract date, that the taxing authority is imposing and collecting on the transactions or property covered by this contract.

"Contract date" means the effective date of this contract and, for any modification to this contract, the effective date of the modification.

"Excepted tax" means social security or other employment taxes, net income and franchise taxes, excess profits taxes, capital stock taxes, transportation taxes, unemployment compensation taxes, and property taxes. "Excepted tax" does not include gross income taxes levied on or measured by sales or receipts from sales, property taxes assessed on completed supplies covered by this contract, or any tax assessed on the Contractor's possession of, interest in, or use of property, title to which is in the Government.

"Local taxes" includes taxes imposed by a possession or territory of the United States, Puerto Rico, or the Northern Mariana Islands, if the contract is performed wholly or partly in any of those areas.

(b)(1) Unless otherwise provided in this contract, the contract price includes all applicable Federal, State, and local taxes and duties, except as provided in subparagraph (b)(2)(i) of this clause.

(2) Taxes imposed under 26 U.S.C. 5000C may not be—

(i) Included in the contract price; nor

(ii) Reimbursed.

(c) The contract price shall be increased by the amount of any after-imposed tax, or of any tax or duty specifically excluded from the contract price by a term or condition of this contract that the Contractor is required to pay or bear, including any interest or penalty, if the Contractor

states in writing that the contract price does not include any contingency for such tax and if liability for such tax, interest, or penalty was not incurred through the Contractor's fault, negligence, or failure to follow instructions of the Contracting Officer.

(d) The contract price shall be decreased by the amount of any after-relieved tax. The Government shall be entitled to interest received by the Contractor incident to a refund of taxes to the extent that such interest was earned after the Contractor was paid by the Government for such taxes. The Government shall be entitled to repayment of any penalty refunded to the Contractor to the extent that the penalty was paid by the Government.

(e) The contract price shall be decreased by the amount of any Federal, State, or local tax, other than an excepted tax, that was included in the contract price and that the Contractor is required to pay or bear, or does not obtain a refund of, through the Contractor's fault, negligence, or failure to follow instructions of the Contracting Officer.

(f) No adjustment shall be made in the contract price under this clause unless the amount of the adjustment exceeds $250.

(g) The Contractor shall promptly notify the Contracting Officer of all matters relating to Federal, State, and local taxes and duties that reasonably may be expected to result in either an increase or decrease in the contract price and shall take appropriate action as the Contracting Officer directs. The contract price shall be equitably adjusted to cover the costs of action taken by the Contractor at the direction of the Contracting Officer, including any interest, penalty, and reasonable attorneys' fees.

(h) The Government shall furnish evidence appropriate to establish exemption from any Federal, State, or local tax when-

(1) The Contractor requests such exemption and states in writing that it applies to a tax excluded from the contract price; and

(2) A reasonable basis exists to sustain the exemption.

SECTION 5.28
RESERVED

SECTION 5.29
TAXES - FOREIGN NEGOTIATED BENEFITS CONTRACTS (JAN 1998) (FEHBAR 1652.229-70)

(a) To the extent that this contract provides for performing services outside the United States, its possessions, and Puerto Rico, this clause applies in lieu of any Federal, State, and local taxes clause of the contract.

(b) "Contract date," as used in this clause, means the effective date of this contract or modification.

"Country concerned," as used in this clause, means any country, other than the United States, its possessions, and Puerto Rico, in which expenditures under this contract are made.

"Tax" and "taxes," as used in this clause, include fees and charges for doing business that are levied by the government of the country concerned or by its political subdivisions.

"All applicable taxes and duties," as used in this clause, means all taxes and duties, in effect on the contract date, that the taxing authority is imposing and collecting on the transactions covered by this contract, pursuant to written ruling or regulation in effect on the contract date.

"After-imposed tax," as used in this clause, means any new or increased tax or duty, or tax that was exempted or excluded on the contract date but whose exemption was later revoked or reduced during the contract period, other than excepted tax, on the transactions covered by this contract that the Carrier is required to pay or bear as the result of legislative, judicial, or administrative action taking effect after the contract date.

"After-relieved tax," as used in this clause, means any amount of tax or duty, other than an excepted tax, that would otherwise have been payable on the transactions covered by this contract, but which the Carrier is not required to pay or bear, or for which the Carrier obtains a refund, as the result of legislative, judicial, or administrative action taking effect after the contract date.

"Excepted tax," as used in this clause, means social security or other employment taxes, net income and franchise taxes, excess profits taxes, capital stock taxes, transportation taxes, unemployment compensation taxes, and property taxes. "Excepted tax" does not include gross income taxes levied on or measured by sales or receipts from sales covered by this contract, or any tax assessed on the Carrier's possession of, interest in, or use of property, title to which is in the U.S. Government.

(c) Unless otherwise provided in this contract, the contract price includes all applicable taxes and duties, except taxes and duties that the Government of the United States and the government of the country concerned have agreed shall not be applicable to expenditures in such country by or on behalf of the United States.

(d) The contract price shall be increased by the amount of any after-imposed tax or of any tax or duty specifically excluded from the contract price by a provision of this contract that the Carrier is required to pay or bear, including any interest or penalty, if the Carrier states in writing that the contract price does not include any contingency for such tax and if liability for such tax, interest, or penalty was not incurred through the Carrier's fault, negligence, or failure to follow instructions of the Contracting Officer or to comply with the provisions of paragraph (i) below.

(e) The contract price shall be decreased by the amount of any after-relieved tax, including any interest or penalty. The Government of the United States shall be entitled to interest received by the Carrier incident to a refund of taxes to the extent that such interest was earned after the Carrier was paid by the Government of the United States for such taxes. The Government of the United States shall be entitled to repayment of any penalty refunded to the Carrier to the extent that the penalty was paid by the Government.

(f) The contract price shall be decreased by the amount of any tax or duty, other than an excepted tax, that was included in the contract and that the Carrier is required to pay or bear, or does not obtain a refund of, through the Carrier's fault, negligence, or failure to follow instructions of the Contracting Officer or to comply with the provisions of paragraph (i) below.

(g) No adjustment shall be made in the contract price under this clause unless the amount of the adjustment exceeds $250.

(h) If the Carrier obtains a reduction in tax liability under the United States Internal Revenue Code (Title 26, U.S. Code) because of the payment of any tax or duty that either was included in the contract price or was the basis of an increase in the contract price, the amount of the reduction shall be paid or credited to the Government of the United States as the Contracting Officer directs.

(i) The Carrier shall take all reasonable action to obtain exemption from or refund of any taxes or duties, including interest or penalty, from which the United States Government, the Carrier, any subcontractor, or the transactions covered by this contract are exempt under the laws of the

country concerned or its political subdivisions or which the governments of the United States and of the country concerned have agreed shall not be applicable to expenditures in such country by or on behalf of the United States.

(j) The Carrier shall promptly notify the Contracting Officer of all matters relating to taxes or duties that reasonably may be expected to result in either an increase or decrease in the contract price and shall take appropriate action as the Contracting Officer directs. The contract price shall be equitably adjusted to cover the costs of action taken by the Carrier at the direction of the Contracting Officer, including any interest, penalty, and reasonable attorneys' fees.

SECTION 5.30
[RESERVED]

SECTION 5.31
[RESERVED]

SECTION 5.32
[RESERVED]

SECTION 5.33
DISCOUNTS FOR PROMPT PAYMENT (FEB 2002) (FAR 52.232-8)

(a) Discounts for prompt payment will not be considered in the evaluation of offers. However, any offered discount will form a part of the award, and will be taken if payment is made within the discount period indicated in the offer by the offeror. As an alternative to offering a discount for prompt payment in conjunction with the offer, offerors awarded contracts may include discounts for prompt payment on individual invoices.

(b) In connection with any discount offered for prompt payment, time shall be computed from the date of the invoice. If the Contractor has not placed a date on the invoice, the due date shall be calculated from the date the designated billing office receives a proper invoice, provided the agency annotates such invoice with the date of receipt at the time of receipt. For the purpose of computing the discount earned, payment shall be considered to have been made on the date that appears on the payment check or, for an electronic funds transfer, the specified payment date. When the discount date falls on a Saturday, Sunday, or legal holiday when Federal Government offices are closed and Government business is not expected to be conducted, payment may be made on the following business day.

SECTION 5.34
INTEREST (MAY 2014) (FAR 52.232-17)

(a) Except as otherwise provided in this contract under a Price Reduction for Defective Certified Cost or Pricing Data clause or a Cost Accounting Standards clause, all amounts that become payable by the Contractor to the Government under this contract shall bear simple interest from the date due until paid unless paid within 30 days of becoming due. The interest rate shall be the interest rate established by the Secretary of the Treasury as provided in 41 U.S.C. 7109, which is applicable to the period in which the amount becomes due, as provided in

paragraph (e) of this clause, and then at the rate applicable for each six-month period as fixed by the Secretary until the amount is paid.

(b) The Government may issue a demand for payment to the Contractor upon finding a debt is due under the contract.

(c) Final Decisions. The Contracting Officer will issue a final decision as required by 33.211 if—

(1) The Contracting Officer and the Contractor are unable to reach agreement on the existence or amount of a debt in a timely manner;

(2) The Contractor fails to liquidate a debt previously demanded by the Contracting Officer within the timeline specified in the demand for payment unless the amounts were not repaid because the Contractor has requested an installment payment agreement; or

(3) The Contractor requests a deferment of collection on a debt previously demanded by the Contracting Officer (see 32.607-2).

(d) If a demand for payment was previously issued for the debt, the demand for payment included in the final decision shall identify the same due date as the original demand for payment.

(e) Amounts shall be due at the earliest of the following dates:

(1) The date fixed under this contract.

(2) The date of the first written demand for payment, including any demand for payment resulting from a default termination.

(f) The interest charge shall be computed for the actual number of calendar days involved beginning on the due date and ending on—

(1) The date on which the designated office receives payment from the Contractor;

(2) The date of issuance of a Government check to the Contractor from which an amount otherwise payable has been withheld as a credit against the contract debt; or

(3) The date on which an amount withheld and applied to the contract debt would otherwise have become payable to the Contractor.

(g) The interest charge made under this clause may be reduced under the procedures prescribed in 32.608-2 of the Federal Acquisition Regulation in effect on the date of this contract.

SECTION 5.35
ASSIGNMENT OF CLAIMS (MAY 2014) (FAR 52.232-23)

(a) The Contractor, under the Assignment of Claims Act, as amended, 31 U.S.C. 3727, 41 U.S.C. 6305 (hereafter referred to as "the Act"), may assign its rights to be paid amounts due or to become due as a result of the performance of this contract to a bank, trust company, or other financing institution, including any Federal lending agency. The assignee under such an assignment may thereafter further assign or reassign its right under the original assignment to any type of financing institution described in the preceding sentence.

(b) Any assignment or reassignment authorized under the Act and this clause shall cover all unpaid amounts payable under this contract, and shall not be made to more than one party, except that an assignment or reassignment may be made to one party as agent or trustee for two or more parties participating in the financing of this contract.

(c) The Contractor shall not furnish or disclose to any assignee under this contract any classified document (including this contract) or information related to work under this contract until the Contracting Officer authorizes such action in writing.

SECTION 5.36
DISPUTES (MAY 2014) (FAR 52.233-1)

(a) This contract is subject to 41 U.S.C chapter 71, Contract Disputes.

(b) Except as provided in 41 U.S.C chapter 71, all disputes arising under or relating to this contract shall be resolved under this clause.

(c) "Claim," as used in this clause, means a written demand or written assertion by one of the contracting parties seeking, as a matter of right, the payment of money in a sum certain, the adjustment or interpretation of contract terms, or other relief arising under or relating to this contract. However, a written demand or written assertion by the Contractor seeking the payment of money exceeding $100,000 is not a claim under 41 U.S.C chapter 71 until certified. A voucher, invoice, or other routine request for payment that is not in dispute when submitted is not a claim under 41 U.S.C chapter 71. The submission may be converted to a claim under 41 U.S.C chapter 71, by complying with the submission and certification requirements of this clause, if it is disputed either as to liability or amount or is not acted upon in a reasonable time.

(d)(1) A claim by the Contractor shall be made in writing and, unless otherwise stated in this contract, submitted within 6 years after accrual of the claim to the Contracting Officer for a written decision. A claim by the Government against the Contractor shall be subject to a written decision by the Contracting Officer.

(2)(i) The Contractor shall provide the certification specified in paragraph (d)(2)(iii) of this clause when submitting any claim exceeding $100,000.

(ii) The certification requirement does not apply to issues in controversy that have not been submitted as all or part of a claim.

(iii) The certification shall state as follows: "I certify that the claim is made in good faith; that the supporting data are accurate and complete to the best of my knowledge and belief; that the amount requested accurately reflects the contract adjustment for which the Contractor believes the Government is liable; and that I am authorized to certify the claim on behalf of the Contractor."

(3) The certification may be executed by any person authorized to bind the Contractor with respect to the claim.

(e) For Contractor claims of $100,000 or less, the Contracting Officer must, if requested in writing by the Contractor, render a decision within 60 days of the request. For Contractor-certified claims over $100,000, the Contracting Officer must, within 60 days, decide the claim or notify the Contractor of the date by which the decision will be made.

(f) The Contracting Officer's decision shall be final unless the Contractor appeals or files a suit as provided in 41 U.S.C chapter 71.

(g) If the claim by the Contractor is submitted to the Contracting Officer or a claim by the Government is presented to the Contractor, the parties, by mutual consent, may agree to use alternative dispute resolution (ADR). If the Contractor refuses an offer for ADR, the Contractor shall inform the Contracting Officer, in writing, of the Contractor's specific reasons for rejecting the offer.

(h) The Government shall pay interest on the amount found due and unpaid from (1) the date that the Contracting Officer receives the claim (certified, if required); or (2) the date that payment otherwise would be due, if that date is later, until the date of payment. With regard to claims having defective certifications, as defined in FAR 33.201, interest shall be paid from the date that the Contracting Officer initially receives the claim. Simple interest on claims shall be paid at the rate, fixed by the Secretary of the Treasury as provided in the Act, which is applicable to the period during which the Contracting Officer receives the claim and then at the rate applicable for each 6-month period as fixed by the Treasury Secretary during the pendency of the claim.

(i) The Contractor shall proceed diligently with performance of this contract, pending final resolution of any request for relief, claim, appeal, or action arising under the contract, and comply with any decision of the Contracting Officer.

SECTION 5.37
NOTICE OF INTENT TO DISALLOW COSTS (APR 1984) (FAR 52.242-1)

(a) Notwithstanding any other clause of this contract--

(1) The Contracting Officer may at any time issue to the Contractor a written notice of intent to disallow specified costs incurred or planned for incurrence under this contract that have been determined not to be allowable under the contract terms; and

(2) The Contractor may, after receiving a notice under subparagraph (1) above, submit a written response to the Contracting Officer, with justification for allowance of the costs. If the Contractor does respond within 60 days, the Contracting Officer shall, within 60 days of receiving the response, either make a written withdrawal of the notice or issue a written decision.

(b) Failure to issue a notice under this Notice of Intent to Disallow Costs clause shall not affect the Government's right to take exception to incurred costs.

SECTION 5.38
CHANGES--NEGOTIATED BENEFITS CONTRACTS (JAN 1998) (FEHBAR 1652.243-70)

(a) The Contracting Officer may at any time, by written order, and without notice to the sureties, if any, make changes within the general scope of this contract in any one or more of the following:

(1) Description of services to be performed.

(2) Time of performance (i.e., hours of the day, days of the week, etc.).

(3) Place of performance of the services.

(b) If any such change causes an increase or decrease in the cost of, or the time required for, performance of any part of the work under this contract, whether or not changed by the order, the Contracting Officer shall make an equitable adjustment in the contract price, the delivery schedule, or both, and shall modify the contract.

(c) The Carrier must assert its right to an adjustment under this clause within 30 days from the date of receipt of the written order. However, if the Contracting Officer decides that the facts justify it, the Contracting Officer may receive and act upon a proposal submitted before final payment of the contract.

(d) Failure to agree to any adjustment shall be a dispute under the Disputes clause. However, nothing in this clause shall excuse the Carrier from proceeding with the contract as changed.

SECTION 5.39
COMPETITION IN SUBCONTRACTING (DEC 1996) (FAR 52.244-5)

(a) The Contractor shall select subcontractors (including suppliers) on a competitive basis to the maximum practical extent consistent with the objectives and requirements of the contract.
(b) If the Contractor is an approved mentor under the Department of Defense Pilot Mentor-Protègè Program (Pub. L. 101-510, section 831 as amended), the Contractor may award subcontracts under this contract on a noncompetitive basis to its protègès.

SECTION 5.40
GOVERNMENT PROPERTY (NEGOTIATED BENEFITS CONTRACTS) (JAN 1998) (FEHBAR 1652.245-70)

(a) Government-furnished property. (1) The Government shall deliver to the Carrier, for use in connection with and under the terms of this contract, the Government-furnished property described in this contract together with any related data and information that the Carrier may request and is reasonably required for the intended use of the property (hereinafter referred to as "Government-furnished property").
(2) The delivery or performance dates for this contract are based upon the expectation that Government-furnished property suitable for use (except for property furnished "as-is") will be delivered to the Carrier at the times stated in this contract or, if not so stated, in sufficient time to enable the Carrier to meet the contract's performance dates.
(3) If Government-furnished property is received by the Carrier in a condition not suitable for the intended use, the Carrier shall, upon receipt of it, notify the Contracting Officer, detailing the facts, and, as directed by the Contracting Officer and at Government expense, either repair, modify, return, or otherwise dispose of the property. After completing the directed action and upon written request of the Carrier, the Contracting Officer shall make an equitable adjustment as provided in paragraph (h) of this clause.
(b) Changes in Government-furnished property. (1) The Contracting Officer may, by written notice, (i) decrease the Government-furnished property provided or to be provided under this contract, or (ii) substitute other Government-furnished property for the property to be provided by the Government, or to be acquired by the Carrier for the Government, under this contract. The Carrier shall promptly take such action as the Contracting Officer may direct regarding the removal, shipment, or disposal of the property covered by such notice.
(2) Upon the Carrier's written request, the Contracting Officer shall make an equitable adjustment to the contract in accordance with paragraph (h) of this clause, if the Government has agreed in this contract to make the property available for performing this contract and there is any -
(i) Decrease or substitution in this property pursuant to subparagraph (b)(1) above; or
(ii) Withdrawal of authority to use this property, if provided under any other contract or lease.
(c) Title in Government property. (1) The Government shall retain title to all Government-furnished property.
(2) All Government-furnished property and all property acquired by the Carrier, title to which vests in the Government under this paragraph (collectively referred to as "Government property"), are subject to the provisions of this clause. Title to Government property shall not be

affected by its incorporation into or attachment to any property not owned by the Government, nor shall Government property become a fixture or lose its identity as personal property by being attached to any real property.

(d) Use of Government property. The Government property shall be used only for performing this contract, unless otherwise provided in this contract or approved by the Contracting Officer.

(e) Property administration. (1) The Carrier shall be responsible and accountable for all Government property provided under this contract and shall comply with Federal Acquisition Regulation (FAR) subpart 45.5, as in effect on the date of this contract.

(2) The Carrier shall establish and maintain a program for the use, maintenance, repair, protection, and preservation of Government property in accordance with sound industrial practice and the applicable provisions of subpart 45.5 of the FAR.

(3) If damage occurs to Government property, the risk of which has been assumed by the Government under this contract, the Government shall replace the items or the Carrier shall make such repairs as the Government directs. However, if the Carrier cannot effect such repairs within the time required, the Carrier shall dispose of the property as directed by the Contracting Officer. When any property for which the Government is responsible is replaced or repaired, the Contracting Officer shall make an equitable adjustment in accordance with paragraph (h) of this clause.

(4) The Carrier represents that the contract price does not include any amount for repairs or replacement for which the Government is responsible. Repair or replacement of property for which the Carrier is responsible shall be accomplished by the Carrier at its own expense.

(f) Access. The Government and all its designees shall have access at all reasonable times to the premises in which any Government property is located for the purpose of inspecting the Government property.

(g) Risk of loss. Unless otherwise provided in this contract, the Carrier assumes the risk of, and shall be responsible for, any loss or destruction of, or damage to, Government property upon its delivery to the Carrier. However, the Carrier is not responsible for reasonable wear and tear to Government property or for Government property properly consumed in performing this contract.

(h) Equitable adjustment. When this clause specifies an equitable adjustment, it shall be made to any affected contract provision in accordance with the procedures of the Changes clause. When appropriate, the Contracting Officer may initiate an equitable adjustment in favor of the Government. The right to an equitable adjustment shall be the Carrier's exclusive remedy. The Government shall not be liable to suit for breach of contract for --

(1) Any delay in delivery of Government-furnished property;

(2) Delivery of Government-furnished property in a condition not suitable for its intended use;

(3) A decrease in or substitution of Government-furnished property; or

(4) Failure to repair or replace Government property for which the Government is responsible.

(i) Final accounting and disposition of Government property. Upon completing this contract, or at such earlier dates as may be fixed by the Contracting Officer, the Carrier shall submit, in a form acceptable to the Contracting Officer, inventory schedules covering all items of Government property (including any resulting scrap) not consumed in performing this contract or delivered to the Government. The Carrier shall prepare for shipment, deliver f.o.b. origin, or dispose of the Government property as may be directed or authorized by the Contracting Officer. The net proceeds of any such disposal shall be credited to the contract price or shall be paid to the Government as the Contracting Officer directs.

(j) Abandonment and restoration of Carrier's premises. Unless otherwise provided herein, the Government -

(1) May abandon any Government property in place, at which time all obligations of the Government regarding such abandoned property shall cease; and

(2) Has no obligation to restore or rehabilitate the Carrier's premises under any circumstances (e.g., abandonment, disposition upon completion of need, or upon contract completion). However, if the Government-furnished property is withdrawn or is unsuitable for the intended use, or if other Government property is substituted, then the equitable adjustment under paragraph (h) of this clause may properly include restoration or rehabilitation costs.

(k) Communications. All communications under this clause shall be in writing.

(l) Overseas contracts. If this contract is to be performed outside of the United States of America, its territories, or possessions, the words "Government" and "Government- furnished" (wherever they appear in this clause) shall be construed as "United States Government" and "United States Government-furnished", respectively.

SECTION 5.41
LIMITATION OF LIABILITY -- SERVICES (FEB 1997) (FAR 52.246-25)

(a) Except as provided in paragraphs (b) and (c) below, and except to the extent that the Contractor is expressly responsible under this contract for deficiencies in the services required to be performed under it (including any materials furnished in conjunction with those services), the Contractor shall not be liable for loss of or damage to property of the Government that (1) occurs after Government acceptance of services performed under this contract and (2) results from any defects or deficiencies in the services performed or materials furnished.

(b) The limitation of liability under paragraph (a) above shall not apply when a defect or deficiency in, or the Government's acceptance of, services performed or materials furnished results from willful misconduct or lack of good faith on the part of any of the Contractor's managerial personnel. The term Contractor's managerial personnel, as used in this clause, means the Contractor's directors, officers, and any of the Contractor's managers, superintendents, or equivalent representatives who have supervision or direction of --

(1) All or substantially all of the Contractor's business;

(2) All or substantially all of the Contractor's operations at any one plant, laboratory, or separate location at which the contract is being performed; or

(3) A separate and complete major industrial operation connected with the performance of this contract.

(c) If the Contractor carries insurance, or has established a reserve for self-insurance, covering liability for loss or damage suffered by the Government through the Contractor's performance of services or furnishing of materials under this contract, the Contractor shall be liable to the Government, to the extent of such insurance or reserve, for loss of or damage to property of the Government occurring after Government acceptance of, and resulting from any defects and deficiencies in, services performed or materials furnished under this contract.

SECTION 5.42
PREFERENCE FOR U.S.-FLAG AIR CARRIERS (JUN 2003) (FAR 52.247-63)

(a) *Definitions*. As used in this clause-

"International air transportation" means transportation by air between a place in the United States and a place outside the United States or between two places both of which are outside the United States.

"United States" means the 50 States, the District of Columbia, and outlying areas.

"U.S.-flag air Carrier" means an air Carrier holding a certificate under 49 U.S.C. Chapter 411.

(b) Section 5 of the International Air Transportation Fair Competitive Practices Act of 1974 (49 U.S.C. 40118) (Fly America Act) requires that all Federal agencies and Government contractors and subcontractors use U.S.-flag air Carriers for U.S. Government-financed international air transportation of personnel (and their personal effects) or property, to the extent that service by those Carriers is available. It requires the Comptroller General of the United States, in the absence of satisfactory proof of the necessity for foreign-flag air transportation, to disallow expenditures from funds, appropriated or otherwise established for the account of the United States, for international air transportation secured aboard a foreign-flag air Carrier if a U.S.-flag air Carrier is available to provide such services.
(c) If available, the Contractor, in performing work under this contract, shall use U.S.-flag Carriers for international air transportation of personnel (and their personal effects) or property.
(d) In the event that the Contractor selects a Carrier other than a U.S.-flag air Carrier for international air transportation, the Contractor shall include a statement on vouchers involving such transportation essentially as follows:

STATEMENT OF UNAVAILABILITY OF U.S.-FLAG AIR CARRIERS
International air transportation of persons (and their personal effects) or property by U.S.-flag air Carrier was not available or it was necessary to use foreign-flag air Carrier service for the following reasons (see section 47.403 of the Federal Acquisition Regulation):
(State reasons):
(End of statement)
(e) The Contractor shall include the substance of this clause, including this paragraph (e), in each subcontract or purchase under this contract that may involve international air transportation.

SECTION 5.43
GOVERNMENT SUPPLY SOURCES (APR 2012) (FAR 52.251-1)

The Contracting Officer may issue the Contractor an authorization to use Government supply sources in the performance of this contract. Title to all property acquired by the Contractor under such an authorization shall vest in the Government unless otherwise specified in the contract. The provisions of the clause at FAR 52.245–1, Government Property, apply to all property acquired under such authorization.

SECTION 5.44
AUTHORIZED DEVIATIONS IN CLAUSES (APR 1984) (FAR 52.252-6)

(a) The use in this solicitation or contract of any Federal Acquisition Regulation (48 CFR Chapter 1) clause with an authorized deviation is indicated by the addition of "(DEVIATION)" after the date of the clause.

(b) The use in this solicitation or contract of any Federal Employees Health Benefits Acquisition Regulation (48 CFR Chapter 16) clause with an authorized deviation is indicated by the addition of "(DEVIATION)" after the name of the regulation.

SECTION 5.45
LIMITATION ON PAYMENTS TO INFLUENCE CERTAIN FEDERAL TRANSACTIONS (JUN 2020) (FAR 52.203-12)

(a) *Definitions*. As used in this clause—

"Agency" means "executive agency" as defined in Federal Acquisition Regulation (FAR) 2.101.

"Covered Federal action" means any of the following actions:

(1) Awarding any Federal contract.

(2) Making any Federal grant.

(3) Making any Federal loan.

(4) Entering into any cooperative agreement.

(5) Extending, continuing, renewing, amending, or modifying any Federal contract, grant, loan, or cooperative agreement.

"Indian tribe" and "tribal organization" have the meaning provided in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b) and include Alaskan Natives.

"Influencing or attempting to influence" means making, with the intent to influence, any communication to or appearance before an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any covered Federal action.

"Local government" means a unit of government in a State and, if chartered, established, or otherwise recognized by a State for the performance of a governmental duty, including a local public authority, a special district, an intrastate district, a council of governments, a sponsor group representative organization, and any other instrumentality of a local government.

"Officer or employee of an agency" includes the following individuals who are employed by an agency:

(1) An individual who is appointed to a position in the Government under Title 5, United States Code, including a position under a temporary appointment.

(2) A member of the uniformed services, as defined in subsection 101(3), Title 37, United States Code.

(3) A special Government employee, as defined in section 202, Title 18, United States Code.

(4) An individual who is a member of a Federal advisory committee, as defined by the Federal Advisory Committee Act, Title 5, United States Code, appendix 2.

"Person" means an individual, corporation, company, association, authority, firm, partnership, society, State, and local government, regardless of whether such entity is operated for profit, or not for profit. This term excludes an Indian tribe, tribal organization, or any other Indian organization eligible to receive Federal contracts, grants, cooperative agreements, or loans from

an agency, but only with respect to expenditures by such tribe or organization that are made for purposes specified in paragraph (b) of this clause and are permitted by other Federal law.

"Reasonable compensation" means, with respect to a regularly employed officer or employee of any person, compensation that is consistent with the normal compensation for such officer or employee for work that is not furnished to, not funded by, or not furnished in cooperation with the Federal Government.

"Reasonable payment" means, with respect to professional and other technical services, a payment in an amount that is consistent with the amount normally paid for such services in the private sector.

"Recipient" includes the Contractor and all subcontractors. This term excludes an Indian tribe, tribal organization, or any other Indian organization eligible to receive Federal contracts, grants, cooperative agreements, or loans from an agency, but only with respect to expenditures by such tribe or organization that are made for purposes specified in paragraph (b) of this clause and *are* permitted by other Federal law.

"Regularly employed" means, with respect to an officer or employee of a person requesting or receiving a Federal contract, an officer or employee who is employed by such person for at least 130 working days within 1 year immediately preceding the date of the submission that initiates agency consideration of such person for receipt of such contract. An officer or employee who is employed by such person for less than 130 working days within 1 year immediately preceding the date of the submission that initiates agency consideration of such person shall be considered to be regularly employed as soon as he or she is employed by such person for 130 working days.

"State" means a State of the United States, the District of Columbia, or an outlying area of the United States, an agency or instrumentality of a State, and multi-State, regional, or interstate entity having governmental duties and powers.

(b) *Prohibition*. 31 U.S.C. 1352 prohibits a recipient of a Federal contract, grant, loan, or cooperative agreement from using appropriated funds to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any covered Federal actions. In accordance with 31 U.S.C. 1352 the Contractor shall not use appropriated funds to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of this contractor the extension, continuation, renewal, amendment, or modification of this contract.

(1) The term *appropriated funds* does not include profit or fee from a covered Federal action.

(2) To the extent the Contractor can demonstrate that the Contractor has sufficient monies, other than Federal appropriated funds, the Government will assume that these other monies were spent for any influencing activities that would be unallowable if paid for with Federal appropriated funds.

(c) *Exceptions*. The prohibition in paragraph (b) of this clause does not apply under the following conditions:

(1) *Agency and legislative liaison by Contractor employees*.

(i) Payment of reasonable compensation made to an officer or employee of the Contractor if the payment is for agency and legislative liaison activities not directly related to this contract. For purposes of this paragraph, providing any information specifically requested by an agency or Congress is permitted at any time.

(ii) Participating with an agency in discussions that are not related to a specific solicitation for any covered Federal action, but that concern—

(A) The qualities and characteristics (including individual demonstrations) of the person's products or services, conditions or terms of sale, and service capabilities; or

(B) The application or adaptation of the person's products or services for an agency's use.

(iii) Providing prior to formal solicitation of any covered Federal action any information not specifically requested but necessary for an agency to make an informed decision about initiation of a covered Federal action;

(iv) Participating in technical discussions regarding the preparation of an unsolicited proposal prior to its official submission; and

(v) Making capability presentations prior to formal solicitation of any covered Federal action by persons seeking awards from an agency pursuant to the provisions of the Small Business Act, as amended by Pub. L. 95-507, and subsequent amendments.

(2) *Professional and technical services*.

(i) A payment of reasonable compensation made to an officer or employee of a person requesting or receiving a covered Federal action or an extension, continuation, renewal, amendment, or modification of a covered Federal action, if payment is for professional or technical services rendered directly in the preparation, submission, or negotiation of any bid, proposal, or application for that Federal action or for meeting requirements imposed by or pursuant to law as a condition for receiving that Federal action.

(ii) Any reasonable payment to a person, other than an officer or employee of a person requesting or receiving a covered Federal action or an extension, continuation, renewal, amendment, or modification of a covered Federal action if the payment is for professional or technical services rendered directly in the preparation, submission, or negotiation of any bid, proposal, or application for that Federal action or for meeting requirements imposed by or pursuant to law as a condition for receiving that Federal action. Persons other than officers or employees of a person requesting or receiving a covered Federal action include consultants and trade associations.

(iii) As used in paragraph (c)(2) of this clause, "professional and technical services" are limited to advice and analysis directly applying any professional or technical discipline (for examples, see FAR 3.803(a)(2)(iii)).

(iv) Requirements imposed by or pursuant to law as a condition for receiving a covered Federal award include those required by law or regulation and any other requirements in the actual award documents.

(3) Only those communications and services expressly authorized by paragraphs (c)(1) and (2) of this clause are permitted.

(d) *Disclosure*.

(1) If the Contractor did not submit OMB Standard Form LLL, Disclosure of Lobbying Activities, with its offer, but registrants under the Lobbying Disclosure Act of 1995 have subsequently made a lobbying contact on behalf of the Contractor with respect to this contract, the Contractor shall complete and submit OMB Standard Form LLL to provide the name of the lobbying registrants, including the individuals performing the services.

(2) If the Contractor did submit OMB Standard Form LLL disclosure pursuant to paragraph (d) of the provision at FAR 52.203-11, Certification and Disclosure Regarding Payments to Influence Certain Federal Transactions, and a change occurs that affects Block 10 of the OMB

Standard Form LLL (name and address of lobbying registrant or individuals performing services), the Contractor shall, at the end of the calendar quarter in which the change occurs, submit to the Contracting Officer within 30 days an updated disclosure using OMB Standard Form LLL.

(e) *Penalties*.

(1) Any person who makes an expenditure prohibited under paragraph (b) of this clause or who fails to file or amend the disclosure to be filed or amended by paragraph (d) of this clause shall be subject to civil penalties as provided for by 31 U.S.C. 1352. An imposition of a civil penalty does not prevent the Government from seeking any other remedy that may be applicable.

(2) Contractors may rely without liability on the representation made by their subcontractors in the certification and disclosure form.

(f) *Cost allowability*. Nothing in this clause makes allowable or reasonable any costs which would otherwise be unallowable or unreasonable. Conversely, costs made specifically unallowable by the requirements in this clause will not be made allowable under any other provision.

(g) *Subcontracts*.

(1) The Contractor shall obtain a declaration, including the certification and disclosure in paragraphs (c) and (d) of the provision at FAR 52.203–11, Certification and Disclosure Regarding Payments to Influence Certain Federal Transactions, from each person requesting or receiving a subcontract under this contract that exceeds the threshold specified in FAR 3.808 on the date of subcontract award.The Contractor or subcontractor that awards the subcontract shall retain the declaration.

(2) A copy of each subcontractor disclosure form (but not certifications) shall be forwarded from tier to tier until received by the prime Contractor. The prime Contractor shall, at the end of the calendar quarter in which the disclosure form is submitted by the subcontractor, submit to the Contracting Officer within 30 days a copy of all disclosures. Each subcontractor certification shall be retained in the subcontract file of the awarding Contractor.

(3) The Contractor shall include the substance of this clause, including this paragraph (g), in any subcontract that exceeds the threshold specified in FAR 3.808 on the date of subcontract award.

SECTION 5.46
[RESERVED]

SECTION 5.47
PROTECTING THE GOVERNMENT'S INTEREST WHEN SUBCONTRACTING WITH CONTRACTORS DEBARRED, SUSPENDED OR PROPOSED FOR DEBARMENT (JUN 2020) (FAR 52.209-6)

(a) Definition. “Commercially available off-the-shelf (COTS)” item, as used in this clause—

(1) Means any item of supply (including construction material) that is—

(i) A commercial item (as defined in paragraph (1) of the definition in Federal Acquisition Regulation (FAR) 2.101);

(ii) Sold in substantial quantities in the commercial marketplace; and

(iii) Offered to the Government, under a contract or subcontract at any tier, without modification, in the same form in which it is sold in the commercial marketplace; and

(2) Does not include bulk cargo, as defined in 46 U.S.C. 40102(4), such as agricultural products and petroleum products.

(b) The Government suspends or debars Contractors to protect the Government's interests. Other than a subcontract for a commercially available off-the-shelf item, the Contractor shall not enter into any subcontract, in excess of the threshold specified in FAR 9.405-2(b) on date of subcontract award with a Contractor that is debarred, suspended, or proposed for debarment by any executive agency unless there is a compelling reason to do so.

(c) The Contractor shall require each proposed subcontractor whose subcontract will exceed the threshold specified in FAR 9.405-2(b) on the date of the subcontract award, other than a subcontractor providing a commercially available off-the-shelf item, to disclose to the Contractor, in writing, whether as of the time of award of the subcontract, the subcontractor, or its principals, is or is not debarred, suspended, or proposed for debarment by the Federal Government.

(d) A corporate officer or a designee of the Contractor shall notify the Contracting Officer, in writing, before entering into a subcontract with a party (other than a subcontractor providing a commercially available off-the-shelf item) that is debarred, suspended, or proposed for debarment (see FAR 9.404 for information on the System for Award Management (SAM) Exclusions). The notice must include the following:

(1) The name of the subcontractor.

(2) The Contractor's knowledge of the reasons for the subcontractor being listed with an exclusion in SAM.

(3) The compelling reason(s) for doing business with the subcontractor notwithstanding its being listed with an exclusion in SAM.

(4) The systems and procedures the Contractor has established to ensure that it is fully protecting the Government's interests when dealing with such subcontractor in view of the specific basis for the party's debarment, suspension, or proposed debarment.

(e) Subcontracts. Unless this is a contract for the acquisition of commercial items, the Contractor shall include the requirements of this clause, including this paragraph (e) (appropriately modified for the identification of the parties), in each subcontract that—

(1) Exceeds the threshold specified in FAR 9.405-2(b) on the date of subcontract award; and

(2) Is not a subcontract for commercially available off-the-shelf items.

SECTION 5.48
BANKRUPTCY (JUL 1995) (FAR 52.242-13)

In the event the Contractor enters into proceedings relating to bankruptcy, whether voluntary or involuntary, the Contractor agrees to furnish, by certified mail or electronic commerce method authorized by the contract, written notification of the bankruptcy to the Contracting Office responsible for administering the contract. This notification shall be furnished within five days of the initiation of the proceedings relating to bankruptcy filing. This notification shall include the date on which the bankruptcy petition was filed, the identity of the court in which the bankruptcy petition was filed, and a listing of Government contract numbers and contracting

offices for all Government contracts against which final payment has not been made. This obligation remains in effect until final payment under this contract.

SECTION 5.49
FEHBP TERMINATION FOR CONVENIENCE OF THE GOVERNMENT--NEGOTIATED BENEFITS CONTRACTS (JAN 1998) (FEHBAR 1652.249-71)

(a) The Government may terminate performance of work under this contract in whole or, from time to time, in part if the Contracting Officer determines that a termination is in the Government's interest. The Contracting Officer shall terminate by delivering to the Carrier a Notice of Termination specifying the extent of terminating and the effective date.

(b) After receipt of a Notice of Termination, and except as directed by the Contracting Officer, the Carrier shall immediately proceed with the following obligations, regardless of any delay in determining or adjusting any amounts due under this clause:

(1) Stop work as specified in the notice.

(2) Place no further subcontracts except as necessary to complete the continued portion of the contract.

(3) Terminate all subcontracts to the extent they relate to the work terminated.

(4) Assign to the Government, as directed by the Contracting Officer, all right, title, and interest of the Carrier under the subcontracts terminated, in which case the Government shall have the right to settle or to pay any termination settlement proposal arising out of those terminations.

(5) With approval or ratification to the extent required by the Contracting Officer, settle all outstanding liabilities and termination settlement proposals arising from the termination of subcontracts; the approval or ratification will be final for purposes of this clause.

(6) As directed by the Contracting Officer, deliver to the Government any data, reports, or studies that, if the contract had been completed, would be required to be furnished to the Government.

(7) Complete performance of the work not terminated.

(c) After termination, the Carrier shall submit a final termination settlement proposal to the Contracting Officer in the form and with the certification prescribed by the Contracting Officer. The Carrier shall submit the proposal promptly, but no later than 1 year from the effective date of termination, unless extended in writing by the Contracting Officer upon written request of the Carrier within this 1-year period. However, if the Contracting Officer determines that the facts justify it, a termination settlement proposal may be received and acted on after 1 year or any extension. If the Carrier fails to submit the proposal within the time allowed, the Contracting Officer may determine, on the basis of information available, the amount, if any, due the Carrier because of the termination and shall pay the amount determined.

(d) Subject to paragraph (c) of this clause, the Carrier and the Contracting Officer may agree upon the whole or any part of the amount to be paid or remaining to be paid because of the termination. The amount may include a reasonable allowance for profit on work done. However, the agreed amount, whether under this paragraph (d) or paragraph (e) of this clause, exclusive of costs shown in subparagraph (e)(3) of this clause, may not exceed the total contract price as reduced by (1) the amount of payments previously made and (2) the contract price of work not terminated. The contract shall be modified, and the Carrier paid the agreed amount.

Paragraph (e) of this clause shall not limit, restrict, or affect the amount that may be agreed upon to be paid under this paragraph.

(e) If the Carrier and the Contracting Officer fail to agree on the whole amount to be paid because of the termination of work, the Contracting Officer shall pay the Carrier the amounts determined by the Contracting Officer as follows, but without duplication of any amounts agreed on under paragraph (d) above:

(1) The contract price for completed services accepted by the Government not previously paid for.

(2) The total of--

(i) The costs incurred in the performance of the work terminated, including initial costs and preparatory expense allocable thereto, but excluding any costs attributable to services paid or to be paid under paragraph (e)(1) of this clause;

(ii) The cost of settling and paying termination settlement proposals under terminated subcontracts that are properly chargeable to the terminated portion of the contract if not included in subdivision (e)(2)(i) of this clause; and

(iii) A sum, as profit on subdivision (e)(2)(i) of this clause, determined by the Contracting Officer under 49.202 of the Federal Acquisition Regulation, in effect on the date of this contract, to be fair and reasonable.

(3) The reasonable costs of settlement of the work terminated, including--

(i) Accounting, legal, clerical, and other expenses reasonably necessary for the preparation of termination settlement proposals and supporting data;

(ii) The termination and settlement of subcontracts (excluding the amounts of such settlements); and

(f) The cost principles and procedures of part 31 of the Federal Acquisition Regulation, in effect on the date of this contract, shall govern all costs claimed, agreed to, or determined under this clause.

(g) The Carrier shall have the right of appeal, under the Disputes clause, from any determination made by the Contracting Officer under paragraph (c), (e), or (i) of this clause, except that if the Carrier failed to submit the termination settlement proposal or request for equitable adjustment within the time provided in paragraph (c) or (i), respectively, and failed to request a time extension, there is no right of appeal.

(h) In arriving at the amount due the Carrier under this clause, there shall be deducted--

(1) All unliquidated advance or other payments to the Carrier under the terminated portion of this contract;

(2) Any claim which the Government has against the Carrier under this contract; and

(i) If the termination is partial, the Carrier may file a proposal with the Contracting Officer for an equitable adjustment of the price(s) of the continued portion of the contract. The Contracting Officer shall make any equitable adjustment agreed upon. Any proposal by the Carrier for an equitable adjustment under this clause shall be requested within 90 days from the effective date of termination unless extended in writing by the Contracting Officer.

(j)(1) The Government may, under the terms and conditions it prescribes, make partial payments and payments against costs incurred by the Carrier for the terminated portion of the contract, if the Contracting Officer believes the total of these payments will not exceed the amount to which the Carrier will be entitled.

(2) If the total payments exceed the amount finally determined to be due, the Carrier shall repay the excess to the Government upon demand, together with interest computed at the rate

established by the Secretary of the Treasury under 50 U.S.C. App. 1215(b)(2). Interest shall be computed for the period from the date the excess payment is received by the Carrier to the date the excess is repaid.

(k) Unless otherwise provided in this contract or by statute, the Carrier shall maintain all records and documents relating to the terminated portion of this contract for 3 years after final settlement. This includes all books and other evidence bearing on the Carrier's costs and expenses under this contract. The Carrier shall make these records and documents available to the Government, at the Carrier's office, at all reasonable times, without any direct charge. If approved by the Contracting Officer, photographs, microphotographs, or other authentic reproductions may be maintained instead of original records and documents.

SECTION 5.50
FEHBP TERMINATION FOR DEFAULT-- NEGOTIATED BENEFITS CONTRACTS (JAN 1998) (FEHBAR 1652.249-72)

(a) (1) The Government may, subject to paragraphs (c) and (d) below, by written notice of default to the Carrier, terminate this contract in whole or in part if the Carrier fails to--

(i) Perform the services within the time specified in this contract or any extension;

(ii) Make progress, so as to endanger performance of this contract (but see subparagraph (a)(2) below); or

(iii) Perform any of the other provisions of this contract (but see subparagraph (a)(2) below).

(2) The Government's right to terminate this contract under subdivisions (1)(ii) and (1)(iii) above, may be exercised if the Carrier does not cure such failure within 10 days (or more if authorized in writing by the Contracting Officer) after receipt of the notice from the Contracting Officer specifying the failure.

(b) If the Government terminates this contract in whole or in part, it may acquire, under the terms and in the manner the Contracting Officer considers appropriate, supplies or service similar to those terminated, and the Carrier will be liable to the Government for any excess costs for those supplies or services. However, the Carrier shall continue the work not terminated.

(c) Except for defaults of subcontractors at any tier, the Carrier shall not be liable for any excess costs if the failure to perform the contract arises from causes beyond the control and without the fault or negligence of the Carrier. Examples of such causes include (1) acts of God or of the public enemy, (2) acts of the Government in either its sovereign or contractual capacity, (3) fires, (4) floods, (5) epidemics, (6) quarantine restrictions, (7) strikes, (8) freight embargoes, and (9) unusually severe weather. In each instance the failure to perform must be beyond the control and without the fault or negligence of the Carrier.

(d) If the failure to perform is caused by the default of a subcontractor at any tier, and if the cause of the default is beyond the control of both the Carrier and subcontractor, and without the fault or negligence of either, the Carrier shall not be liable for any excess costs for failure to perform, unless the subcontracted supplies or services were obtainable from other sources in sufficient time for the Carrier to meet the required delivery schedule.

(e) If this contract is terminated for default, the Government may require the Carrier to transfer title and deliver to the Government, as directed by the Contracting Officer, any completed or partially completed information and contract rights that the Carrier has specifically produced or acquired for the terminated portion of this contract.

(f) If, after termination, it is determined that the Carrier was not in default, or that the default was excusable, the rights and obligations of the parties shall be the same as if the termination had been issued for the convenience of the Government.

(g) The rights and remedies of the Government in this clause are in addition to any other rights and remedies provided by law or under this contract.

SECTION 5.51
PENSION ADJUSTMENTS AND ASSET REVERSIONS (OCT 2010) (FAR 52.215-15)

(a) The Contractor shall promptly notify the Contracting Officer in writing when it determines that it will terminate a defined benefit pension plan or otherwise recapture such pension fund assets.

(b) For segment closings, pension plan terminations, or curtailment of benefits, the amount of the adjustment shall be-

(1) For contracts and subcontracts that are subject to full coverage under Cost Accounting Standards (CAS) Board rules and regulations (48 CFR Chapter 99), the amount measured, assigned, and allocated in accordance with 48 CFR 9904.413-50(c)(12); and

(2) For contracts and subcontracts that are not subject to full coverage under CAS, the amount measured, assigned, and allocated in accordance with 48 CFR 9904.413-50(c)(12), except the numerator of the fraction at 48 CFR 9904.413-50(c)(12)(vi)shall be the sum of the pension plan costs allocated to all non-CAS-covered contracts and subcontracts that are subject to Federal Acquisition Regulation (FAR) Subpart 31.2 or for which certified cost or pricing data were submitted.

(c) For all other situations where assets revert to the Contractor, or such assets are constructively received by it for any reason, the Contractor shall, at the Government's option, make a refund or give a credit to the Government for its equitable share of the gross amount withdrawn. The Government's equitable share shall reflect the Government's participation in pension costs through those contracts for which certified cost or pricing data were submitted or that are subject to FAR Subpart 31.2.

(d) The Contractor shall include the substance of this clause in all subcontracts under this contract that meet the applicability requirement of FAR 15.408(g).

SECTION 5.52
REVERSION OR ADJUSTMENT OF PLANS FOR POSTRETIREMENT BENEFITS (PRB) OTHER THAN PENSIONS (JUL 2005) (FAR 52.215-18)

(a) The Contractor shall promptly notify the Contracting Officer in writing when it determines that it will terminate or reduce a PRB plan.

(b) If PRB fund assets revert, or inure to the Contractor, or are constructively received by it under a plan termination or otherwise, the Contractor shall make a refund or give a credit to the Government for its equitable share as required by 31.205-6(o)(6) of the Federal Acquisition Regulation (FAR). When determining or agreeing on the method for recovery of the Government's equitable share, the contracting parties should consider the following methods: cost reduction, amortizing the credit over a number of years (with appropriate interest), cash refund, or some other agreed upon method. Should the parties be unable to agree on the method

for recovery of the Government's equitable share, through good faith negotiations, the Contracting Officer shall designate the method of recovery.

(c)The Contractor shall insert the substance of this clause in all subcontracts that meet the applicability requirements of FAR 15.408(j).

SECTION 5.53
NOTICE TO THE GOVERNMENT OF LABOR DISPUTES (FEB 1997) (FAR 52.222-1)

If the Contractor has knowledge that any actual or potential labor dispute is delaying or threatens to delay the timely performance of this contract, the Contractor shall immediately give notice, including all relevant information, to the Contracting Officer.

SECTION 5.54
PENALTIES FOR UNALLOWABLE COSTS (SEP 2021) (FAR 52.242-3)

(a) Definition. Proposal, as used in this clause, means either --

(1) A final indirect cost rate proposal submitted by the Contractor after the expiration of its fiscal year which--

(i) Relates to any payment made on the basis of billing rates; or

(ii) Will be used in negotiating the final contract price; or

(2) The final statement of costs incurred and estimated to be incurred under the Incentive Price Revision clause (if applicable), which is used to establish the final contract price.

(b) Contractors which include unallowable indirect costs in a proposal may be subject to penalties. The penalties are prescribed in 10 U.S.C. 2324 or 41 U.S.C. chapter 43, as applicable, which is implemented in Section 42.709 of the Federal Acquisition Regulation (FAR).

(c) The Contractor shall not include in any proposal any cost that is unallowable, as defined in subpart 2.1 of the FAR, or an executive agency supplement to the FAR.

(d) If the Contracting Officer determines that a cost submitted by the Contractor in its proposal is expressly unallowable under a cost principle in the FAR, or an executive agency supplement to the FAR, that defines the allowability of specific selected costs, the Contractor shall be assessed a penalty equal to--

(1) The amount of the disallowed cost allocated to this contract; plus

(2) Simple interest, to be computed--

(i) On the amount the Contractor was paid (whether as a progress or billing payment) in excess of the amount to which the Contractor was entitled; and

(ii) Using the applicable rate effective for each six-month interval prescribed by the Secretary of the Treasury pursuant to Pub. L. 92-41 (85 Stat. 97).

(e) If the Contracting Officer determines that a cost submitted by the Contractor in its proposal includes a cost previously determined to be unallowable for that Contractor, then the Contractor will be assessed a penalty in an amount equal to two times the amount of the disallowed cost allocated to this contract.

(f) Determinations under paragraphs (d) and (e) of this clause are final decisions within the meaning of 41 U.S.C. chapter 71, Contract Disputes.

(g) Pursuant to the criteria in FAR 42.709-6, the Contracting Officer may waive the penalties in paragraph (d) or (e) of this clause.

(h) Payment by the Contractor of any penalty assessed under this clause does not constitute repayment to the Government of any unallowable cost which has been paid by the Government to the Contractor.

SECTION 5.55
EMPLOYMENT REPORTS ON VETERANS (JUN 2020) (FAR 52.222-37)

(a) Definitions. As used in this clause, "active duty wartime or campaign badge veteran," "Armed Forces service medal veteran," "disabled veteran" "protected veteran," and "recently separated veteran," have the meanings given in FAR 22.1301.

(b) Unless the Contractor is a State or local government agency, the Contractor shall report at least annually, as required by the Secretary of Labor, on—

(1) The total number of employees in the contractor's workforce, by job category and hiring location, who are protected veterans (i.e., active duty wartime or campaign badge veterans, Armed Forces service medal veterans, disabled veterans and recently separated veterans);

(2) The total number of new employees hired during the period covered by the report, and of the total, the number of protected veterans (i.e., active duty wartime or campaign badge veterans, Armed Forces service medal veterans, disabled veterans, and recently separated veterans); and

(3) The maximum number and minimum number of employees of the Contractor or subcontractor at each hiring location during the period covered by the report.

(c) The Contractor shall report the above items by filing the Form VETS-4212, entitled "Federal Contractor Veterans' Employment Report" (see VETS-4212 Federal Contractor Reporting" and Filing Your VETS-4212 Report" at
http://www.dol.gov/vets/vets4212.htm)"

(d) The Contractor shall submit VETS-4212Reports no later than September 30 of each year.

(e) The employment activity report required by paragraphs (b)(2) and (b)(3) of this clause shall reflect total new hires, and maximum and minimum number of employees, during the most recent 12-month period preceding the ending date selected for the report. Contractors may select an ending date—

(1) As of the end of any pay period between July 1 and August 31 of the year the report is due; or

(2) As of December 31, if the Contractor has prior written approval from the Equal Employment Opportunity Commission to do so for purposes of submitting the Employer Information Report EEO-1 (Standard Form 100).

(f) The number of veterans reported must be based on data known to the contractor when completing the VETS–4212The contractor's knowledge of veterans status may be obtained in a variety of ways, including an invitation to applicants to self-identify (in accordance with 41 CFR 60–300.42), voluntary self-disclosure by employees, or actual knowledge of veteran status by the contractor. This paragraph does not relieve an employer of liability for discrimination under 38 U.S.C. 4212.

(g) The Contractor shall insert the terms of this clause in subcontracts valued at or above the threshold specified in FAR 22.1303(a) on the date of subcontract award, unless exempted by rules, regulations, or orders of the Secretary of Labor.

SECTION 5.56
AUTHORIZATION AND CONSENT (DEC 2007) (FAR 52.227-1)

(a) The Government authorizes and consents to all use and manufacture, in performing this contract or any subcontract at any tier, of any invention described in and covered by a United States patent—

(1) Embodied in the structure or composition of any article the delivery of which is accepted by the Government under this contract; or

(2) Used in machinery, tools, or methods whose use necessarily results from compliance by the Contractor or a subcontractor with (i) specifications or written provisions forming a part of this contract or (ii) specific written instructions given by the Contracting Officer directing the manner of performance. the entire liability to the Government for infringement of a United States patent shall be determined solely by the provisions of the indemnity clause, if any, included in this contract or any subcontract hereunder (including any lower-tier subcontract), and the Government assumes liability for all other infringement to the extent of the authorization and consent hereinabove granted.

(b) The Contractor shall include the substance of this clause, including this paragraph (b), in all subcontracts that are expected to exceed the simplified acquisition threshold, as defined in Federal Acquisition Regulation (FAR) 2.101 on the date of subcontract award. However, omission of this clause from any subcontract, including those at or below the simplified acquisition threshold, as defined in Federal Acquisition Regulation (FAR) 2.101 on the date of subcontract award, does not affect this authorization and consent.

SECTION 5.57
NOTICE AND ASSISTANCE REGARDING PATENT AND COPYRIGHT INFRINGEMENT (JUN 2020) (FAR 52.227-2)

a) The Contractor shall report to the Contracting Officer, promptly and in reasonable written detail, each notice or claim of patent or copyright infringement based on the performance of this contract of which the Contractor has knowledge.

(b) In the event of any claim or suit against the Government on account of any alleged patent or copyright infringement arising out of the performance of this contract or out of the use of any supplies furnished or work or services performed under this contract, the Contractor shall furnish to the Government, when requested by the Contracting Officer, all evidence and information in the Contractor's possession pertaining to such claim or suit. Such evidence and information shall be furnished at the expense of the Government except where the Contractor has agreed to indemnify the Government.

(c) The Contractor shall include the substance of this clause, including this paragraph (c), in all subcontracts that are expected to exceed the simplified acquisition threshold, as defined in Federal Acquisition Regulation (FAR) 2.101 on the date of subcontract award.

SECTION 5.58
PAYMENT BY ELECTRONIC FUNDS TRANSFER–SYSTEM FOR AWARD MANAGEMENT (OCT 2018) (FAR 52.232-33)

(a) Method of payment.

(1) All payments by the Government under this contract shall be made by electronic funds transfer (EFT), except as provided in paragraph (a)(2) of this clause. As used in this clause, the term "EFT" refers to the funds transfer and may also include the payment information transfer.

(2) In the event the Government is unable to release one or more payments by EFT, the Contractor agrees to either—

(i) Accept payment by check or some other mutually agreeable method of payment; or

(ii) Request the Government to extend the payment due date until such time as the Government can make payment by EFT (but see paragraph (d) of this clause).

(b) *Contractor's EFT information*. The Government shall make payment to the Contractor using the EFT information contained in the System for Award Management (SAM). In the event that the EFT information changes, the Contractor shall be responsible for providing the updated information to SAM.

(c) *Mechanisms for EFT payment*. The Government may make payment by EFT through either the Automated Clearing House (ACH) network, subject to the rules of the National Automated Clearing House Association, or the Fedwire Transfer System. The rules governing Federal payments through the ACH are contained in 31 CFR Part 210.

(d) *Suspension of payment*. If the Contractor's EFT information in SAM is incorrect, then the Government need not make payment to the Contractor under this contract until correct EFT information is entered into SAM; and any invoice or contract financing request shall be deemed not to be a proper invoice for the purpose of prompt payment under this contract. The prompt payment terms of the contract regarding notice of an improper invoice and delays in accrual of interest penalties apply.

(e) Liability for uncompleted or erroneous transfers.

(1) If an uncompleted or erroneous transfer occurs because the Government used the Contractor's EFT information incorrectly, the Government remains responsible for—

(i) Making a correct payment;

(ii) Paying any prompt payment penalty due; and

(iii) Recovering any erroneously directed funds.

(2) If an uncompleted or erroneous transfer occurs because the Contractor's EFT information was incorrect, or was revised within 30 days of Government release of the EFT payment transaction instruction to the Federal Reserve System, and—

(i) If the funds are no longer under the control of the payment office, the Government is deemed to have made payment and the Contractor is responsible for recovery of any erroneously directed funds; or

(ii) If the funds remain under the control of the payment office, the Government shall not make payment, and the provisions of paragraph (d) of this clause shall apply.

(f) *EFT and prompt payment*. A payment shall be deemed to have been made in a timely manner in accordance with the prompt payment terms of this contract if, in the EFT payment transaction instruction released to the Federal Reserve System, the date specified for settlement of the payment is on or before the prompt payment due date, provided the specified payment date is a valid date under the rules of the Federal Reserve System.

(g) *EFT and assignment of claims*. If the Contractor assigns the proceeds of this contract as provided for in the assignment of claims terms of this contract, the Contractor shall require as a condition of any such assignment, that the assignee shall register separately in the SAM and

shall be paid by EFT in accordance with the terms of this clause. Notwithstanding any other requirement of this contract, payment to an ultimate recipient other than the Contractor, or a financial institution properly recognized under an assignment of claims pursuant to Subpart 32.8, is not permitted. In all respects, the requirements of this clause shall apply to the assignee as if it were the Contractor. EFT information that shows the ultimate recipient of the transfer to be other than the Contractor, in the absence of a proper assignment of claims acceptable to the Government, is incorrect EFT information within the meaning of paragraph (d) of this clause.

(h) *Liability for change of EFT information by financial agent*. The Government is not liable for errors resulting from changes to EFT information made by the Contractor's financial agent.

(i) *Payment information*. The payment or disbursing office shall forward to the Contractor available payment information that is suitable for transmission as of the date of release of the EFT instruction to the Federal Reserve System. The Government may request the Contractor to designate a desired format and method(s) for delivery of payment information from a list of formats and methods the payment office is capable of executing. However, the Government does not guarantee that any particular format or method of delivery is available at any particular payment office and retains the latitude to use the format and delivery method most convenient to the Government. If the Government makes payment by check in accordance with paragraph (a) of this clause, the Government shall mail the payment information to the remittance address contained in SAM.

SECTION 5.59
PROHIBITION OF SEGREGATED FACILITIES (APR 2015) (FAR 52.222-21)

(a) Definitions. As used in this clause

"Gender identity" has the meaning given by the Department of Labor's Office of Federal Contract Compliance Programs, and is found at www.dol.gov/ofccp/LGBT/LGBT_FAQs.html.

"Segregated facilities," , means any waiting rooms, work areas, rest rooms and wash rooms, restaurants and other eating areas, time clocks, locker rooms and other storage or dressing areas, parking lots, drinking fountains, recreation or entertainment areas, transportation, and housing facilities provided for employees, that are segregated by explicit directive or are in fact segregated on the basis of race, color, religion, sex, sexual orientation, gender identity, or national origin because of written or oral policies or employee custom. The term does not include separate or single-user rest rooms or necessary dressing or sleeping areas provided to assure privacy between the sexes.

"Sexual orientation" has the meaning given by the Department of Labor's Office of Federal Contract Compliance Programs, and is found at www.dol.gov/ofccp/LGBT/LGBT_FAQs.html.

(b) The Contractor agrees that it does not and will not maintain or provide for its employees any segregated facilities at any of its establishments, and that it does not and will not permit its employees to perform their services at any location under its control where segregated facilities are maintained. The Contractor agrees that a breach of this clause is a violation of the Equal Opportunity clause in this contract.

(c) The Contractor shall include this clause in every subcontract and purchase order that is subject to the Equal Opportunity clause of this contract.

SECTION 5.60
SUBCONTRACTS FOR COMMERCIAL ITEMS (JUL 2021) (FAR 52.244-6)

(a) Definitions. As used in this clause —

"Commercial item" and "commercially available off-the-shelf item" have the meanings contained in Federal Acquisition Regulation 2.101.

"Subcontract" includes a transfer of commercial items between divisions, subsidiaries, or affiliates of the Contractor or subcontractor at any tier.

(b) To the maximum extent practicable, the Contractor shall incorporate, and require its subcontractors at all tiers to incorporate, commercial items or non-developmental items as components of items to be supplied under this contract.

(c)(1) The Contractor shall insert the following clauses in subcontracts for commercial items:

(i) 52.203-13, Contractor Code of Business Ethics and Conduct (Jun 2020) (41 U.S.C. 3509), if the subcontract exceeds the threshold specified in FAR 3.1004(a) on the date of subcontract award, and has a performance period of more than 120 days. In altering this clause to identify the appropriate parties, all disclosures of violation of the civil False Claims Act or of Federal criminal law shall be directed to the agency Office of the Inspector General, with a copy to the Contracting Officer.

(ii) 52.203-15, Whistleblower Protections Under the American Recovery and Reinvestment Act of 2009 (Jun 2010) (Section 1553 of Pub. L. 111-5), if the subcontract is funded under the Recovery Act.

(iii) 52.203-19, Prohibition on Requiring Certain Internal Confidentiality Agreements or Statements (JAN 2017).

(iv) 52.204–21, Basic Safeguarding of Covered Contractor Information Systems (June, 2016), other than subcontracts for commercially available off-the-shelf items, if flow down is required in accordance with paragraph (c) of FAR clause 52.204–21.

(v) 52.204-23, Prohibition on Contracting for Hardware, Software, and Services Developed or Provided by Kaspersky Lab and Other Covered Entities (Jul 2018) (Section 1634 of Pub. L. 115-91).

(vi) 52.204-25, Prohibition on Contracting for Certain Telecommunications and Video Surveillance Services or Equipment. (Aug 2020) (Section 889(a)(1)(A) of Pub. L. 115-232).

(vii) 52.219-8, Utilization of Small Business Concerns (OCT 2018) (15 U.S.C. 637(d)(2) and (3)), if the subcontract offers further subcontracting opportunities. If the subcontract (except subcontracts to small business concerns) exceeds, the applicable threshold specified in FAR 19.702(a) on the date of subcontract award, the subcontractor must include 52.219-8 in lower tier subcontracts that offer subcontracting opportunities.

(viii) 52.222-21 Prohibition of Segregated Facilities (Apr 2015)

(ix) 52.222-26, Equal Opportunity (Sep 2015) (E.O. 11246).

(x) 52.222-35, Equal Opportunity for Veterans (Jun 2020) (38 U.S.C. 4212(a).

(xi) 52.222-36, Equal Opportunity for Workers with Disabilities (Jun 2020) (29 U.S.C. 793).

(xii) 52.222-37, Employment Reports on Veterans (Jun 2020) (38 U.S.C. 4212).

(xiii) 52.222-40, Notification of Employee Rights Under the National Labor Relations Act (Dec 2010) (E.O. 13496), if flow down is required in accordance with paragraph (f) of FAR clause 52.222-40.

(xiv)(A) 52.222-50, Combating Trafficking in Persons (OCT 2020) (22 U.S.C. chapter 78 and E.O. 13627).

(B) Alternate I (MAR 2015) of 52.222-50 (22 U.S.C. chapter 78 and E.O. 13627).

(xv) 52.222-55 , Minimum Wages under Executive Order 13658 (Nov 2020), if flow down is required in accordance with paragraph (k) of FAR clause 52.222-55.

(xvi) 52.222-62, Paid Sick Leave Under Executive Order 13706 (Jan 2017) (E.O. 13706), if flowdown is required in accordance with paragraph (m) of FAR clause 52.222-62.

(xvii) (A) 52.224-3, Privacy Training (Jan 2017) (5 U.S.C. 552a) if flow down is required in accordance with 52.224-3(f).

(B) Alternate I (Jan 2017) of 52.224-3, if flow down is required in accordance with 52.224-3(f) and the agency specifies that only its agency-provided training is acceptable).

(xviii) 52.225-26, Contractors Performing Private Security Functions Outside the United States (Oct 2016) (Section 862, as amended, of the National Defense Authorization Act for Fiscal Year 2008; 10 U.S.C. 2302 Note).

(xvix) 52.232-40, Providing Accelerated Payments to Small Business Subcontractors (Dec 2013), if flow down is required in accordance with paragraph (c) of FAR clause 52.232-40.

(xx) 52.247-64, Preference for Privately Owned U.S.-Flag Commercial Vessels (Feb 2006) 46 U.S.C. 55305 and 10 U.S.C. 2631), if flow down is required in accordance with paragraph (d) of FAR clause 52.247-64).

(2) While not required, the Contractor may flow down to subcontracts for commercial items a minimal number of additional clauses necessary to satisfy its contractual obligations.

(d) The Contractor shall include the terms of this clause, including this paragraph (d), in subcontracts awarded under this contract.

SECTION 5.61
NOTIFICATION OF EMPLOYEE RIGHTS UNDER NATIONAL LABOR RELATIONS ACT (DEC 2010) (FAR 52.222-40)

(a) During the term of this contract, the Contractor shall post an employee notice, of such size and in such form, and containing such content as prescribed by the Secretary of Labor, in conspicuous places in and about its plants and offices where employees covered by the National Labor Relations Act engage in activities relating to the performance of the contract, including all places where notices to employees are customarily posted both physically and electronically, in the languages employees speak, in accordance with 29 CFR 471.2(d) and (f).

(1) Physical posting of the employee notice shall be in conspicuous places in and about the Contractor's plants and offices so that the notice is prominent and readily seen by employees who are covered by the National Labor Relations Act and engage in activities related to the performance of the contract.

(2) If the Contractor customarily posts notices to employees electronically, then the Contractor shall also post the required notice electronically by displaying prominently, on any Web site that is maintained by the Contractor and is customarily used for notices to employees about terms and conditions of employment, a link to the Department of Labor's Web site that contains the full text of the poster. The link to the Department's Web site, as referenced in (b)(3) of this section, must read, ''Important Notice about Employee Rights to Organize and Bargain Collectively with Their Employers.''

(b) This required employee notice, printed by the Department of Labor, may be—

(1) Obtained from the Division of Interpretations and Standards, Office of Labor-Management Standards, U.S. Department of Labor, 200 Constitution Avenue, NW, Room N–5609, Washington, DC 20210, (202) 693–0123, or from any field office of the Office of Labor-Management Standards or Office of Federal Contract Compliance Programs;

(2) Provided by the Federal contracting agency if requested;

(3) Downloaded from the Office of Labor-Management Standards Web site at *http://www.dol.gov/olms/regs/compliance/EO13496.htm;* or

(4) Reproduced and used as exact duplicate copies of the Department of Labor's official poster.

(c) The required text of the employee notice referred to in this clause is located at Appendix A, Subpart A, 29 CFR Part 471.

(d) The Contractor shall comply with all provisions of the employee notice and related rules, regulations, and orders of the Secretary of Labor.

(e) In the event that the Contractor does not comply with the requirements set forth in paragraphs (a) through (d) of this clause, this contract may be terminated or suspended in whole or in part, and the Contractor may be suspended or debarred in accordance with 29 CFR 471.14 and subpart 9.4. Such other sanctions or remedies may be imposed as are provided by 29 CFR part 471, which implements Executive Order 13496 or as otherwise provided by law.

(f) *Subcontracts.*

(1) The Contractor shall include the substance of this clause, including this paragraph (f), in every subcontract that exceeds $10,000 and will be performed wholly or partially in the United States, unless exempted by the rules, regulations, or orders of the Secretary of Labor issued pursuant to section 3 of Executive Order 13496 of January 30, 2009, so that such provisions will be binding upon each subcontractor.

(2) The Contractor shall not procure supplies or services in a way designed to avoid the applicability of Executive Order 13496 or this clause.

(3) The Contractor shall take such action with respect to any such subcontract as may be directed by the Secretary of Labor as a means of enforcing such provisions, including the imposition of sanctions for noncompliance.

(4) However, if the Contractor becomes involved in litigation with a subcontractor, or is threatened with such involvement, as a result of such direction, the Contractor may request the United States, through the Secretary of Labor, to enter into such litigation to protect the interests of the United States.

SECTION 5.62
APPLICABLE LAW FOR BREACH OF CONTRACT CLAIM (OCT 2004) (FAR 52.233-4)

United States law will apply to resolve any claim of breach of this contract.

SECTION 5.63
SYSTEM FOR AWARD MANAGEMENT (OCT 2018) (FAR 52.204-7)

(a) Definitions. As used in this provision—

"Electronic Funds Transfer (EFT) indicator" means a four-character suffix to the unique entity identifier. The suffix is assigned at the discretion of the commercial, nonprofit, or Government entity to establish additional System for Award Management records for identifying

alternative EFT accounts (see subpart 32.11) for the same entity.

"Registered in the System for Award Management (SAM) database" means that—

(1) The Offeror has entered all mandatory information, including the unique entity identifier and the EFT indicator, if applicable, the Commercial and Government Entity (CAGE) code, as well as data required by the Federal Funding Accountability and Transparency Act of 2006 (see subpart 4.14) into SAM;

(2) The offeror has completed the Core, Assertions, and Representations and Certifications, and Points of Contact sections of the registration in SAM;

(3) The Government has validated all mandatory data fields, to include validation of the Taxpayer Identification Number (TIN) with the Internal Revenue Service (IRS). The offeror will be required to provide consent for TIN validation to the Government as a part of SAM registration process; and

(4) The Government has marked the record "Active".

"Unique entity identifier" means a number or other identifier used to identify a specific commercial, nonprofit, or Government entity. See www.sam.gov for the designated entity for establishing unique entity identifiers.

(b)(1) An Offeror is required to be registered in SAM when submitting an offer or quotation, and shall continue to be registered until time of award, during performance, and through final payment of any contract, basic agreement, basic ordering agreement, or blanket purchasing agreement resulting from this solicitation.

(2) The Offeror shall enter, in the block with its name and address on the cover page of its offer, the annotation "Unique Entity Identifier" followed by the unique entity identifier that identifies the Offeror's name and address exactly as stated in the offer. The Offeror also shall enter its EFT indicator, if applicable. The unique entity identifier will be used by the Contracting Officer to verify that the Offeror is registered in SAM.

(c) If the Offeror does not have a unique entity identifier, it should contact the entity designated at www.sam.gov for establishment of the unique entity identifier directly to obtain one.

The Offeror should be prepared to provide the following information:

(1) Company legal business name.

(2) Tradestyle, doing business, or other name by which your entity is commonly recognized.

(3) Company Physical Street Address, City, State, and Zip Code.

(4) Company Mailing Address, City, State and Zip Code (if separate from physical).

(5) Company telephone number.

(6) Date the company was started.

(7) Number of employees at your location.

(8) Chief executive officer/key manager.

(9) Line of business (industry).

(10) Company Headquarters name and address (reporting relationship within your entity).

(d) If the Offeror does not become registered in SAM in the time prescribed by the Contracting Officer, the Contracting Officer will proceed to award to the next otherwise successful registered Offeror.

SECTION 5.64

CONTRACTOR CODE OF BUSINESS ETHICS AND CONDUCT (JUN 2020) (FAR 52.203–13).

(a) *Definitions*. As used in this clause--

Agent means any individual, including a director, an officer, an employee, or an independent Contractor, authorized to act on behalf of the organization.

Full cooperation--(1) Means disclosure to the Government of the information sufficient for law enforcement to identify the nature and extent of the offense and the individuals responsible for the conduct. It includes providing timely and complete response to Government auditors' and investigators' request for documents and access to employees with information;

(2) Does not foreclose any Contractor rights arising in law, the FAR, or the terms of the contract. It does not require--

(i) A Contractor to waive its attorney-client privilege or the protections afforded by the attorney work product doctrine; or

(ii) Any officer, director, owner, or employee of the Contractor, including a sole proprietor, to waive his or her attorney client privilege or Fifth Amendment rights; and

(3) Does not restrict a Contractor from--

(i) Conducting an internal investigation; or

(ii) Defending a proceeding or dispute arising under the contract or related to a potential or disclosed violation.

"*Principal"* means an officer, director, owner, partner, or a person having primary management or supervisory responsibilities within a business entity (e.g., general manager; plant manager; head of a division, or business segment; and similar positions).

"*Subcontract"* means any contract entered into by a subcontractor to furnish supplies or services for performance of a prime contract or a subcontract.

"*Subcontractor"* means any supplier, distributor, vendor, or firm that furnished supplies or services to or for a prime contractor or another subcontractor.

"*United States"* means the 50 States, the District of Columbia, and outlying areas.

(b) *Code of business ethics and conduct*.

(1) Within 30 days after contract award, unless the Contracting Officer establishes a longer time period, the Contractor shall—

(i) Have a written code of business ethics and conduct; and

(ii) Make a copy of the code available to each employee engaged in performance of the contract.

(2) The Contractor shall--

(i) Exercise due diligence to prevent and detect criminal conduct; and

(ii) Otherwise promote an organizational culture that encourages ethical conduct and a commitment to compliance with the law.

(3)(i) The Contractor shall timely disclose, in writing, to the agency Office of the Inspector General (OIG), with a copy to the Contracting Officer, whenever, in connection with the award, performance, or closeout of this contract or any subcontract thereunder, the Contractor has credible evidence that a principal, employee, agent, or subcontractor of the Contractor has committed--

(A) A violation of Federal criminal law involving fraud, conflict of interest, bribery, or gratuity violations found in Title 18 of the United States Code; or

(B) A violation of the civil False Claims Act (31 U.S.C. 3729-3733).

(ii) The Government, to the extent permitted by law and regulation, will safeguard and treat information obtained pursuant to the Contractor's disclosure as confidential where the information has been marked ``confidential'' or ``proprietary'' by the company.
To the extent permitted by law and regulation, such information will not be released by the Government to the public pursuant to a Freedom of Information Act request, 5 U.S.C. Section 552, without prior notification to the Contractor. The Government may transfer documents provided by the Contractor to any department or agency within the Executive Branch if the information relates to matters within the organization's jurisdiction.

(iii) If the violation relates to an order against a Government wide acquisition contract, a multi-agency contract, a multiple-award schedule contract such as the Federal Supply Schedule, or any other procurement instrument intended for use by multiple agencies, the Contractor shall notify the OIG of the ordering agency and the IG of the agency responsible for the basic contract.

(c) Business ethics awareness and compliance program and internal control system. This paragraph (c) does not apply if the Contractor has represented itself as a small business concern pursuant to the award of this contract or if this contract is for the acquisition of a commercial item as defined at FAR 2.101. The Contractor shall establish the following within 90 days after contract award, unless the Contracting Officer establishes a longer time period:

(1) An ongoing business ethics awareness and compliance program.

(i) This program shall include reasonable steps to communicate periodically and in a practical manner the Contractor's standards and procedures and other aspects of the Contractor's business ethics awareness and compliance program and internal control system, by conducting effective training programs and otherwise disseminating information appropriate to an individual's respective roles and responsibilities.

(ii) The training conducted under this program shall be provided to the Contractor's principals and employees, and as appropriate, the Contractor's agents and subcontractors.

(2) An internal control system.

(i) The Contractor's internal control system shall--

(A) Establish standards and procedures to facilitate timely discovery of improper conduct in connection with Government contracts; and

(B) Ensure corrective measures are promptly instituted and carried out.

(ii) At a minimum, the Contractor's internal control system shall provide for the following:

(A) Assignment of responsibility at a sufficiently high level and adequate resources to ensure effectiveness of the business ethics awareness and compliance program and internal control system.

(B) Reasonable efforts not to include an individual as a principal, whom due diligence would have exposed as having engaged in conduct that is in conflict with the Contractor's code of business ethics and conduct.

(C) Periodic reviews of company business practices, procedures, policies, and internal controls for compliance with the Contractor's code of business ethics and conduct and the special requirements of Government contracting, including--

(1) Monitoring and auditing to detect criminal conduct;

(2) Periodic evaluation of the effectiveness of the business ethics awareness and compliance program and internal control system, especially if criminal conduct has been detected; and

(3) Periodic assessment of the risk of criminal conduct, with appropriate steps to design, implement, or modify the business ethics awareness and compliance program and the internal control system as necessary to reduce the risk of criminal conduct identified through this process.

(D) An internal reporting mechanism, such as a hotline, which allows for anonymity or confidentiality, by which employees may report suspected instances of improper conduct, and instructions that encourage employees to make such reports.

(E) Disciplinary action for improper conduct or for failing to take reasonable steps to prevent or detect improper conduct.

(F) Timely disclosure, in writing, to the agency OIG, with a copy to the Contracting Officer, whenever, in connection with the award, performance, or closeout of any Government contract performed by the Contractor or a subcontract thereunder, the Contractor has credible evidence that a principal, employee, agent, or subcontractor of the Contractor has committed a violation of Federal criminal law involving fraud, conflict of interest, bribery, or gratuity violations found in Title 18 U.S.C. or a violation of the civil False Claims Act (31 U.S.C. 3729-3733).

(1) If a violation relates to more than one Government contract, the Contractor may make the disclosure to the agency OIG and Contracting Officer responsible for the largest dollar value contract impacted by the violation.

(2) If the violation relates to an order against a Government wide acquisition contract, a multi-agency contract, a multiple-award schedule contract such as the Federal Supply Schedule, or any other procurement instrument intended for use by multiple agencies, the contractor shall notify the OIG of the ordering agency and the IG of the agency responsible for the basic contract, and the respective agencies' contracting officers.

(3) The disclosure requirement for an individual contract continues until at least 3 years after final payment on the contract.

(4) The Government will safeguard such disclosures in accordance with paragraph (b)(3)(ii) of this clause.

(G) Full cooperation with any Government agencies responsible for audits, investigations, or corrective actions.

(d) Subcontracts. (1) The Contractor shall include the substance of this clause, including this paragraph (d), in subcontracts that exceed the threshold specified in FAR 3.1004(a) on the date of subcontract award and a performance period of more than 120 days.

(2) In altering this clause to identify the appropriate parties, all disclosures of violation of the civil False Claims Act or of Federal criminal law shall be directed to the agency Office of the Inspector General, with a copy to the Contracting Officer.

SECTION 5.65
EMPLOYMENT ELIGIBILITY VERIFICATION (OCT 2015) (FAR 52.222-54).

(a) Definitions. As used in this clause--

"Commercially available off-the-shelf (COTS) item"—

(1) Means any item of supply that is--

(i) A commercial item (as defined in paragraph (1) of the definition at 2.101);

(ii) Sold in substantial quantities in the commercial marketplace; and

(iii) Offered to the Government, without modification, in the same form in which it is sold in the commercial marketplace; and

(2) Does not include bulk cargo, as defined in 46 U.S.C. 40102(4), such as agricultural products and petroleum products. Per 46 CFR 525.1 (c)(2), "bulk cargo" means cargo that is loaded and carried in bulk onboard ship without mark or count, in a loose unpackaged form,

having homogenous characteristics. Bulk cargo loaded into intermodal equipment, except LASH or Seabee barges, is subject to mark and count and, therefore, ceases to be bulk cargo.

"Employee assigned to the contract" means an employee who was hired after November 6, 1986 (after November 27, 2009 in the Commonwealth of the Northern Mariana Islands), who is directly performing work, in the United States, under a contract that is required to include the clause prescribed at 22.1803. An employee is not considered to be directly performing work under a contract if the employee—

(1) Normally performs support work, such as indirect or overhead functions; and

(2) Does not perform any substantial duties applicable to the contract.

"Subcontract" means any contract, as defined in 2.101, entered into by a subcontractor to furnish supplies or services for performance of a prime contract or a subcontract. It includes but is not limited to purchase orders, and changes and modifications to purchase orders.

"Subcontractor" means any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime Contractor or another subcontractor.

"United States", as defined in 8 U.S.C. 1101(a)(38), means the 50 States, the District of Columbia, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, and the U.S. Virgin Islands.

(b) Enrollment and verification requirements.

(1) If the Contractor is not enrolled as a Federal Contractor in E-Verify at time of contract award, the Contractor shall—

(i) Enroll. Enroll as a Federal Contractor in the E-Verify program within 30 calendar days of contract award;

(ii) Verify all new employees. Within 90 calendar days of enrollment in the E-Verify program, begin to use E-Verify to initiate verification of employment eligibility of all new hires of the Contractor, who are working in the United States, whether or not assigned to the contract, within 3 business days after the date of hire (but see paragraph (b)(3) of this section); and

(iii) Verify employees assigned to the contract. For each employee assigned to the contract, initiate verification within 90 calendar days after date of enrollment or within 30 calendar days of the employee's assignment to the contract, whichever date is later (but see paragraph (b)(4) of this section).

(2) If the Contractor is enrolled as a Federal Contractor in E-Verify at time of contract award, the Contractor shall use E-Verify to initiate verification of employment eligibility of—

(i) All new employees.

(A) Enrolled 90 calendar days or more. The Contractor shall initiate verification of all new hires of the Contractor, who are working in the United States, whether or not assigned to the contract, within 3 business days after the date of hire (but see paragraph (b)(3) of this section); or

(B) Enrolled less than 90 calendar days. Within 90 calendar days after enrollment as a Federal Contractor in E-Verify, the Contractor shall initiate verification of all new hires of the Contractor, who are working in the United States, whether or not assigned to the contract, within 3 business days after the date of hire (but see paragraph (b)(3) of this section); or

(ii) Employees assigned to the contract. For each employee assigned to the contract, the Contractor shall initiate verification within 90 calendar days after date of contract award or within 30 days after assignment to the contract, whichever date is later (but see paragraph (b)(4) of this section).

(3) If the Contractor is an institution of higher education (as defined at 20 U.S.C. 1001(a)); a State or local government or the government of a Federally recognized Indian tribe;

or a surety performing under a takeover agreement entered into with a Federal agency pursuant to a performance bond, the Contractor may choose to verify only employees assigned to the contract, whether existing employees or new hires. The Contractor shall follow the applicable verification requirements at (b)(1) or (b)(2)~~,~~ respectively, except that any requirement for verification of new employees applies only to new employees assigned to the contract.

(4) Option to verify employment eligibility of all employees. The Contractor may elect to verify all existing employees hired after November 6, 1986 (after November 27, 2009, in the Commonwealth of the Northern Mariana Islands), rather than just those employees assigned to the contract. The Contractor shall initiate verification for each existing employee working in the United States who was hired after November 6, 1986 (after November 27, 2009, in the Commonwealth of the Northern Mariana Islands), within 180 calendar days of—

(i) Enrollment in the E-Verify program; or

(ii) Notification to E-Verify Operations of the Contractor's decision to exercise this option, using the contact information provided in the E-Verify program Memorandum of Understanding (MOU).

(5) The Contractor shall comply, for the period of performance of this contract, with the requirements of the E-Verify program MOU.

(i) The Department of Homeland Security (DHS) or the Social Security Administration (SSA) may terminate the Contractor's MOU and deny access to the E-Verify system in accordance with the terms of the MOU. In such case, the Contractor will be referred to a suspension or debarment official.

(ii) During the period between termination of the MOU and a decision by the suspension or debarment official whether to suspend or debar, the Contractor is excused from its obligations under paragraph (b) of this clause. If the suspension or debarment official determines not to suspend or debar the Contractor, then the Contractor must reenroll in E-Verify.

(c) Web site. Information on registration for and use of the E-Verify program can be obtained via the Internet at the Department of Homeland Security Web site: http://www.dhs.gov/E-Verify.

(d) Individuals previously verified. The Contractor is not required by this clause to perform additional employment verification using E-Verify for any employee –

(1) Whose employment eligibility was previously verified by the Contractor through the E-Verify program;

(2) Who has been granted and holds an active U.S. Government security clearance for access to confidential, secret, or top secret information in accordance with the National Industrial Security Program Operating Manual; or

(3) Who has undergone a completed background investigation and been issued credentials pursuant to Homeland Security Presidential Directive (HSPD)-12, Policy for a Common Identification Standard for Federal Employees and Contractors.

(e) Subcontracts. The Contractor shall include the requirements of this clause, including this paragraph (e) (appropriately modified for identification of the parties), in each subcontract that –

(1) Is for—

(i) Commercial or noncommercial services (except for commercial services that are part of the purchase of a COTS item (or an item that would be a COTS item, but for minor modifications), performed by the COTS provider, and are normally provided for that COTS item); or

(ii) Construction;
(2) Has a value of more than $3,500; and
(3) Includes work performed in the United States.

SECTION 5.66
UPDATES OF PUBLICALLY AVAILABLE INFORMATION REGARDING RESPONSIBILITY MATTERS (OCT 2018) (FAR 52.209-9)

(a) The Contractor shall update the information in the Federal Awardee Performance and Integrity Information System (FAPIIS) on a semi-annual basis, throughout the life of the contract, by posting the required information in the System for Award Management database via www.sam.gov.

(b) As required by section 3010 of the Supplemental Appropriations Act, 2010 (Pub. L. 111-212), all information posted in FAPIIS on or after April 15, 2011, except past performance reviews, will be publicly available. FAPIIS consists of two segments—

(1) The non-public segment, into which Government officials and the Contractor post information, which can only be viewed by—

(i) Government personnel and authorized users performing business on behalf of the Government; or

(ii) The Contractor, when viewing data on itself; and

(2) The publicly-available segment, to which all data in the non-public segment of FAPIIS is automatically transferred after a waiting period of 14 calendar days, except for—

(i) Past performance reviews required by subpart 42.15;

(ii) Information that was entered prior to April 15, 2011; or

(iii) Information that is withdrawn during the 14-calendar-day waiting period by the Government official who posted it in accordance with paragraph (c)(1) of this clause.

(c) The Contractor will receive notification when the Government posts new information to the Contractor's record.

(1) If the Contractor asserts in writing within 7 calendar days, to the Government official who posted the information, that some of the information posted to the non-public segment of FAPIIS is covered by a disclosure exemption under the Freedom of Information Act, the Government official who posted the information must within 7 calendar days remove the posting from FAPIIS and resolve the issue in accordance with agency Freedom of Information procedures, prior to reposting the releasable information. The contractor must cite 52.209-9 and request removal within 7 calendar days of the posting to FAPIIS.

(2) The Contractor will also have an opportunity to post comments regarding information that has been posted by the Government. The comments will be retained as long as the associated information is retained, i.e.~~.~~, for a total period of 6 years. Contractor comments will remain a part of the record unless the Contractor revises them.

(3) As required by section 3010 of Pub. L. 111-212, all information posted in FAPIIS on or after April 15, 2011, except past performance reviews, will be publicly available.

(d) Public requests for system information posted prior to April 15, 2011, will be handled under Freedom of Information Act procedures, including, where appropriate, procedures promulgated under E.O. 12600.

SECTION 5.67
PERSONAL IDENTITY VERIFICATION OF CONTRACTOR PERSONNEL (JAN 2011) (FAR 52.204-9)

(a) The Contractor shall comply with agency personal identity verification procedures identified in the contract that implement Homeland Security Presidential Directive-12 (HSPD-12), Office of Management and Budget (OMB) guidance M-05-24 and Federal Information Processing Standards Publication (FIPS PUB) Number 201.

(b) The Contractor shall account for all forms of Government-provided identification issued to the Contractor employees in connection with performance under this contract. The Contractor shall return such identification to the issuing agency at the earliest of any of the following, unless otherwise determined by the Government:

(1) When no longer needed for contract performance.

(2) Upon completion of the Contractor employee's employment.

(3) Upon contract completion or termination.

(c) The Contracting Officer may delay final payment under a contract if the Contractor fails to comply with these requirements.

(d) The Contractor shall insert the substance of this clause, including this paragraph (d), in all subcontracts when the subcontractor's employees are required to have routine physical access to a Federally-controlled facility and/or routine access to a Federally-controlled information system. It shall be the responsibility of the prime Contractor to return such identification to the issuing agency in accordance with the terms set forth in paragraph (b) of this section, unless otherwise approved in writing by the Contracting Officer.

[Note: For purposes of this Contract, a Federally-controlled information system means the OPM Letter of Credit System.]

SECTION 5.68
PRIVACY OR SECURITY SAFEGUARDS (AUG 1996) (FAR 52.239-1)

(a) The Contractor shall not publish or disclose in any manner, without the Contracting Officer's written consent, the details of any safeguards either designed or developed by the Contractor under this contract or otherwise provided by the Government.

(b) To the extent required to carry out a program of inspection to safeguard against threats and hazards to the security, integrity, and confidentiality of Government data, the Contractor shall afford the Government access to the Contractor's facilities, installations, technical capabilities, operations, documentation, records, and databases.

(c) If new or unanticipated threats or hazards are discovered by either the Government or the Contractor, or if existing safeguards have ceased to function, the discoverer shall immediately bring the situation to the attention of the other party.

[Note: For purposes of this Contract and this clause, privacy or security safeguards pertain to the OPM Letter of Credit System.]

SECTION 5.69
ENCOURAGING CONTRACTOR POLICIES TO BAN TEXT MESSAGING WHILE

DRIVING (JUN 2020) (FAR 52.223-18)

(a) Definitions. As used in this clause—

"Driving"–

(1) Means operating a motor vehicle on an active roadway with the motor running, including while temporarily stationary because of traffic, a traffic light, stop sign, or otherwise.

(2) Does not include operating a motor vehicle with or without the motor running when one has pulled over to the side of, or off, an active roadway and has halted in a location where one can safely remain stationary.

"Text messaging" means reading from or entering data into any handheld or other electronic device, including for the purpose of short message service texting, e-mailing, instant messaging, obtaining navigational information, or engaging in any other form of electronic data retrieval or electronic data communication. The term does not include glancing at or listening to a navigational device that is secured in a commercially designed holder affixed to the vehicle, provided that the destination and route are programmed into the device either before driving or while stopped in a location off the roadway where it is safe and legal to park.

(b) This clause implements Executive Order 13513, Federal Leadership on Reducing Text Messaging While Driving, dated October 1, 2009.

(c) The Contractor is encouraged to—

(1) Adopt and enforce policies that ban text messaging while driving—

(i) Company-owned or -rented vehicles or Government-owned vehicles; or

(ii) Privately-owned vehicles when on official Government business or when performing any work for or on behalf of the Government.

(2) Conduct initiatives in a manner commensurate with the size of the business, such as—

(i) Establishment of new rules and programs or re-evaluation of existing programs to prohibit text messaging while driving; and

(ii) Education, awareness, and other outreach to employees about the safety risks associated with texting while driving.

(d) Subcontracts. The Contractor shall insert the substance of this clause, including this paragraph (d), in all subcontracts that exceed the micro-purchase threshold, as defined in Federal Acquisition Regulation 2.101 on the date of subcontract award.

SECTION 5.70
CONTRACTOR EMPLOYEE WHISTLEBLOWER RIGHTS AND REQUIREMENT TO INFORM EMPLOYEES OF WHISTLEBLOWER RIGHTS (JUN 2020) (FAR 52.203-17).

(a) This contract and employees working on this contract will be subject to the whistleblower rights and remedies in the pilot program on Contractor employee whistleblower protections established at 41 U.S.C. 4712 by section 828 of the National Defense Authorization Act for Fiscal Year 2013 (Pub. L. 112-239) and Federal Acquisition Regulation (FAR) 3.908

(b) The Contractor shall inform its employees in writing, in the predominant language of the workforce, of employee whistleblower rights and protections under 41 U.S.C. 4712, as described in section FAR 3.908.

(c) The Contractor shall insert the substance of this clause, including this paragraph (c), in all subcontracts over the simplified acquisition threshold, as defined in FAR 2.101 on the date of subcontract award.

SECTION 5.71
COMBATING TRAFFICKING IN PERSONS (OCT 2020) (FAR 52.222-50)

(a) Definitions. As used in this clause—

"Agent" means any individual, including a director, an officer, an employee, or an independent contractor, authorized to act on behalf of the organization.

"Coercion" means—

(1) Threats of serious harm to or physical restraint against any person;

(2) Any scheme, plan, or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to or physical restraint against any person; or

(3) The abuse or threatened abuse of the legal process. "Commercial sex act" means any sex act on account of which anything of value is given to or received by any person.

"Commercially available off-the-shelf (COTS) item" means-

(1) Any item of supply (including construction material) that is-

(i) A commercial item (as defined in paragraph (1) of the definition at FAR 2.101);

(ii) Sold in substantial quantities in the commercial marketplace; and

(iii) Offered to the Government, under a contract or subcontract at any tier, without modification, in the same form in which it is sold in the commercial marketplace; and

(2) Does not include bulk cargo, as defined in 46 U.S.C. 40102(4), such as agricultural products and petroleum products.

"Debt bondage" means the status or condition of a debtor arising from a pledge by the debtor of his or her personal services or of those of a person under his or her control as a security for debt, if the value of those services as reasonably assessed is not applied toward the liquidation of the debt or the length and nature of those services are not respectively limited and defined.

"Employee" means an employee of the Contractor directly engaged in the performance of work under the contract who has other than a minimal impact or involvement in contract performance.

"Forced labor" means knowingly providing or obtaining the labor or services of a person—

(1) By threats of serious harm to, or physical restraint against, that person or another person;

(2) By means of any scheme, plan, or pattern intended to cause the person to believe that, if the person did not perform such labor or services, that person or another person would suffer serious harm or physical restraint; or

(3) By means of the abuse or threatened abuse of law or the legal process.

"Involuntary servitude" includes a condition of servitude induced by means of—

(1) Any scheme, plan, or pattern intended to cause a person to believe that, if the person did not enter into or continue in such conditions, that person or another person would suffer serious harm or physical restraint; or

(2) The abuse or threatened abuse of the legal process.

"Recruitment fees" means fees of any type, including charges, costs, assessments, or other financial obligations, that are associated with the recruiting process, regardless of the time, manner, or location of imposition or collection of the fee.

(1) Recruitment fees include, but are not limited to, the following fees (when they are associated with the recruiting process) for—

(i) Soliciting, identifying, considering, interviewing, referring, retaining, transferring, selecting, training, providing orientation to, skills testing, recommending, or placing employees or potential employees;

(ii) Advertising;

(iii) Obtaining permanent or temporary labor certification, including any associated fees;

(iv) Processing applications and petitions;

(v) Acquiring visas, including any associated fees;

(vi) Acquiring photographs and identity or immigration documents, such as passports, including any associated fees;

(vii) Accessing the job opportunity, including required medical examinations and immunizations; background, reference, and security clearance checks and examinations; and additional certifications;

(viii) An employer's recruiters, agents or attorneys, or other notary or legal fees;

(ix) Language interpretation or translation, arranging for or accompanying on travel, or providing other advice to employees or potential employees;

(x) Government-mandated fees, such as border crossing fees, levies, or worker welfare funds;

(xi) Transportation and subsistence costs—

(A) While in transit, including, but not limited to, airfare or costs of other modes of transportation, terminal fees, and travel taxes associated with travel from the country of origin to the country of performance and the return journey upon the end of employment; and

(B) From the airport or disembarkation point to the worksite;

(xii) Security deposits, bonds, and insurance; and

(xiii) Equipment charges.

(2) A recruitment fee, as described in the introductory text of this definition, is a recruitment fee, regardless of whether the payment is—

(i) Paid in property or money;

(ii) Deducted from wages;

(iii) Paid back in wage or benefit concessions;

(iv) Paid back as a kickback, bribe, in-kind payment, free labor, tip, or tribute; or

(v) Collected by an employer or a third party, whether licensed or unlicensed, including, but not limited to—

(A) Agents;

(B) Labor brokers;

(C) Recruiters;

(D) Staffing firms (including private employment and placement firms);

(E) Subsidiaries/affiliates of the employer;

(F) Any agent or employee of such entities; and

(G) Subcontractors at all tiers.

"Severe forms of trafficking in persons" means—

(1) Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or

(2) The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

"Sex trafficking" means the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act.

"Subcontract" means any contract entered into by a subcontractor to furnish supplies or services for performance of a prime contract or a subcontract.

"Subcontractor" means any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime contractor or another subcontractor.

"United States" means the 50 States, the District of Columbia, and outlying areas.

(b) Policy. The United States Government has adopted a policy prohibiting trafficking in persons including the trafficking-related activities of this clause. Contractors, contractor employees, and their agents shall not—

(1) Engage in severe forms of trafficking in persons during the period of performance of the contract;

(2) Procure commercial sex acts during the period of performance of the contract; or

(3) Use forced labor in the performance of the contract.

(4) Destroy, conceal, confiscate, or otherwise deny access by an employee to the employee's identity or immigration documents, such as passports or drivers' licenses, regardless of issuing authority;

(5)(i) Use misleading or fraudulent practices during the recruitment of employees or offering of employment, such as failing to disclose, in a format and language understood by the employee or potential employee, basic information or making material misrepresentations during the recruitment of employees regarding the key terms and conditions of employment, including wages and fringe benefits, the location of work, the living conditions, housing and associated costs (if employer or agent provided or arranged), any significant cost to be charged to the employee, and, if applicable, the hazardous nature of the work;

(ii) Use recruiters that do not comply with local labor laws of the country in which the recruiting takes place;

(6) Charge employees or potential employees recruitment fees;

(7)(i) Fail to provide return transportation or pay for the cost of return transportation upon the end of employment-

(A) For an employee who is not a national of the country in which the work is taking place and who was brought into that country for the purpose of working on a U.S. Government contract or subcontract (for portions of contracts performed outside the United States); or

(B) For an employee who is not a United States national and who was brought into the United States for the purpose of working on a U.S. Government contract or subcontract, if the payment of such costs is required under existing temporary worker programs or pursuant to a written agreement with the employee (for portions of contracts performed inside the United States); except that-

(ii) The requirements of paragraphs (b)(7)(i) of this clause shall not apply to an employee who is-

(A) Legally permitted to remain in the country of employment and who chooses to do so; or

(B) Exempted by an authorized official of the contracting agency from the requirement to provide return transportation or pay for the cost of return transportation;

(iii) The requirements of paragraph (b)(7)(i) of this clause are modified for a victim of trafficking in persons who is seeking victim services or legal redress in the country of employment, or for a witness in an enforcement action related to trafficking in persons. The contractor shall provide the return transportation or pay the cost of return transportation in a way that does not obstruct the victim services, legal redress, or witness activity. For example, the contractor shall not only offer return transportation to a witness at a time when the witness is still

needed to testify. This paragraph does not apply when the exemptions at paragraph (b)(7)(ii) of this clause apply.

(8) Provide or arrange housing that fails to meet the host country housing and safety standards; or

(9) If required by law or contract, fail to provide an employment contract, recruitment agreement, or other required work document in writing. Such written work document shall be in a language the employee understands. If the employee must relocate to perform the work, the work document shall be provided to the employee at least five days prior to the employee relocating. The employee's work document shall include, but is not limited to, details about work description, wages, prohibition on charging recruitment fees, work location(s), living accommodations and associated costs, time off, roundtrip transportation arrangements, grievance process, and the content of applicable laws and regulations that prohibit trafficking in persons.

(c) Contractor requirements. The Contractor shall—

(1) Notify its employees and agents of—

(i) The United States Government's policy prohibiting trafficking in persons, described in paragraph (b) of this clause; and

(ii) The actions that will be taken against employees or agents for violations of this policy. Such actions for employees may include, but are not limited to, removal from the contract, reduction in benefits, or termination of employment; and

(2) Take appropriate action, up to and including termination, against employees, agents, or subcontractors that violate the policy in paragraph (b) of this clause.

(d) *Notification*.

(1) The Contractor shall inform the Contracting Officer and the agency Inspector General immediately of—

(i)Any credible information it receives from any source (including host country law enforcement) that alleges a Contractor employee, subcontractor, subcontractor employee, or their agent has engaged in conduct that violates the policy; in in paragraph (b) of this clause (see also 18 U.S.C. 1351, Fraud in Foreign Labor Contracting, and 52.203-13(b)(3)(i)(A), if that clause is included in the solicitation or contract, which requires disclosure to the agency Office of the Inspector General when the Contractor has credible evidence of fraud) ; and

(ii) Any actions taken against a Contractor employee, subcontractor, or subcontractor employee, or their agent pursuant to this clause.

(2) If the allegation may be associated with more than one contract, the Contractor shall inform the contracting officer for the contract with the highest dollar value.

(e) *Remedies*. In addition to other remedies available to the Government, the Contractor's failure to comply with the requirements of paragraphs (c), (d), (g), (h) or (i) of this clause may result in—

(1) Requiring the Contractor to remove a Contractor employee or employees from the performance of the contract;

(2) Requiring the Contractor to terminate a subcontract;

(3) Suspension of contract payments until the Contractor has taken appropriate remedial action;

(4) Loss of award fee, consistent with the award fee plan, for the performance period in which the Government determined Contractor non-compliance;

(5) Declining to exercise available options under the contract;

(6) Termination of the contract for default or cause, in accordance with the termination clause of this contract; or

(7) Suspension or debarment.

(f) Mitigating and aggravating factors. When determining remedies, the Contracting Officer may consider the following:

(1) Mitigating factors. The Contractor had a Trafficking in Persons compliance plan or an awareness program at the time of the violation, was in compliance with the plan, and has taken appropriate remedial actions for the violation, that may include reparation to victims for such violations.

(2) Aggravating factors. The Contractor failed to abate an alleged violation or enforce the requirements of a compliance plan, when directed by the Contracting Officer to do so.

(g) Full cooperation.

(1) The Contractor shall, at a minimum-

(i) Disclose to the agency Inspector General information sufficient to identify the nature and extent of an offense and the individuals responsible for the conduct;

(ii) Provide timely and complete responses to Government auditors' and investigators' requests for documents;

(iii) Cooperate fully in providing reasonable access to its facilities and staff (both inside and outside the U.S.) to allow contracting agencies and other responsible Federal agencies to conduct audits, investigations, or other actions to ascertain compliance with the Trafficking Victims Protection Act of 2000 (22 U.S.C. chapter 78), E.O. 13627, or any other applicable law or regulation establishing restrictions on trafficking in persons, the procurement of commercial sex acts, or the use of forced labor; and

(iv) Protect all employees suspected of being victims of or witnesses to prohibited activities, prior to returning to the country from which the employee was recruited, and shall not prevent or hinder the ability of these employees from cooperating fully with Government authorities.

(2) The requirement for full cooperation does not foreclose any Contractor rights arising in law, the FAR, or the terms of the contract. It does not-

(i) Require the Contractor to waive its attorney-client privilege or the protections afforded by the attorney work product doctrine;

(ii) Require any officer, director, owner, employee, or agent of the Contractor, including a sole proprietor, to waive his or her attorney client privilege or Fifth Amendment rights; or

(iii) Restrict the Contractor from-

(A) Conducting an internal investigation; or

(B) Defending a proceeding or dispute arising under the contract or related to a potential or disclosed violation.

(h) Compliance plan.

(1) This paragraph (h) applies to any portion of the contract that-

(i) Is for supplies, other than commercially available off-the-shelf items, acquired outside the United States, or services to be performed outside the United States; and

(ii) Has an estimated value that exceeds $550,000.

(2) The Contractor shall maintain a compliance plan during the performance of the contract that is appropriate-

(i) To the size and complexity of the contract; and

(ii) To the nature and scope of the activities to be performed for the Government, including the number of non-United States citizens expected to be employed and the risk that the contract or subcontract will involve services or supplies susceptible to trafficking in persons.

(3) Minimum requirements. The compliance plan must include, at a minimum, the following:

(i) An awareness program to inform contractor employees about the Government's policy prohibiting trafficking-related activities described in paragraph (b) of this clause, the activities prohibited, and the actions that will be taken against the employee for violations. Additional information about Trafficking in Persons and examples of awareness programs can be found at the website for the Department of State's Office to Monitor and Combat Trafficking in Persons at http://www.state.gov/j/tip/.

(ii) A process for employees to report, without fear of retaliation, activity inconsistent with the policy prohibiting trafficking in persons, including a means to make available to all employees the hotline phone number of the Global Human Trafficking Hotline at 1-844-888-FREE and its email address at help@befree.org.

(iii) A recruitment and wage plan that only permits the use of recruitment companies with trained employees, prohibits charging recruitment fees to the employee or potential employees, and ensures that wages meet applicable host-country legal requirements or explains any variance.

(iv) A housing plan, if the Contractor or subcontractor intends to provide or arrange housing, that ensures that the housing meets host-country housing and safety standards.

(v) Procedures to prevent agents and subcontractors at any tier and at any dollar value from engaging in trafficking in persons (including activities in paragraph (b) of this clause) and to monitor, detect, and terminate any agents, subcontracts, or subcontractor employees that have engaged in such activities.

(4) Posting.

(i) The Contractor shall post the relevant contents of the compliance plan, no later than the initiation of contract performance, at the workplace (unless the work is to be performed in the field or not in a fixed location) and on the Contractor's Web site (if one is maintained). If posting at the workplace or on the Web site is impracticable, the Contractor shall provide the relevant contents of the compliance plan to each worker in writing.

(ii) The Contractor shall provide the compliance plan to the Contracting Officer upon request.

(5) Certification. Annually after receiving an award, the Contractor shall submit a certification to the Contracting Officer that-

(i) It has implemented a compliance plan to prevent any prohibited activities identified at paragraph (b) of this clause and to monitor, detect, and terminate any agent, subcontract or subcontractor employee engaging in prohibited activities; and

(ii) After having conducted due diligence, either-

(A) To the best of the Contractor's knowledge and belief, neither it nor any of its agents, subcontractors, or their agents is engaged in any such activities; or

(B) If abuses relating to any of the prohibited activities identified in paragraph (b) of this clause have been found, the Contractor or subcontractor has taken the appropriate remedial and referral actions.

(i) *Subcontracts*.

(1) The Contractor shall include the substance of this clause, including this paragraph (f), in all subcontracts and in all contracts with agents. The requirements in paragraph (h) of this clause apply only to any portion of the subcontract that-

(i) Is for supplies, other than commercially available off-the-shelf items, acquired outside the United States, or services to be performed outside the United States; and

(ii) Has an estimated value that exceeds $550,000.

(2) If any subcontractor is required by this clause to submit a certification, the Contractor shall require submission prior to the award of the subcontract and annually thereafter. The certification shall cover the items in paragraph (h)(5) of this clause.

SECTION 5.72
BASIC SAFEGUARDING OF COVERED CONTRACTOR INFORMATION SYSTEMS (JUN 2016) (FAR 52.204-21)

(a) Definitions. As used in this clause Covered contractor information system means an information system that is owned or operated by a contractor that processes, stores, or transmits Federal contract information.

Federal contract information means information, not intended for public release, that is provided by or generated for the Government under a contract to develop or deliver a product or service to the Government, but not including information provided by the Government to the public (such as on public Web sites) or simple transactional information, such as necessary to process payments.

Information means any communication or representation of knowledge such as facts, data, or opinions, in any medium or form, including textual, numerical, graphic, cartographic, narrative, or audiovisual (Committee on National Security Systems Instruction (CNSSI) 4009).

Information system means a discrete set of information resources organized for the collection, processing, maintenance, use, sharing, dissemination, or disposition of information (44 U.S.C. 3502).

Safeguarding means measures or controls that are prescribed to protect information systems.

(b) Safeguarding requirements and procedures. (1) The Contractor shall apply the following basic safeguarding requirements and procedures to protect covered contractor information systems. Requirements and procedures for basic safeguarding of covered contractor information systems shall include, at a minimum, the following security controls:

(i) Limit information system access to authorized users, processes acting on behalf of authorized users, or devices (including other information systems).

(ii) Limit information system access to the types of transactions and functions that authorized users are permitted to execute.

(iii) Verify and control/limit connections to and use of external information systems.

(iv) Control information posted or processed on publicly accessible information systems.

(v) Identify information system users, processes acting on behalf of users, or devices.

(vi) Authenticate (or verify) the identities of those users, processes, or devices, as a prerequisite to allowing access to organizational information systems.

(vii) Sanitize or destroy information system media containing Federal Contract Information before disposal or release for reuse.

(viii) Limit physical access to organizational information systems, equipment, and the respective operating environments to authorized individuals.

(ix) Escort visitors and monitor visitor activity; maintain audit logs of physical access; and control and manage physical access devices.

(x) Monitor, control, and protect organizational communications (i.e., information transmitted or received by organizational information systems) at the external boundaries and key internal boundaries of the information systems.

(xi) Implement subnetworks for publicly accessible system components that are physically or logically separated from internal networks.

(xii) Identify, report, and correct information and information system flaws in a timely manner.

(xiii) Provide protection from malicious code at appropriate locations within organizational information systems.

(xiv) Update malicious code protection mechanisms when new releases are available.

(xv) Perform periodic scans of the information system and real-time scans of files from external sources as files are downloaded, opened, or executed.

(2) Other requirements. This clause does not relieve the Contractor of any other specific safeguarding requirements specified by Federal agencies and departments relating to covered contractor information systems generally or other Federal safeguarding requirements for controlled unclassified information (CUI) as established by Executive Order 13556.

(c) Subcontracts. The Contractor shall include the substance of this clause, including this paragraph (c), in subcontracts under this contract (including subcontracts for the acquisition of commercial items, other than commercially available off-the-shelf items), in which the subcontractor may have Federal contract information residing in or transiting through its information system.

SECTION 5.73
PROHIBITION ON REQUIRING CERTAIN INTERNAL CONFIDENTIALITY AGREEMENTS OR STATEMENTS (JAN 2017) (FAR 52.203-19)

(a) *Definitions*. As used in this clause–

"Internal confidentiality agreement or statement" means a confidentiality agreement or any other written statement that the contractor requires any of its employees or subcontractors to sign regarding nondisclosure of contractor information, except that it does not include confidentiality agreements arising out of civil litigation or confidentiality agreements that contractor employees or subcontractors sign at the behest of a Federal agency.

"Subcontract" means any contract as defined in subpart 2.1 entered into by a subcontractor to furnish supplies or services for performance of a prime contract or a subcontract. It includes but is not limited to purchase orders, and changes and modifications to purchase orders.

"Subcontractor" means any supplier, distributor, vendor, or firm (including a consultant) that furnishes supplies or services to or for a prime contractor or another subcontractor.

(b) The Contractor shall not require its employees or subcontractors to sign or comply with internal confidentiality agreements or statements prohibiting or otherwise restricting such

employees or subcontractors from lawfully reporting waste, fraud, or abuse related to the performance of a Government contract to a designated investigative or law enforcement representative of a Federal department or agency authorized to receive such information (*e.g.*, agency Office of the Inspector General).

(c) The Contractor shall notify current employees and subcontractors that prohibitions and restrictions of any preexisting internal confidentiality agreements or statements covered by this clause, to the extent that such prohibitions and restrictions are inconsistent with the prohibitions of this clause, are no longer in effect.

(d) The prohibition in paragraph (b) of this clause does not contravene requirements applicable to Standard Form 312 (Classified Information Nondisclosure Agreement), Form 4414 (Sensitive Compartmented Information Nondisclosure Agreement), or any other form issued by a Federal department or agency governing the nondisclosure of classified information.

(e) In accordance with section 743 of Division E, Title VII, of the Consolidated and Further Continuing Appropriations Act, 2015, (Pub. L. 113-235), and its successor provisions in subsequent appropriations acts (and as extended in continuing resolutions) use of funds appropriated (or otherwise made available) is prohibited, if the Government determines that the Contractor is not in compliance with the provisions of this clause.

(f) The Contractor shall include the substance of this clause, including this paragraph (f), in subcontracts under such contracts.

SECTION 5.74
PROHIBITION ON CONTRACTING FOR HARDWARE, SOFTWARE, AND SERVICES DEVELOPED OR PROVIDED BY KASPERSKY LAB AND OTHER COVERED ENTITIES (JUL 2018) (FAR 52.204-23).

(a) *Definitions*. As used in this clause—

"Covered article" means any hardware, software, or service that–

(1) Is developed or provided by a covered entity;

(2) Includes any hardware, software, or service developed or provided in whole or in part by a covered entity; or

(3) Contains components using any hardware or software developed in whole or in part by a covered entity.

"Covered entity" means–

(1) Kaspersky Lab;

(2) Any successor entity to Kaspersky Lab;

(3) Any entity that controls, is controlled by, or is under common control with Kaspersky Lab; or

(4) Any entity of which Kaspersky Lab has a majority ownership.

(b) *Prohibition*. Section 1634 of Division A of the National Defense Authorization Act for Fiscal Year 2018 (Pub. L. 115-91) prohibits Government use of any covered article. The Contractor is prohibited from—

(1) Providing any covered article that the Government will use on or after October 1, 2018; and

(2) Using any covered article on or after October 1, 2018, in the development of data or deliverables first produced in the performance of the contract.

(c) *Reporting requirement*.

(1) In the event the Contractor identifies a covered article provided to the Government during contract performance, or the Contractor is notified of such by a subcontractor at any tier

or any other source, the Contractor shall report, in writing, to the Contracting Officer or, in the case of the Department of Defense, to the website at https://dibnet.dod.mil. For indefinite delivery contracts, the Contractor shall report to the Contracting Officer for the indefinite delivery contract and the Contracting Officer(s) for any affected order or, in the case of the Department of Defense, identify both the indefinite delivery contract and any affected orders in the report provided at https://dibnet.dod.mil.

(2) The Contractor shall report the following information pursuant to paragraph (c)(1) of this clause:

(i) Within 1 business day from the date of such identification or notification: the contract number; the order number(s), if applicable; supplier name; brand; model number (Original Equipment Manufacturer (OEM) number, manufacturer part number, or wholesaler number); item description; and any readily available information about mitigation actions undertaken or recommended.

(ii) Within 10 business days of submitting the report pursuant to paragraph (c)(1) of this clause: any further available information about mitigation actions undertaken or recommended. In addition, the Contractor shall describe the efforts it undertook to prevent use or submission of a covered article, any reasons that led to the use or submission of the covered article, and any additional efforts that will be incorporated to prevent future use or submission of covered articles.

(d) Subcontracts. The Contractor shall insert the substance of this clause, including this paragraph (d), in all subcontracts, including subcontracts for the acquisition of commercial items.

SECTION 5.75
PROHIBITION ON CONTRACTING FOR CERTAIN TELECOMMUNICATIONS AND VIDEO SURVEILLANCE SERVICES OR EQUIPMENT (AUG 2020) (FAR 52.204-25).

(a) *Definitions.* As used in this clause—

"Backhaul" means intermediate links between the core network, or backbone network, and the small subnetworks at the edge of the network (e.g., connecting cell phones/towers to the core telephone network). Backhaul can be wireless (e.g., microwave) or wired (e.g., fiber optic, coaxial cable, Ethernet).

"Covered foreign country" means The People's Republic of China.

"Covered telecommunications equipment or services" means–

(1) Telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities);

(2) For the purpose of public safety, security of Government facilities, physical security surveillance of critical infrastructure, and other national security purposes, video surveillance and telecommunications equipment produced by Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities);

(3) Telecommunications or video surveillance services provided by such entities or using such equipment; or

(4) Telecommunications or video surveillance equipment or services produced or provided by an entity that the Secretary of Defense, in consultation with the Director of National Intelligence or the Director of the Federal Bureau of Investigation, reasonably believes to be an entity owned or controlled by, or otherwise connected to, the government of a covered foreign country.

"Critical technology" means–

(1) Defense articles or defense services included on the United States Munitions List set forth in the International Traffic in Arms Regulations under subchapter M of chapter I of title 22, Code of Federal Regulations;

(2) Items included on the Commerce Control List set forth in Supplement No. 1 to part 774 of the Export Administration Regulations under subchapter C of chapter VII of title 15, Code of Federal Regulations, and controlled-

(i) Pursuant to multilateral regimes, including for reasons relating to national security, chemical and biological weapons proliferation, nuclear nonproliferation, or missile technology; or

(ii) For reasons relating to regional stability or surreptitious listening;

(3) Specially designed and prepared nuclear equipment, parts and components, materials, software, and technology covered by part 810 of title 10, Code of Federal Regulations (relating to assistance to foreign atomic energy activities);

(4) Nuclear facilities, equipment, and material covered by part 110 of title 10, Code of Federal Regulations (relating to export and import of nuclear equipment and material);

(5) Select agents and toxins covered by part 331 of title 7, Code of Federal Regulations, part 121 of title 9 of such Code, or part 73 of title 42 of such Code; or

(6) Emerging and foundational technologies controlled pursuant to section 1758 of the Export Control Reform Act of 2018 (50 U.S.C. 4817).

"Interconnection arrangements" means arrangements governing the physical connection of two or more networks to allow the use of another's network to hand off traffic where it is ultimately delivered (e.g., connection of a customer of telephone provider A to a customer of telephone company B) or sharing data and other information resources.

"Reasonable inquiry" means an inquiry designed to uncover any information in the entity's possession about the identity of the producer or provider of covered telecommunications equipment or services used by the entity that excludes the need to include an internal or third- party audit.

"Roaming" means cellular communications services (e.g., voice, video, data) received from a visited network when unable to connect to the facilities of the home network either because signal coverage is too weak or because traffic is too high.

"Substantial or essential component" means any component necessary for the proper function or performance of a piece of equipment, system, or service.

(b) *Prohibition.* (1) Section 889(a)(1)(A) of the John S. McCain National Defense Authorization Act for Fiscal Year 2019 (Pub. L. 115–232) prohibits the head of an executive agency on or after August 13, 2019, from procuring or obtaining, or extending or renewing a contract to procure or obtain, any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system. The Contractor is prohibited from providing to the Government any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system, unless an exception at paragraph (c) of this clause applies or the covered telecommunication equipment or services are covered by a waiver described in FAR 4.2104.

(2) Section 889(a)(1)(B) of the John S. McCain National Defense Authorization Act for Fiscal Year 2019 (Pub. L. 115–232) prohibits the head of an executive agency on or after August 13, 2020, from entering into a contract, or extending or renewing a contract, with an entity that uses any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of

any system, unless an exception at paragraph (c) of this clause applies or the covered telecommunication equipment or services are covered by a waiver described in FAR 4.2104. This prohibition applies to the use of covered telecommunications equipment or services, regardless of whether that use is in performance of work under a Federal contract.

(c) *Exceptions.* This clause does not prohibit contractors from providing—

(1) A service that connects to the facilities of a third-party, such as backhaul, roaming, or interconnection arrangements; or

(2) Telecommunications equipment that cannot route or redirect user data traffic or permit visibility into any user data or packets that such equipment transmits or otherwise handles.

(d) Reporting requirement. (1)In the event the Contractor identifies covered telecommunications equipment or services used as a substantial or essential component of any system, or as critical technology as part of any system, during contract performance, or the Contractor is notified of such by a subcontractor at any tier or by any other source, the Contractor shall report the information in paragraph (d)(2) of this clause to the Contracting Officer, unless elsewhere in this contract are established procedures for reporting the information; in the case of the Department of Defense, the Contractor shall report to the website at https://dibnet.dod.mil. For indefinite delivery contracts, the Contractor shall report to the Contracting Officer for the indefinite delivery contract and the Contracting Officer(s) for any affected order or, in the case of the Department of Defense, identify both the indefinite delivery contract and any affected orders in the report provided at https://dibnet.dod.mil.

(2) The Contractor shall report the following information pursuant to paragraph (d)(1) of this clause

(i) Within one business day from the date of such identification or notification: the contract number; the order number(s), if applicable; supplier name; supplier unique entity identifier (if known); supplier Commercial and Government Entity (CAGE) code (if known); brand; model number (original equipment manufacturer number, manufacturer part number, or wholesaler number); item description; and any readily available information about mitigation actions undertaken or recommended.

(ii) Within 10 business days of submitting the information in paragraph (d)(2)(i) of this clause: any further available information about mitigation actions undertaken or recommended. In addition, the Contractor shall describe the efforts it undertook to prevent use or submission of covered telecommunications equipment or services, and any additional efforts that will be incorporated to prevent future use or submission of covered telecommunications equipment or services.

(e) *Subcontracts.* The Contractor shall insert the substance of this clause, including this paragraph (e) and excluding (b)(2), in all subcontracts and other contractual instruments, including subcontracts for the acquisition of commercial items.

SECTION 5.76
ENSURING ADEQUATE COVID-19 SAFETY PROTOCOLS FOR FEDERAL CONTRACTORS (JAN 2022) (DEVIATION)

(a) Definition. As used in this clause – United States or its outlying areas means—

(1) The fifty States;

(2) The District of Columbia;

(3) The commonwealths of Puerto Rico and the Northern Mariana Islands;

(4) The territories of American Samoa, Guam, and the United States Virgin Islands; and

(5) The minor outlying islands of Baker Island, Howland Island, Jarvis Island, Johnston Atoll, Kingman Reef, Midway Islands, Navassa Island, Palmyra Atoll, and Wake Atoll.

(b) Authority. This clause implements Executive Order 14042, Ensuring Adequate COVID Safety Protocols for Federal Contractors, dated September 9, 2021 (published in the Federal Register on September 14, 2021, 86 FR 50985).

(c) Compliance. The Contractor shall comply with all guidance, including guidance conveyed through Frequently Asked Questions, as amended during the performance of this contract, for contractor or subcontractor workplace locations published by the Safer Federal Workforce Task Force (Task Force Guidance) at https:/www.saferfederalworkforce.gov/contractors/.

(d) Subcontracts. The Contractor shall include the substance of this clause, including this paragraph (d), in subcontracts at any tier that exceed the simplified acquisition threshold, as defined in Federal Acquisition Regulation 2.101 on the date of subcontract award, and are for services, including construction, performed in whole or in part within the United States or its outlying areas.

APPENDIX A

ATTACH

2022 FEHB BROCHURE

APPENDIX B

SUBSCRIPTION RATES, CHARGES, ALLOWANCES AND LIMITATIONS

Fee-For-Service Carrier

(Blue Cross and Blue Shield Association)
CONTRACT NO. CS 1039
Effective January 1, 2022

(a) Biweekly net-to-Carrier rates, with appropriate adjustments for Enrollees paid on other than a biweekly basis, are as follows:

$308.40 Self, $693.04 Self Plus One, and $756.17 Family BASIC Option
$358.01 Self, $782.92 Self Plus One, and $854.08 Family STANDARD Option
$204.40 Self, $439.44 Self Plus One, and $483.37 Family FOCUS Option

(b)The amount of administrative expenses and charges to be included in the Annual Accounting Statement required by Section 3.2 shall be as set out in the schedule below:

Item	Amount
(i) Administrative Expenses	Actual, but not to exceed the Contractual Expense Limitation for 2022,* plus an amount sufficient to cover the costs needed to pay the Plan's Independent Public Accountant to undertake the audits and agreed upon procedures required in the "FEHBP Experienced-Rated Carrier and Service Organization Audit Guide."
(ii) Taxes	Actual (except that premium taxes as defined are not allowable).
(iii) Service Charge**	[redacted]

*The Contractual Expense Limitation for 2022 is [redacted]. Notwithstanding Section 3.2(b) of this Contract, costs of "activities that improve healthcare quality" as determined in accordance with the medical loss ratio provision of the Affordable Care Act (Section 2718 of the Public Health Service act; 42 U.S.C. 300gg-18 and its implementing regulations), are accounted for as benefits and not counted toward the Contractual Expense Limit.

** The Service Charge for the 2022 contract year is based on the Overall Performance Score calculated in accordance with the 2021 Appendix F. The Service Charge for the 2023 contract year will be based on the Overall Performance Score calculated in accordance with the 2022 Appendix F.

APPENDIX C
FEHB Supplemental Literature Guidelines
(RV JAN 2016)

This is the primary guide a Carrier should use to assess whether the Carrier's supplemental marketing literature, including website material, complies with FEHBAR 1603.70, Misleading, Deceptive or Unfair Advertising. (Use the NAIC Guidelines for additional guidance when needed.)

a) GENERAL

1. Section 1.13 of the FEHB contract requires that the Carrier may not distribute or display marketing materials or other supplemental literature (including provider directories) in a Federal or Tribal Employer facility or arrange for the distribution of such documents by Federal agencies or Tribal Employers unless the documents have been prepared in accordance with FEHBAR 1652.203-70, and the Carrier has certified to OPM that is the case.

2. Review supplemental marketing material for compliance each year, whether or not it changed from the past year.

3. Word the literature simply and concisely to get a readily understandable, attractive marketing piece.

4. Include sufficient detail to ensure accuracy.

5. Under the FEHBP, the FEHB brochure is based on text approved by OPM and is a complete statement of benefits, limitations, and exclusions. Include the following statement (website material should include the statement as a preface) in all supplemental literature which in any way discusses Plan benefits:

"This is a summary [or brief description] of the features of the [insert Plan's name]. Before making a final decision, please read the Plan's Federal brochure ([insert brochure number]). All benefits are subject to the definitions, limitations, and exclusions set forth in the Federal brochure."

6. You may include non-FEHBP benefits, i.e., benefits which are not FEHB benefits and are not guaranteed under the Federal contract with the following disclaimer:

"These benefits are neither offered nor guaranteed under contract with the FEHB Program, but are made available to all Enrollees and family members who become members of [insert Plan's name]."

7. Supplemental literature must be clearly distinguishable from the Federal brochure.

8. Do not use the FEHB logo in your supplemental literature.

9. Do not use material which conflicts with the Federal brochure. If your material conflicts, you must change the material or not distribute it.

b) RATE PRESENTATIONS

Under the FEHBP there are only three categories of enrollment, Self Only, Self Plus One, and Self and Family. For most enrollments, the premium for each enrollee's enrollment is shared between the enrollee and the Government or Tribal Employer. The Government or Tribal Employer contribution is based on the formula provided in the FEHB law. Deductions for most enrollees' share, along with the Government's contribution or Tribal Employer's contribution, are made in accordance with the schedule on which the employee, Tribal Employee, or annuitant's (retiree) salary or annuitant check is issued by the Enrollee's agency, Tribal Employer, or annuitant's system. Most employees are paid biweekly. Annuitants are issued monthly checks.

Employees, Tribal Employees, and annuitants do not have separate categories of enrollment. They pay the same rates, whether on a biweekly, semimonthly, or monthly basis, and receive the same benefits when they are in the same FEHB Plan, except that active Postal employees pay a lesser share, as their cost sharing formula with the Postal Service calls for a greater Government contribution.

The Enrollee's share for each FEHB Plan for each type of enrollment (Self Only, Self Plus One, and Self and Family) can be found on the FEHB Program website. Biweekly and monthly rates are also shown on an insert you prepare for your brochure.

In making your rate presentations:

1. With the exception of the Summary of Benefits and Coverage referenced at section 1.13(e), list your FEHB rates in each piece of supplemental material which lists benefits. Do not list the rates of any competitor Plan.
2. Immediately above the rates include the following statement:
"These rates do not apply to all Enrollees. If you are in a special enrollment category, please refer to the FEHB Program website or contact the agency or Tribal Employer which maintains your health benefits enrollment."
3. If you wish to list Postal rates in addition to non-Postal rates, Postal and non-Postal rates should be clearly identified and listed separately. (Please note there are no monthly Postal rates; upon retirement, Postal employees receive the non-postal contribution.)

c) BENEFIT PRESENTATIONS

Please note the following:

1. Do not compare your benefits or operations with that of any other Plan.
2. Accurately describe your FEHB benefits offering.
3. Avoid incomplete or overstated benefit descriptions, or those which conflict with the Federal brochure.
4. Show applicable coverage limitations, such as day or dollar limitations, coinsurance or deductibles.
5. Do not list exclusions and limitations not listed in the Federal brochure.
6. Do not include general references not in the brochure.
7. Do not reference coverage for which a Federal employee, Tribal Employee, or retiree would have to drop FEHB coverage. Exception: 5 CFR 890.301 provides that an annuitant or former spouse, as defined in 5 U.S.C. 8901(10), who cancels FEHBP enrollment for the purpose of enrolling in a prepaid health Plan under sections 1833 or 1876 of the Social Security Act may register to re-enroll. Therefore, if yours is such a prepaid Plan contracting with Medicare you must describe your Medicare supplemental program for Medicare-covered retirees.

d) ENROLLMENT INSTRUCTIONS

Enrollment under the FEHBP is governed solely by the Federal Employees Health Benefits law and applicable regulations. The various Federal agencies and Tribal Employers have responsibility for administering the law and regulations during the annual open enrollment period (Open Season) and at all other times during the year. Agency and Tribal Employer personnel offices perform the basic health benefits functions, such as instructing employees about the conduct of the Open Season and other health benefits matters, answering employee questions, and processing elections and changes of enrollment, including determinations of eligibility and assignment of effective dates of coverage. Agency and Tribal Employer payroll offices make the necessary salary deductions.

The Federal instrument for electing to enroll in a Plan or changing an existing

enrollment in a Plan from Self Only, Self Plus One, or Self and Family to another category of enrollment is the Standard Form (SF) 2809, or alternative electronic or telephonic method approved by OPM. Carriers must be able to accept electronic file transfers. The effective date for Open Season enrollments is the first day of the first pay period which begins on or after January 1 for employees and Tribal Employees; the effective date generally is January 1 for annuitants. The specific effective date for an individual will be assigned by the individual's personnel office.

Covered family members are as defined in the FEHB regulations. Basically, family members are immediate family members, including spouse and children under age 26. When Self and Family coverage is established for an individual, all family members as defined under the regulations are automatically covered as of the effective date assigned by the personnel office, whether or not they are listed on the SF 2809, on other documents, or communicated by electronic or telephonic transmittal. Family members (e.g., newborns) who are added under an existing Self and Family enrollment are automatically covered from the date the individual becomes a family member, e.g., from birth. Personnel offices do not issue any notification when a new dependent is added under an existing Self and Family enrollment and the Enrollee does not submit a new SF 2809 or other election instrument. For a Self Plus One enrollment, the Carrier is required to receive an SF 2809 from the personnel office with enrollment information about the designated covered family member. If an employee wishes to change the designated covered family member to another eligible family member, the Carrier is required to receive a new SF 2809 from the personnel office with enrollment information about the new designated covered family member.

The agencies and Tribal Employers are the primary contact point for employees and Tribal Employees on health benefits enrollment matters. OPM's Office of Retirement Programs performs this function for annuitants (retirees). As highlighted below, Carriers may not impose their own enrollment requirements and procedures.

1. Do not give specific instructions on enrollment.
2. While the Carrier may ask Enrollees for information (see Section f) and may follow-up with Enrollees and, when necessary, the employing office, the Carrier will not require a member complete plan specific enrollment or application forms. (You may ask the Enrollee to complete "information" forms.) You may ask the Enrollee to keep you advised of family member changes and you may verify the change, but failure to complete a form does not render an eligible family member ineligible.
3. Personnel offices will not stock your Plan's forms. Do not indicate otherwise.
4. If supplemental literature is directed to potential members rather than just-enrolled members, do not include statements indicating otherwise.
5. Again, the Federal brochure, rather than any other plan document, is the member's complete statement of benefits. Do not indicate otherwise.

e) PROVIDER DIRECTORIES

The provider directory must conform to the requirements listed below. Carriers must provide access to the provider directory on their website and send a provider directory to any Enrollee who requests one.

Please note that a Federal employee, Tribal Employee, or annuitant choosing your Plan during the Open Season is doing so with the expectation that the Plan's provider directory is accurate and that providers shown will be available starting January 1.

1. Show the Plan's hospitals, individual physicians, and group practice medical facilities. State the addresses of the medical facilities and show the general location within the service area for individual doctors and hospitals.

2. In the directory, display prominently the following statement: "It is important to know when you enroll in this Plan, benefits are available as described in the Plan's Federal brochure, but the continued participation of any one doctor, hospital or other provider cannot be guaranteed."

3. Do not list enrollment or eligibility requirements on the provider directory.

f) INFORMATION FORMS

You may distribute forms to obtain information from Enrollees about the Enrollee and any family members. For instance, to obtain the information regarding Medicare you will need for rate-setting purposes under the Federal Program, you may ask who is enrolled under Medicare Part A, Medicare Part B or Medicare Parts A and B. For another example, you may ask that a primary care doctor be selected. If you wish to distribute an information form, you may find such forms are more readily returned if they are postage-paid. If the Member must select a medical group or independent physician association, also provide space for the Member to make such a selection. Do not indicate enrollment in the Plan is contingent upon completing and returning the form.

APPENDIX D
RULES FOR COORDINATION OF BENEFITS
Model Regulation Service--October 2013
National Association of Insurance Commissioners

When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows:

A. (1) The primary plan shall pay or provide its benefits as if the secondary plan or plans did not exist.

(2) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(3) When multiple contracts providing coordinated coverage are treated as a single plan under this regulation, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one Carrier pays or provides benefits under the plan, the Carrier designated as primary within the plan shall be responsible for the plan's compliance with this regulation.

(4) If a person is covered by more than one secondary plan, the order of benefit determination rules of this regulation decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the rules of this regulation, has its benefits determined before those of that secondary plan.

B. (1) Except as provided in Paragraph (2), a plan that does not contain order of benefit determination provisions that are consistent with this regulation is always the primary plan unless the provisions of both plans, regardless of the provisions of this paragraph, state that the complying plan is primary.

Drafting Note: The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts (often referred to as "med pay"), which is included in the definition of "plan" under Section 3K(3) of this model regulation, does not normally contain order of benefit determinations provisions. As such, unless state law or regulation specifies otherwise, in accordance with paragraph (1), such coverage would be primary. Med pay coverage is not liability coverage and is not dependent upon fault.

(2) Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A plan may take into consideration the benefits paid or provided by another plan only when, under the rules of this regulation, it is secondary to that other plan.

D. Order of Benefit Determination

Each plan determines its order of benefits using the first of the following rules that applies:

(1) Non-Dependent or Dependent

(a) Subject to Subparagraph (b) of this paragraph, the plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

(b) (i) If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(I) Secondary to the plan covering the person as a dependent; and

(II) Primary to the plan covering the person as other than a dependent (e.g. a retired employee),

(ii) Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

Drafting Note: The provisions of Subparagraph (b) address the situation where federal law requires Medicare to be secondary with respect to group health plans in certain situations despite state law order of benefit determination provisions to the contrary. One example of this type of situation arises when a person, who is a Medicare beneficiary, is also covered under his or her own group health plan as a retiree and under a group health plan as a dependent of an active employee. In this situation, each of the three plans is secondary to the other as the following illustrates: (1) Medicare is secondary to the group health plan covering the person as a dependent of an active employee as required pursuant to the Medicare secondary payer rules; (2) the group health plan covering the person as a dependent of an active employee is secondary to the group health plan covering the person as a retiree, as required under Subparagraph (a); and (3) the group health plan covering the

claimant as retiree is secondary to Medicare because the plan is designed to supplement Medicare when Medicare is the primary plan. Subparagraph (b) resolves this problem by making the group health plan covering the person as a dependent of an active employee the primary plan. The dependent coverage pays before the non-dependent coverage even though under state law order of benefit determination provisions in the absence of Subparagraph (b), the non-dependent coverage (e.g. retiree coverage) would be expected to pay before the dependent coverage. Therefore, in cases that involve Medicare, generally, the dependent coverage pays first as the primary plan, Medicare pays second as the secondary plan, and the non-dependent coverage (e.g. retiree coverage) pays third.

The reason why Subparagraph (b) provides for this order of benefits making the plan covering the person as dependent of an active employee primary is because Medicare will not be primary in most situations to any coverage that a dependent has on the basis of active employment and, as such, Medicare will not provide any information as to what Medicare would have paid had it been primary. The plan covering the person as a retiree cannot determine its payment as a secondary plan unless it has information about what the primary plan paid. The plan covering the person as a dependent of an active employee could be subject to penalties under the Medicare secondary payer rules if it refuses to pay its benefits. The plan covering the person as a retiree is not subject to the same penalties because, in this particular situation, as described above, which does not involve a person eligible for Medicare based on end-stage renal disease (ESRD), the plan can never be primary to Medicare. As such, out of the three plans providing coverage to the person, the plan covering the person as a dependent of an active employee can determine its benefits most easily.

(2) Dependent Child Covered Under More Than One Plan

Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(ii) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

(b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any plan year during which benefits

are paid or provided before the entity has actual knowledge of the court decree provision;

(ii)If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(I) The plan covering the custodial parent;

(II) The plan covering the custodial parent's spouse;

(III) The plan covering the non-custodial parent; and then

(IV) The plan covering the non-custodial parent's spouse.

(c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph (a) or (b) of this paragraph as if those individuals were parents of the child.

Drafting Note: Subparagraph (c) addresses the situation where individuals other than the parents of a child are responsible for the child's health care expenses or provide health care coverage for the child under each of their plans. In this situation, for the purpose of determining the order of benefits under this paragraph, Subparagraph (c) requires that these individuals be treated in the same manner as parents of the child.

(d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in Paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the dependent child's parents(s) and the dependent's spouse.

Drafting Note: Subparagraph (d) is intended to address the situation created by the enactment of Section 2714 of the Public Health Service Act, as that section was added by the federal Patient Protection and Affordable Care Act (Public Law 111-148) (ACA), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152). Section 2714 of the PHSA extended coverage for dependents to age 26 regardless of any dependency factors, such as support, residency, student status or marital status.

(3) Active Employee or Retired or Laid-Off Employee

(a) The plan that covers a person as an active employee that is, an employee who is neither laid off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

(b) If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

(c) This rule does not apply if the rule in Paragraph (1) can determine the order of benefits.

Drafting Note: This rule applies only in the situation when the same person is covered under two plans, one of which is provided on the basis of active employment and the other of which is provided to retired or laid-off employees. The rule in Paragraph (1) does not apply because the person is covered either as a non-dependent under both plans (i.e. the person is covered under one plan as an active employee and at the same time is covered as a retired or laid-off employee under the other plan) or as a dependent under both plans (i.e. the person is covered under one plan as a dependent of an active employee and at the same time is covered under the other plan as a dependent of a retired or laid-off employee). This rule does not apply when a person is covered under his or her own plan as an active employee or retired or laid-off employee and a dependent under a spouse's plan provided to the spouse on the basis of active employment. In this situation, the rule in Paragraph (1) applies because the person is covered as a non-dependent under one plan (i.e. the person is covered as an active employee or retired or laid-off employee) and at the same time is covered as a dependent under the other plan (i.e. the person is covered as a dependent under a plan provided on the basis of active employment or a plan that is provided to retired or laid-off employees).

(4) COBRA or State Continuation Coverage

(a) If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

(b) If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(c) This rule does not apply if the rule in Paragraph (1) can determine the order of benefits

Drafting Note: COBRA originally provided that coverage under a new group health plan caused the COBRA coverage to end. An amendment passed as part of P.L. 101-239, the Omnibus Budget Reconciliation Act of 1989 (OBRA 89), allows the COBRA coverage to continue if the newly acquired group health plan contains any preexisting condition exclusion or limitation. In this instance two group health plans will cover the person, and the rule above will be used to determine which of the plans determines its benefits first. In addition, some states have continuation provisions comparable to COBRA.

Drafting Note: This rule applies only in the situation when a person has coverage pursuant to COBRA or under a right of continuation pursuant to state or other federal law and has coverage under another plan on the basis of employment. The rule under Paragraph (1) does not apply because the person is covered either: (a) as a non-dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as an employee or as a retired employee and is covered under his or her own plan as an employee, member, subscriber or retiree); or (b) as a dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as a dependent of an employee, member or subscriber or retired employee and is covered under the other plan as a dependent of an employee, member, subscriber or retiree). The rule under Paragraph (1) applies when the person is covered pursuant to COBRA or under a right of continuation pursuant to state or other federal law as a non-dependent and covered under the other plan as a dependent of an employee, member, subscriber or retiree. The rule in this paragraph does not apply because the person is covered as a non-dependent under one of the plans and as a dependent under the other plan.

(5) Longer or Shorter Length of Coverage

(a) If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

(b) To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.

(c) The start of a new plan does not include:

(i) A change in the amount or scope of a plan's benefits;

(ii) A change in the entity that pays, provides or administers the plan's benefits; or

(iii) A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

(d) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

(6) If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.

APPENDIX E

Small Business Subcontracting Plan (SEP 2021)

(a) This clause does not apply to small business concerns.

(b) *Definitions*. As used in this clause—

"Alaska Native Corporation (ANC)" means any Regional Corporation, Village Corporation, Urban Corporation, or Group Corporation organized under the laws of the State of Alaska in accordance with the Alaska Native Claims Settlement Act, as amended (43 U.S.C. 1601, et seq.) and which is considered a minority and economically disadvantaged concern under the criteria at 43 U.S.C. 1626(e)(1). This definition also includes ANC direct and indirect subsidiary corporations, joint ventures, and partnerships that meet the requirements of 43 U.S.C. 1626(e)(2).

"Commercial item" means a product or service that satisfies the definition of commercial item in Federal Acquisition Regulation (FAR) 2.101.

"Commercial plan" means a subcontracting plan (including goals) that covers the offeror's fiscal year and that applies to the entire production of commercial items sold by either the entire company or a portion thereof (*e.g.,* division, plant, or product line).

"Indian tribe" means any Indian tribe, band, group, pueblo, or community, including native villages and native groups (including corporations organized by Kenai, Juneau, Sitka, and Kodiak) as defined in the Alaska Native Claims Settlement Act (43 U.S.C.A. 1601 et seq.), that is recognized by the Federal Government as eligible for services from the Bureau of Indian Affairs in accordance with 25 U.S.C. 1452(c). This definition also includes Indian-owned economic enterprises that meet the requirements of 25 U.S.C. 1452(e).

"Individual subcontracting plan" means a subcontracting plan that covers the entire contract period (including option periods), applies to a specific contract, and has goals that are based on the offeror's planned subcontracting in support of the specific contract, except that indirect costs incurred for common or joint purposes may be allocated on a prorated basis to the contract.

"Master subcontracting plan" means a subcontracting plan that contains all the required elements of an individual subcontracting plan, except goals, and may be incorporated into individual subcontracting plans, provided the master subcontracting plan has been approved.

"Reduced payment" means a payment that is for less than the amount agreed upon in a subcontract in accordance with its terms and conditions, for supplies and services for which the Government has paid the prime contractor.

"Subcontract" means any agreement (other than one involving an employer-employee relationship) entered into by a Federal Government prime Contractor or subcontractor calling for supplies or services required for performance of the contract or subcontract.

"Total contract dollars" means the final anticipated dollar value, including the dollar value of all options.

"Untimely payment" means a payment to a subcontractor that is more than 90 days past due under the terms and conditions of a subcontract for supplies and services for which the Government has paid the prime contractor.

(c) (1) The Offeror, upon request by the Contracting Officer, shall submit and negotiate a subcontracting plan, where applicable, that separately addresses subcontracting with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business

concerns. If the Offeror is submitting an individual subcontracting plan, the plan must separately address subcontracting with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns, with a separate part for the basic contract and separate parts for each option (if any). The subcontracting plan shall be included in and made a part of the resultant contract. The subcontracting plan shall be negotiated within the time specified by the Contracting Officer. Failure to submit and negotiate the subcontracting plan shall make the Offeror ineligible for award of a contract.

2)(i) The Contractor may accept a subcontractor's written representations of its size and socioeconomic status as a small business, small disadvantaged business, veteran-owned small business, service-disabled veteran-owned small business, or a women-owned small business if the subcontractor represents that the size and socioeconomic status representations with its offer are current, accurate, and complete as of the date of the offer for the subcontract.

(ii) The Contractor may accept a subcontractor's representations of its size and socioeconomic status as a small business, small disadvantaged business, veteran-owned small business, service-disabled veteran-owned small business, or a women-owned small business in the System for Award Management (SAM) if–

(A) The subcontractor is registered in SAM; and

(B) The subcontractor represents that the size and socioeconomic status representations made in SAM are current, accurate and complete as of the date of the offer for the subcontract.

(iii) The Contractor may not require the use of SAM for the purposes of representing size or socioeconomic status in connection with a subcontract.

(iv) In accordance with 13 CFR 121.411, 124.1015, 125.29, 126.900, and 127.700, a contractor acting in good faith is not liable for misrepresentations made by its subcontractors regarding the subcontractor's size or socioeconomic status.

(d) The offeror's subcontracting plan shall include the following:

(1) Separate goals, expressed in terms of total dollars subcontracted, and as a percentage of total planned subcontracting dollars, for the use of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns as subcontractors. For individual subcontracting plans, and if required by the Contracting Officer, goals shall also be expressed in terms of percentage of total contract dollars, in addition to the goals expressed as a percentage of total subcontract dollars. The Offeror shall include all subcontracts that contribute to contract performance, and may include a proportionate share of products and services that are normally allocated as indirect costs. In accordance with 43 U.S.C. 1626–

(i) Subcontracts awarded to an ANC or Indian tribe shall be counted towards the subcontracting goals for small business and small disadvantaged business concerns, regardless of the size or Small Business Administration certification status of the ANC or Indian tribe; and

(ii) Where one or more subcontractors are in the subcontract tier between the prime Contractor and the ANC or Indian tribe, the ANC or Indian tribe shall designate the appropriate Contractor(s) to count the subcontract towards its small business and small disadvantaged business subcontracting goals.

(A) In most cases, the appropriate Contractor is the Contractor that awarded the subcontract to the ANC or Indian tribe.

(B) If the ANC or Indian tribe designates more than one Contractor to count the subcontract toward its goals, the ANC or Indian tribe shall designate only a portion of the total subcontract award to each Contractor. The sum of the amounts designated to various Contractors cannot exceed the total value of the subcontract.

(C) The ANC or Indian tribe shall give a copy of the written designation to the Contracting Officer, the prime Contractor, and the subcontractors in between the prime Contractor and the ANC or Indian tribe within 30 days of the date of the subcontract award.

(D) If the Contracting Officer does not receive a copy of the ANC's or the Indian tribe's written designation within 30 days of the subcontract award, the Contractor that awarded the subcontract to the ANC or Indian tribe will be considered the designated Contractor.

(2) A statement of—

(i) Total dollars planned to be subcontracted for an individual subcontracting plan; or the Offeror's total projected sales, expressed in dollars, and the total value of projected subcontracts, including all indirect costs except as described in paragraph (g) of this clause, to support the sales for a commercial plan;

(ii) Total dollars planned to be subcontracted to small business concerns (including ANC and Indian tribes); and

(iii) Total dollars planned to be subcontracted to veteran-owned small business concerns;

(iv) Total dollars planned to be subcontracted to service-disabled veteran-owned small business;

(v) Total dollars planned to be subcontracted to HUBZone small business concerns;

(vi) Total dollars planned to be subcontracted to small disadvantaged business concerns (including ANC and Indian tribes); and

(vii) Total dollars planned to be subcontracted to women-owned small business concerns

(3) A description of the principal types of supplies and services to be subcontracted, and an identification of the types planned for subcontracting to—

(i) Small business concerns;

(ii) Veteran-owned small business concerns;

(iii) Service-disabled veteran-owned small business concerns;

(iv) HUBZone small business concerns;

(v) Small disadvantaged business concerns; and

(vi) Women-owned small business concerns.

(4) A description of the method used to develop the subcontracting goals in paragraph (d)(1) of this clause.

(5) A description of the method used to identify potential sources for solicitation purposes (*e.g.,* existing company source lists, SAM, veterans service organizations, the National Minority Purchasing Council Vendor Information Service, the Research and Information Division of the Minority Business Development Agency in the Department of Commerce, or small, HUBZone, small disadvantaged, and women-owned small business trade associations). A firm may rely on the information contained in SAM as an accurate representation of a concern's size and ownership characteristics for the purposes of maintaining a small, veteran-owned small, service-disabled veteran-owned small, HUBZone small, small disadvantaged, and women-owned small business source list. Use of SAM as its source list does not relieve a firm of its responsibilities (*e.g.,* outreach, assistance, counseling, or publicizing subcontracting opportunities) in this clause.

(6) A statement as to whether or not the Offeror included indirect costs in establishing subcontracting goals, and a description of the method used to determine the proportionate share of indirect costs to be incurred with—

(i) Small business concerns (including ANC and Indian tribes);

(ii) Veteran-owned small business concerns;

(iii) Service-disabled veteran-owned small business concerns;

(iv) HUBZone small business concerns;

(v) Small disadvantaged business concerns; and

(vi) Women-owned small business concerns.

(7) The name of the individual employed by the Offeror who will administer the Offeror's subcontracting program, and a description of the duties of the individual.

(8) A description of the efforts the Offeror will make to assure that small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns have an equitable opportunity to compete for subcontracts.

(9) Assurances that the Offeror will include the clause of this contract entitled "Utilization of Small Business Concerns" in all subcontracts that offer further subcontracting opportunities, and that the Offeror will require all subcontractors (except small business concerns) that receive subcontracts in excess of the applicable threshold specified in FAR 19.702(a) on the date of subcontract award, with further subcontracting possibilities to adopt a subcontracting plan that complies with the requirements of this clause.

(10) Assurances that the Offeror will—

(i) Cooperate in any studies or surveys as may be required;

(ii) Submit periodic reports so that the Government can determine the extent of compliance by the Offeror with the subcontracting plan;

(iii) After November 30, 2017, include subcontracting data for each order when reporting subcontracting achievements for indefinite-delivery, indefinite-quantity contracts with individual subcontracting plans where the contract is intended for use by multiple agencies;

(iv) Submit Standard Form (SF) 294 Subcontracting Report for Individual Contract in accordance with paragraph (l) of this clause. Submit the Summary Subcontract Report (SSR), in accordance with paragraph (l) of this clause. The reports shall provide information on subcontract awards to small business concerns (including ANCs and Indian tribes that are not small businesses), veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns (including ANCs and Indian tribes that have not been certified by the Small Business Administration as small disadvantaged businesses), women-owned small business concerns, and for NASA only, Historically Black Colleges and Universities and Minority Institutions. Reporting shall be in accordance with this clause, or as provided in agency regulations;

(v) Ensure that its subcontractors with subcontracting plans agree to submit the SF 294 in accordance with paragraph (l) of this clause. Ensure that its subcontractors with subcontracting plans agree to submit the SSR in accordance with paragraph (l) of this clause

(vi) [RESERVED]; and

(vii) Require that each subcontractor with a subcontracting plan provide the prime contract number, its own unique entity identifier, and the e-mail address of the subcontractor's official responsible for acknowledging receipt of or rejecting the Standard Forms 294, to its subcontractors with subcontracting plans.

(11) A description of the types of records that will be maintained concerning procedures that have been adopted to comply with the requirements and goals in the plan, including establishing source lists; and a description of the offeror's efforts to locate small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns and award subcontracts to them. The records shall include at least the following (on a plant-wide or company-wide basis, unless otherwise indicated):

(i) Source lists (*e.g.,* SAM), guides, and other data that identify small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns.

(ii) Organizations contacted in an attempt to locate sources that are small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, or women-owned small business concerns.

(iii) Records on each subcontract solicitation resulting in an award of more than the simplified acquisition threshold, as defined in FAR 2.101 on the date of subcontract award, indicating—

(A) Whether small business concerns were solicited and, if not, why not;

(B) Whether veteran-owned small business concerns were solicited and, if not, why not;

(C) Whether service-disabled veteran-owned small business concerns were solicited and, if not, why not;

(D) Whether HUBZone small business concerns were solicited and, if not, why not;

(E) Whether small disadvantaged business concerns were solicited and, if not, why not;

(F) Whether women-owned small business concerns were solicited and, if not, why not; and

(G) If applicable, the reason award was not made to a small business concern.

(iv) Records of any outreach efforts to contact—

(A) Trade associations;

(B) Business development organizations;

(C) Conferences and trade fairs to locate small, HUBZone small, small disadvantaged service-disabled veteran-owned, and women-owned small business sources; and

(D) Veterans service organizations.

(v) Records of internal guidance and encouragement provided to buyers through—

(A) Workshops, seminars, training, etc.; and

(B) Monitoring performance to evaluate compliance with the program's requirements.

(vi) On a contract-by-contract basis, records to support award data submitted by the offeror to the Government, including the name, address, and business size of each subcontractor. Contractors having commercial plans need not comply with this requirement.

(12) Assurances that the Offeror will make a good faith effort to acquire articles, equipment, supplies, services, or materials, or obtain the performance of construction work from the small business concerns that it used in preparing the bid or proposal, in the same or greater scope, amount, and quality used in preparing and submitting the bid or proposal. Responding to a request for a quote does not constitute use in preparing a bid or proposal. The Offeror used a small business concern in preparing the bid or proposal if–

(i) The Offeror identifies the small business concern as a subcontractor in the bid or proposal or associated small business subcontracting plan, to furnish certain supplies or perform a portion of the subcontract; or

(ii) The Offeror used the small business concern's pricing or cost information or technical expertise in preparing the bid or proposal, where there is written evidence of an intent or understanding that the small business concern will be awarded a subcontract for the related work if the Offeror is awarded the contract.

(13) Assurances that the Contractor will provide the Contracting Officer with a written explanation if the Contractor fails to acquire articles, equipment, supplies, services or materials or obtain the performance of construction work as described in (d)(12) of this clause. This

written explanation must be submitted to the Contracting Officer within 30 days of contract completion.

(14) Assurances that the Contractor will not prohibit a subcontractor from discussing with the Contracting Officer any material matter pertaining to payment to or utilization of a subcontractor.

(15) Assurances that the Offeror will pay its small business subcontractors on time and in accordance with the terms and conditions of the underlying subcontract, and notify the contracting officer when the prime contractor makes either a reduced or an untimely payment to a small business subcontractor (see 52.242-5).

(e) In order to effectively implement this plan to the extent consistent with efficient contract performance, the Contractor shall perform the following functions:

(1) Assist small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns by arranging solicitations, time for the preparation of bids, quantities, specifications, and delivery schedules so as to facilitate the participation by such concerns. Where the Contractor's lists of potential small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business subcontractors are excessively long, reasonable effort shall be made to give all such small business concerns an opportunity to compete over a period of time.

(2) Provide adequate and timely consideration of the potentialities of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns in all "make-or-buy" decisions.

(3) Counsel and discuss subcontracting opportunities with representatives of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business firms.

(4) Confirm that a subcontractor representing itself as a HUBZone small business concern is certified by SBA as a HUBZone small business concern in accordance with 52.219-8(d)(2).

(5) Provide notice to subcontractors concerning penalties and remedies for misrepresentations of business status as small, veteran-owned small business, HUBZone small, small disadvantaged, or women-owned small business for the purpose of obtaining a subcontract that is to be included as part or all of a goal contained in the Contractor's subcontracting plan.

(6) For all competitive subcontracts over the simplified acquisition threshold, as defined in FAR 2.101 on the date of subcontract award, in which a small business concern received a small business preference, upon determination of the successful subcontract Offeror, prior to award of the subcontract the Contractor must inform each unsuccessful small business subcontract Offeror in writing of the name and location of the apparent successful Offeror and if the successful subcontract Offeror is a small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, or women-owned small business concern.

(7) Assign each subcontract the NAICS code and corresponding size standard that best describes the principal purpose of the subcontract.

(f) A master subcontracting plan on a plant or division-wide basis that contains all the elements required by paragraph (d) of this clause, except goals, may be incorporated by reference as a part of the subcontracting plan required of the Offeror by this clause; provided—

(1) The master subcontracting plan has been approved;

(2) The Offeror ensures that the master subcontracting plan is updated as necessary and provides copies of the approved master subcontracting plan, including evidence of its approval, to the Contracting Officer; and

(3) Goals and any deviations from the master subcontracting plan deemed necessary by the Contracting Officer to satisfy the requirements of this contract are set forth in the individual subcontracting plan.

(g) A commercial plan is the preferred type of subcontracting plan for contractors furnishing commercial items. The commercial plan shall relate to the offeror's planned subcontracting generally, for both commercial and Government business, rather than solely to the Government contract. Once the Contractor's commercial plan has been approved, the Government will not require another subcontracting plan from the same Contractor while the plan remains in effect, as long as the product or service being provided by the Contractor continues to meet the definition of a commercial item. A Contractor with a commercial plan shall comply with the reporting requirements stated in paragraph (d)(10) of this clause by submitting one SSR for all contracts covered by its commercial plan. A Contractor authorized to use a commercial subcontracting plan shall include in its subcontracting goals and in its SSR all indirect costs, with the exception of those such as the following: Employee salaries and benefits; payments for petty cash; depreciation; interest; income taxes; property taxes; lease payments; bank fees; fines, claims, and dues; original equipment manufacturer relationships during warranty periods (negotiated up front with the product); utilities and other services purchased from a municipality or an entity solely authorized by the municipality to provide those services in a particular geographical region; and philanthropic contributions. This report shall be acknowledged or rejected by the Contracting Officer who approved the plan. This report shall be submitted within 30 days after the end of the Government's fiscal year.

(h) Prior compliance of the offeror with other such subcontracting plans under previous contracts will be considered by the Contracting Officer in determining the responsibility of the offeror for award of the contract.

(i) A contract may have no more than one subcontracting plan. When a contract modification exceeds the subcontracting plan threshold in 19.702(a), or an option is exercised, the goals of the existing subcontracting plan shall be amended to reflect any new subcontracting opportunities. When the goals in a subcontracting plan are amended, these goal changes do not apply retroactively.

(j) Subcontracting plans are not required from subcontractors when the prime contract contains the clause at 52.212-5, Contract Terms and Conditions Required to Implement Statutes or Executive Orders—Commercial Items, or when the subcontractor provides a commercial item subject to the clause at 52.244-6, Subcontracts for Commercial Items, under a prime contract.

(k)The failure of the Contractor or subcontractor to comply in good faith with—

(1) the clause of this contract entitled "Utilization Of Small Business Concerns," or

(2) an approved plan required by this clause, shall be a material breach of the contract and may be considered in any past performance evaluation of the Contractor.

(l) The Contractor shall submit a SF 294. Purchases from a corporation, company, or subdivision that is an affiliate of the Contractor or subcontractor are not included in these reports. Subcontract awards by affiliates shall be treated as subcontract awards by the Contractor. Subcontract award data reported by the Contractor and subcontractors shall be limited to awards made to their immediate next-tier subcontractors. Credit cannot be taken for awards made to lower tier subcontractors, unless the Contractor or subcontractor has been designated to receive a small business or small disadvantaged business credit from an ANC or Indian tribe. Only subcontracts involving performance in the U.S. or its outlying areas should be included in these

reports with the exception of subcontracts under a contract awarded by the State Department or any other agency that has statutory or regulatory authority to require subcontracting plans for subcontracts performed outside the United States and its outlying areas.

(1) SF 294. This report is not required for commercial plans. The report is required for each contract containing an individual subcontracting plan.

(i) The report shall be submitted semi-annually during contract performance for the periods ending March 31 and September 30. A report is also required for each contract within 30 days of contract completion. Reports are due 30 days after the close of each reporting period, unless otherwise directed by the Contracting Officer. Reports are required when due, regardless of whether there has been any subcontracting activity since the inception of the contract or the previous reporting period. When a Contracting Officer rejects a report, the Contractor shall submit a revised report within 30 days of receiving the notice of report rejection.

(ii) (A) When a subcontracting plan contains separate goals for the basic contract and each option, as prescribed by FAR 19.704(c), the dollar goal inserted on this report shall be the sum of the base period through the current option; for example, for a report submitted after the second option is exercised, the dollar goal would be the sum of the goals for the basic contract, the first option, and the second option.

(B) If a subcontracting plan has been added to the contract pursuant to 19.702(a)(3) or 19.301-2(e), the Contractor's achievements must be reported in the report on a cumulative basis from the date of incorporation of the subcontracting plan into the contract.

(i) When a subcontracting plan includes indirect costs in the goals, these costs must be included in this report.

(ii) The authority to acknowledge receipt or reject the SF 294 resides–

(A) In the case of the prime Contractor, with the Contracting Officer; and

(B) In the case of a subcontract with a subcontracting plan, with the entity that awarded the subcontract.

(2) SSR. (i) Reports submitted under individual contract plans.

(A) This report encompasses all subcontracting under prime contracts and subcontracts with an executive agency, regardless of the dollar value of the subcontracts. This report also includes indirect costs on a prorated basis when the indirect costs are excluded from the subcontracting goals.

(B) The report may be submitted on a corporate, company or subdivision (e.g., plant or division operating as a separate profit center) basis, unless otherwise directed by the agency.

(C) If the Contractor and/or a subcontractor is performing work for more than one executive agency, a separate report shall be submitted to each executive agency covering only that agency's contracts, provided at least one of that agency's contracts is over the applicable threshold specified in FAR 19.702(a), and the contract contains a subcontracting plan. For DoD, a consolidated report shall be submitted for all contracts awarded by military departments/agencies and/or subcontracts awarded by DoD prime contractors.

(D) The report shall be submitted annually by October 30, for the twelve month period ending September 30. When a Contracting Officer rejects an SSR, the Contractor is required to submit a revised SSR within 30 days of receiving the notice of report rejection.

(E) Subcontract awards that are related to work for more than one executive agency shall be appropriately allocated.

(F) The authority to acknowledge or reject SSRs, including SSRs submitted by subcontractors with subcontracting plans, resides with the Government agency awarding the prime contracts unless stated otherwise in the contract.

(ii) Reports submitted under a commercial plan.

(A) The report shall include all subcontract awards under the commercial plan in effect during the Government's fiscal year and all indirect costs.

(B) The report shall be submitted annually, within 30 days after the end of the Government's fiscal year.

(C) If a Contractor has a commercial plan and is performing work for more than one executive agency, the Contractor shall specify the percentage of dollars attributable to each agency.

(D) The authority to acknowledge or reject SSRs for commercial plans resides with the Contracting Officer who approved the commercial plan.

APPENDIX F
Measures and contributions to performance areas and scores for 2022 Performance and 2023 Service Charge

To be performed in accordance with the 2022 FEHB Plan Performance Assessment Procedure Manual and the FEHB Plan Performance Assessment Methodology Carrier Letter (CL 2020-15). The Service Charge for the 2023 contract year will be based on the Overall Performance Score calculated in accordance with this Appendix F.

1. Performance Area Contributions to Overall Performance Score (OPS)

Performance Area	Contribution to Overall Performance Score
Clinical Quality, Customer Service, and Resource Use	65%
Contract Oversight	35%

2. Clinical Quality, Customer Service, and Resource Use (QCR) Performance Area Measures

Performance Area	Measure	Abbrv	Measure Source	Priority Level	Measure Weight
Clinical Quality	Controlling High Blood Pressure	CBP	HEDIS	1	2.50
	Comprehensive Diabetes Care (HbA1c Control <8.0%)	CDC	HEDIS	1	2.50
	Prenatal and Postpartum Care (Timeliness of Prenatal Care)	PPC	HEDIS	1	2.50
	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)	AAB(18-64)	HEDIS	2	1.25
	Asthma Medication Ratio	AMR	HEDIS	2	1.25
	Breast Cancer Screening	BCS	HEDIS	2	1.25
	Cervical Cancer Screening	CCS	HEDIS	2	1.25

	Colorectal Cancer Screening	COL	HEDIS	2	1.25
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dep. (30 Day)	FUA30	HEDIS	2	1.25
	Follow-Up After Emergency Department Visit for Mental Illness (30 Day)	FUM30	HEDIS	2	1.25
	Flu Vaccinations for Adults (18-64)	FVA	CAHPS	2	1.25
	Statin Therapy for Patients with Cardiovascular Disease Statin Adherence 80%	SPC	HEDIS	2	1.25
	Well Child Visits First 30 Months of Life – Well-Child Visits in the First 15 months: 6 or More Well-Child Visits	W30(15)	HEDIS	2	1.25
Customer Service	Coordination of Care	CoC	CAHPS	3	1.00
	Claims Processing	CP	CAHPS	3	1.00
	Getting Care Quickly	GCQ	CAHPS	3	1.00
	Getting Needed Care	GNC	CAHPS	3	1.00
	Overall Health Plan Rating	RHP	CAHPS	3	1.00
	Overall Personal Doctor Rating	RPD	CAHPS	3	1.00
Resource Use	Use of Imaging Studies for Low Back Pain	LBP	HEDIS	1	2.50
	Plan All Cause Readmissions: Observed/Expected (O/E) Ratio	PCR	HEDIS	2	1.25

EXHIBIT C

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Standard Contract Amendment

For

Fee-For-Service Carriers

2018

AMENDMENT TO CONTRACT CS 1039

CONTRACT NO: 1039
EFFECTIVE: January 1, 1960

AMENDMENT NO. 2018A
EFFECTIVE: January 1, 2018

BETWEEN: THE UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
hereafter called the OPM, the Agency, or the Government

Address: 1900 E Street, NW
Washington, DC 20415-3610

AND

CONTRACTOR: Blue Cross and Blue Shield Association
hereafter also called the Carrier

Address: 1310 G. Street, NW, Suite 900
Washington, DC 20005

In consideration of payment by the Agency of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract, including Appendix A.

FOR THE CARRIER

William A. Breskin
Name of Person Authorized to Execute Contract (Type or print)

Senior Vice President, Government Programs
Title

Signature

12/20/17
Date Signed

FOR THE GOVERNMENT

Sylvia V. Pulley
Name of Contracting Officer (Type or print)

Contracting Officer
Health Insurance Group I
Title

Signature

12/26/2017
Date Signed

1. **Section 1.9 Plan Performance—Fee-For-Service Contracts**

Section 1.9 of the FEHB Fee-For-Service Standard Contract must be amended to reflect the updated Fraud, Waste, and Abuse (FWA) reporting requirements established in Carrier Letter 2017-13. The Carrier Letter established these requirements in Attachments 1 and 5 of the Carrier Letter to be utilized beginning with the 2018 contract year.

SECTION 1.9
PLAN PERFORMANCE—FEE-FOR-SERVICE CONTRACTS (JAN 2018)

(a) Detection of Fraud, Waste, and Abuse (FWA). The Carrier shall conduct a program to assess its vulnerability to FWA to include, but not limited to, performing post-payment reviews and audits of providers identified either proactively or reactively. The Carrier shall operate a system designed to detect and eliminate FWA internally by Carrier employees and Subcontractors, by providers providing goods or services to FEHB Members, and by individual FEHB Members. In addition, FEHBP Carriers must demonstrate they have submitted written notification to OPM-OIG within 30 business days of identifying potential FWA issue impacting the FEHB Program regardless of dollar value. The program must specify provisions in place for cost avoidance, not just fraud detection, along with criteria for follow-up actions. The Carrier must submit to OPM an annual analysis of the costs and benefits of its FWA program. The Carrier must submit annual reports to OPM by March 31 addressing the following:

1) Number of Allegations/Complaints Opened/Received;
2) Number of Allegations/Complaints where there is FEHBP Program Exposure;
3) Number of Cases Developed Through Proactive Fraud Prevention/Detection Software;
4) Number of Cases Referred to Local, State, or Federal Law Enforcement/Oversight Agencies;
5) Number of Case Notifications/Referrals Sent to OPM-OIG;
6) Number of Cases Resolved Administratively;
7) Dollars Identified as Loss;
8) Estimated Financial Losses;
9) Non-Recoverable Loss;
10) Dollars Recovered by SIU;
11) Vendor Recoveries;
12) Actual Savings;
13) Prevented Loss;
14) Number of Criminal Convictions;
15) Prepayment Review;
16) Fraudulent Schemes;
17) Fraudulent Geographic Areas;
18) FWA Program Costs;
19) Other Associated Costs of the FWA Program;
20) Return on Investment; and
21) Best Practices

The report will also include the industry standards checklist.

(b) Clinical Care Measures. The Carrier shall measure and/or collect data on the quality of the health care services it provides to its members as requested by OPM. Measurement/data collection efforts may include performance measurement systems such as Healthcare

Effectiveness Data and Information Set (HEDIS), measures developed by the Pharmacy Quality Alliance (PQA), and similar measures developed by accrediting organizations such as, but not limited to, the Association for Ambulatory Health Care (AAAHC), the National Committee for Quality Assurance (NCQA), and URAC or endorsed by the National Quality Forum. Costs incurred by the Carrier for collecting or contracting with a vendor to collect quality measures/data shall be the Carrier's responsibility and are allowable administrative expenses, subject to the administrative cost limitation.

(c) Patient Safety. The Carrier shall implement a patient safety improvement program. At a minimum, the Carrier shall --

(1) Report to OPM on its current patient safety initiatives;

(2) Report to OPM on how it will strengthen its patient safety program for the future;

(3) Assist OPM in providing its Members with consumer information and education regarding patient safety; and

(4) Work with its providers, independent accrediting organizations, and others to implement patient safety improvement programs.

(d) Accreditation. To demonstrate its commitment to providing quality health care, the Carrier shall continue to pursue and maintain accreditation according to the steps and timeframes outlined by OPM. The Carrier shall submit accreditation changes and updates to its OPM contract representative.

(e) Consumer Assessments of Healthcare Providers and Systems (CAHPS). In addition to any other means of surveying Plan members that the Carrier may develop, the Carrier shall participate in the Consumer Assessments of Healthcare Providers and Systems (CAHPS) to provide feedback to Enrollees on Enrollee experience with the various FEHBP plans. The Carrier shall take into account the published results of the survey, or other results as directed by OPM, in identifying areas for improvement as part of the Carrier's quality assurance program. Payment of survey charges will be in accordance with Section 3.11.

(f) Contract Quality Assurance. The Carrier shall develop and apply a quality assurance program specifying procedures for assuring contract quality. At a minimum the Carrier shall meet the following standards and submit an annual report to OPM on these standards by July 1 of the following contract period:

(1) *Claims Processing Accuracy* - the number of FEHB claims processed accurately and the total number of FEHB claims processed for the given time period, expressed as a percentage.

REQUIRED STANDARD: An average of 95 percent of FEHB claims must be processed accurately.

(2) *Claims Coding Accuracy* - the number of FEHB claims coded accurately divided by the total number of FEHB claims coded for the given time period, expressed as a percentage.

REQUIRED STANDARD: An average of 98 percent of FEHB claims shall be coded accurately.

(3) *Recovery of Erroneous Payments* - the average number of working days it takes for the Carrier to begin collection action against an FEHB provider or member following identification of an erroneous payment, including overpayments.

REQUIRED STANDARD: The Carrier takes an average of no more than 30 working days from the date it identifies an FEHB erroneous payment to the date it begins the collection action.

(4) *Coordination of Benefits (COB)* - the Carrier must demonstrate that a statistically valid sampling technique is routinely used to identify FEHB claims prior to or after processing that require(d) coordination of benefits (COB) with a third party payer. As an alternative, the Carrier may provide evidence that it pursues all claims for COB.

(5) *Claims Timeliness* - the average number of working days from the date the Carrier receives an FEHB claim to the date it adjudicates it (paid, denied or a request for further information is sent out), for the given time period, expressed as a cumulative percentage.

REQUIRED STANDARD: The Carrier adjudicates 95 percent of claims within 30 working days.

(6) *Processing ID cards on change of plan or option* - the number of calendar days from the date the Carrier receives the enrollment from the Enrollee's agency, Tribal Employer, or retirement system to the date it issues the ID card.

REQUIRED STANDARD: The Carrier issues the ID card within fifteen calendar days after receiving the enrollment from the Enrollee's agency, Tribal Employer, or retirement system except that the Carrier will issue ID cards resulting from an open season election within fifteen calendar days or by December 15, whichever is later.

(7) *Member Inquiries* - the number of working days taken to respond to an FEHB member's written inquiry, expressed as a cumulative percentage, for the given time period.

REQUIRED STANDARD: The Carrier responds to 90 percent of inquiries within 15 working days (including internet inquiries).

(8) *Written Inquiries Accuracy* – the number of FEHB written inquiries handled accurately divided by the total number of FEHB written inquiries handled for the given time period, expressed as a percentage.

REQUIRED STANDARD: A minimum of 97 percent of FEHB written inquiries shall be answered accurately.

(9) *Telephone Inquiries Accuracy* – the number of FEHB telephone inquiries handled accurately divided by the total number of FEHB telephone inquiries handled for the given time period, expressed as a percentage.

REQUIRED STANDARD: A minimum of 97 percent of FEHB telephone inquiries shall be answered accurately.

(10) *Internet Inquiries Accuracy* – the number of FEHB Internet inquiries handled accurately divided by the total number of FEHB Internet inquiries handled for the given time period, expressed as a percentage.

REQUIRED STANDARD: A minimum of 97 percent of FEHB Internet inquiries shall be answered accurately.

(11) *Telephone Access* - the Carrier shall report on the following statistics concerning telephone access to the member services department (or its equivalent) for the given time period. Except that, if the Carrier does not have a computerized phone system, report results of periodic surveys on telephone access.

(i) Call Answer Timeliness - the average number of seconds elapsing before the Carrier connects a member's telephone call to its service representative.

REQUIRED STANDARD: On average, no more than 30 seconds elapse before the Carrier connects a member's telephone call to its service representative.

(ii) Telephone Blockage Rate - the percentage of time that callers receive a busy signal when calling the Carrier.

REQUIRED STANDARD: No more than 5 percent of callers receive a busy signal.

(iii) Telephone Abandonment Rate - the number of calls attempted but not completed (presumably because callers tired of waiting to be connected to a Carrier representative) divided by the total number of calls attempted (both completed and not completed), expressed as a percentage.

REQUIRED STANDARD: On average, Enrollees abandon the effort no more than 5 percent of the time.

(*iv*) *Initial Call Resolution* – the percentage of issues resolved during the initial call.

REQUIRED STANDARD: On average, caller's issues must be resolved during the initial call at least 80 percent of the time.

(12) *Responsiveness to FEHB Member Requests for Reconsideration*:

REQUIRED STANDARD: For 100 percent of written FEHB disputed claim requests received for the given time period, within 30 days after receipt by the Carrier, the Carrier shall affirm the denial in writing to the FEHB member, pay the claim, provide or authorize coverage of the service, or request additional information reasonably necessary to make a determination.

(g) Quality Assurance Plan. The Carrier must demonstrate that a statistically valid sampling technique is routinely used prior to or after processing to randomly sample FEHB claims against Carrier quality assurance/fraud and abuse prevention standards.

(h) Reporting Compliance. The Carrier shall keep complete records of its quality assurance procedures and fraud prevention program and the results of their implementation and make them available to the Government as determined by OPM.

(i) FEHB Clearinghouse (CLER). The Carrier shall not have any CLER records with a 160 error code and a fail count of four or higher. A '160' error is when a Carrier reports an enrollment but no agency or Tribal Employer reports that enrollment.

(j) Correction of Deficiencies. The Contracting Officer may order the correction of a deficiency in the Carrier's quality assurance program or fraud prevention program. The Carrier shall take the necessary action promptly to implement the Contracting Officer's order. If the Contracting Officer orders a modification of the Carrier's quality assurance program or fraud prevention program pursuant to this paragraph (j) after the contract year has begun, the costs incurred to correct the deficiency may be excluded from the administrative expenses -- for the contract year -- that are subject to the administrative expenses limitation specified at Appendix B; provided the Carrier demonstrates that the correction of the deficiency significantly increases the Carrier's liability under this contract.

(k) In order to allow sufficient implementation time, the Contracting Officer will notify the Carrier reasonably in advance of any new requirement(s) under paragraphs (a) through (j).

2. Section 5.14 Utilization of Small Business Concerns

Subsection (a), and (d) were amended in accordance to November 2016 FAR Clause FAR 52.219-8. The contractor may accept the written representation of the subcontractor size and socioeconomic status if certain requirements are met.

SECTION 5.14
UTILIZATION OF SMALL BUSINESS CONCERNS (NOV 2016) (FAR 52.219-8)

(a) Definitions. As used in this contract --

"HUBZone small business concern" means a small business concern, certified by the Small Business Administration, that appears on the List of Qualified HUBZone Small Business Concerns maintained by the Small Business Administration.
"Service-disabled veteran-owned small business concern"
(1) Means a small business concern–
(i) Not less than 51 percent of which is owned by one or more service-disabled veterans or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more service-disabled veterans; and
(ii) The management and daily business operations of which are controlled by one or more service-disabled veterans or, in the case of a service-disabled veteran with permanent and severe disability, the spouse or permanent caregiver of such veteran.
(2) Service-disabled veteran means a veteran, as defined in 38 U.S.C. 101(2), with a disability that is service-connected, as defined in 38 U.S.C. 101(16).
"Small business concern" means a small business as defined pursuant to Section 3 of the Small Business Act and relevant regulations promulgated pursuant thereto.
"Small disadvantaged business concern", consistent with 13 CFR 124.1002, means a small business concern under the size standard applicable to the acquisition, that--
(1) Is at least 51 percent unconditionally and directly owned (as defined at 13 CFR 124.105) by—
(i) One or more socially disadvantaged (as defined at 13 CFR 124.103) and economically disadvantaged (as defined at 13 CFR 124.104) individuals who are citizens of the United States; and
(ii) Each individual claiming economic disadvantage has a net worth not exceeding $750,000 after taking into account the applicable exclusions set forth at 13 CFR 124.104(c)(2); and
(2) The management and daily business operations of which are controlled (as defined at 13.CFR 124.106) by individuals, who meet the criteria in paragraphs (1)(i) and (ii) of this definition.
"Veteran-owned small business concern" means a small business concern–
(1) Not less than 51 percent of which is owned by one or more veterans (as defined at 38 U.S.C. 101(2)) or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more veterans; and
(2) The management and daily business operations of which are controlled by one or more veterans.
"Women-owned small business concern" means a small business concern–
(1) That is at least 51 percent owned by one or more women, or, in the case of any publicly owned business, at least 51 percent of the stock of which is owned by one or more women; and

(2) Whose management and daily business operations are controlled by one or more women.
(b) It is the policy of the United States that small business concerns, veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns, and women-owned small business concerns shall have the maximum practicable opportunity to participate in performing contracts let by any Federal agency, including contracts and subcontracts for subsystems, assemblies, components, and related services for major systems. It is further the policy of the United States that its prime contractors establish procedures to ensure the timely payment of amounts due pursuant to the terms of their subcontracts with small business concerns, veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small

business concerns, small disadvantaged business concerns, and women-owned small business concerns.
(c) The Contractor hereby agrees to carry out this policy in the awarding of subcontracts to the fullest extent consistent with efficient contract performance. The Contractor further agrees to cooperate in any studies or surveys as may be conducted by the United States Small Business Administration or the awarding agency of the United States as may be necessary to determine the extent of the Contractor's compliance with this clause.
(d)(1) The Contractor may accept a subcontractor's written representations of its size and socioeconomic status as a small business, small disadvantaged business, a veteran-owned small business, service-disabled veteran-owned small business or a women-owned small business if the subcontractor represents that the size and socioeconomic status representations with its offer are current, accurate, and complete as of the date of the offer for the subcontract.
(2) The Contractor may accept a subcontractor's representations of its size and socioeconomic status as a small business, small disadvantaged business, veteran-owned small business, service-disabled veteran-owned small business, or a women-owned small business in the System for Award Management (SAM) if–
(i) The subcontractor is registered in SAM; and
(ii) The subcontractor represents that the size and socioeconomic status representations made in SAM are current, accurate and complete as of the date of the offer for the subcontract.
(3) The Contractor may not require the use of SAM for the purposes of representing size or socioeconomic status in connection with a subcontract.
(4) In accordance with 13 CFR 121.411, 124.1015, 125.29, 126.900, and 127.700, a contractor acting in good faith is not liable for misrepresentations made by its subcontractors regarding the subcontractor's size or socioeconomic status.
(5) The Contractor shall confirm that a subcontractor representing itself as a HUBZone small business concern is certified by SBA as a HUBZone small business concern by accessing the System for Award Management database or by contacting the SBA. Options for contacting the SBA include—
(i) HUBZone small business database search application web page at http://dsbs.sba.gov/dsbs/search/dsp_searchhubzone.cfm; or http://www.sba.gov/hubzone;
(ii) In writing to the Director/HUB, U.S. Small Business Administration, 409 3rd Street, SW., Washington, DC 20416; or
(iii) The SBA HUBZone Help Desk at hubzone@sba.gov.

3. **Section 5.19 Equal Opportunity**

Subsections (a) and (c)(5) were amended in accordance to the September 2016 FAR Clause 52.222-26. Definitions for "Compensation", "Compensation information" and "Essential job functions" are now included in the amended FAR clause. Language has been added to prohibit the Contractor from discharging or discriminating against an employee or applicant based on certain activities regarding disclosure of compensation.

SECTION 5.19
EQUAL OPPORTUNITY (SEP 2016) (FAR 52.222-26)

(a) Definition. As used in this clause

"Compensation" means any payments made to, or on behalf of, an employee or offered to an applicant as remuneration for employment, including but not limited to salary, wages, overtime pay, shift differentials, bonuses, commissions, vacation and holiday pay, allowances, insurance and other benefits, stock options and awards, profit sharing, and retirement.
"Compensation information" means the amount and type of compensation provided to employees or offered to applicants, including, but not limited to, the desire of the Contractor to attract and retain a particular employee for the value the employee is perceived to add to the Contractor's profit or productivity; the availability of employees with like skills in the marketplace; market research about the worth of similar jobs in the relevant marketplace; job analysis, descriptions, and evaluations; salary and pay structures; salary surveys; labor union agreements; and Contractor decisions, statements and policies related to setting or altering employee compensation.
"Essential job functions" means the fundamental job duties of the employment position an individual holds. A job function may be considered essential if–
(1) The access to compensation information is necessary in order to perform that function or another routinely assigned business task; or
(2) The function or duties of the position include protecting and maintaining the privacy of employee personnel records, including compensation information.
"Gender identity" has the meaning given by the Department of Labor's Office of Federal Contract Compliance Programs, and is found at www.dol.gov/ofccp/LGBT/LGBT_FAQs.html.
"Sexual orientation" has the meaning given by the Department of Labor's Office of Federal Contract Compliance Programs, and is found at www.dol.gov/ofccp/LGBT/LGBT_FAQs.html.
"United States," means the 50 States, the District of Columbia, Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, the U.S. Virgin Islands, and Wake Island.
(b)(1) If, during any 12-month period (including the 12 months preceding the award of this contract), the Contractor has been or is awarded nonexempt Federal contracts and/or subcontracts that have an aggregate value in excess of $10,000, the Contractor shall comply with this clause, except for work performed outside the United States by employees who were not recruited within the United States. Upon request, the Contractor shall provide information necessary to determine the applicability of this clause.
(2) If the Contractor is a religious corporation, association, educational institution, or society, the requirements of this clause do not apply with respect to the employment of individuals of a particular religion to perform work connected with the carrying on of the Contractor's activities (41 CFR 60-1.5).
(c)(1) The Contractor shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, sexual orientation, gender identity, or national origin. However, it shall not be a violation of this clause for the Contractor to extend a publicly announced preference in employment to Indians living on or near an Indian reservation, in connection with employment opportunities on or near an Indian reservation, as permitted by 41 CFR 60-1.5.
(2) The Contractor shall take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, sexual orientation, gender identity, or national origin. This shall include, but not be limited to—
(i) Employment;
(ii) Upgrading;
(iii) Demotion;
(iv) Transfer;

(v) Recruitment or recruitment advertising;
(vi) Layoff or termination;
(vii) Rates of pay or other forms of compensation; and
(viii) Selection for training, including apprenticeship.
(3) The Contractor shall post in conspicuous places available to employees and applicants for employment the notices to be provided by the Contracting Officer that explain this clause.
(4) The Contractor shall, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, or national origin.
(5) (i) The Contractor shall not discharge or in any other manner discriminate against any employee or applicant for employment because such employee or applicant has inquired about, discussed, or disclosed the compensation of the employee or applicant or another employee or applicant. This prohibition against discrimination does not apply to instances in which an employee who has access to the compensation information of other employees or applicants as a part of such employee's essential job functions discloses the compensation of such other employees or applicants to individuals who do not otherwise have access to such information, unless such disclosure is in response to a formal complaint or charge, in furtherance of an investigation, proceeding, hearing, or action, including an investigation conducted by the employer, or is consistent with the Contractor's legal duty to furnish information.
(ii) The Contractor shall disseminate the prohibition on discrimination in paragraph (c)(5)(i) of this clause, using language prescribed by the Director of the Office of Federal Contract Compliance Programs (OFCCP), to employees and applicants by–
(A) Incorporation ~~into exis~~ting employee manuals or handbooks; and
(B) Electronic posting or by posting a copy of the provision in conspicuous places available to employees and applicants for employment.
(6) The Contractor shall send, to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, the notice to be provided by the Contracting Officer advising the labor union or workers' representative of the Contractor's commitments under this clause, and post copies of the notice in conspicuous places available to employees and applicants for employment.
(7) The Contractor shall comply with Executive Order 11246, as amended, and the rules, regulations, and orders of the Secretary of Labor.
(8) The Contractor shall furnish to the contracting agency all information required by Executive Order 11246, as amended, and by the rules, regulations, and orders of the Secretary of Labor. The Contractor shall also file Standard Form 100 (EEO-1), or any successor form, as prescribed in 41 CFR Part 60-1. Unless the Contractor has filed within the 12 months preceding the date of contract award, the Contractor shall, within 30 days after contract award, apply to either the regional Office of Federal Contract Compliance Programs (OFCCP) or the local office of the Equal Employment Opportunity Commission for the necessary forms.
(9) The Contractor shall permit access to its premises, during normal business hours, by the contracting agency or the OFCCP for the purpose of conducting on-site compliance evaluations and complaint investigations. The Contractor shall permit the Government to inspect and copy any books, accounts, records (including computerized records), and other material that may be relevant to the matter under investigation and pertinent to compliance with Executive Order 11246, as amended, and rules and regulations that implement the Executive Order.

(10) If the OFCCP determines that the Contractor is not in compliance with this clause or any rule, regulation, or order of the Secretary of Labor, this contract may be canceled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further Government contracts, under the procedures authorized in Executive Order 11246, as amended. In addition, sanctions may be imposed and remedies invoked against the Contractor as provided in Executive Order 11246, as amended; in the rules, regulations, and orders of the Secretary of Labor; or as otherwise provided by law.
(11) The Contractor shall include the terms and conditions of this clause in every subcontract or purchase order that is not exempted by the rules, regulations, or orders of the Secretary of Labor issued under Executive Order 11246, as amended, so that these terms and conditions will be binding upon each subcontractor or vendor.
(12) The Contractor shall take such action with respect to any subcontract or purchase order as the Contracting Officer may direct as a means of enforcing these terms and conditions, including sanctions for noncompliance, provided, that if the Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of any direction, the Contractor may request the United States to enter into the litigation to protect the interests of the United States.
(d) Notwithstanding any other clause in this contract, disputes relative to this clause will be governed by the procedures in 41 CFR part 60-1.

4. **Section 5.60 Subcontracts for Commercial Items**

Subsection (c)(1) requires prohibitions on whistleblowing to flow down to subcontracts. Additionally, the ~~Fair Pay and~~ Safe Workspaces rule was required by Congress to have no force or effect.

SECTION 5.60
SUBCONTRACTS FOR COMMERCIAL ITEMS (NOV 2017) (FAR 52.244-6)

(a) Definitions. As used in this clause —
"Commercial item" and "commercially available off-the-shelf item" have the meanings contained in Federal Acquisition Regulation 2.101, Definitions.
"Subcontract" includes a transfer of commercial items between divisions, subsidiaries, or affiliates of the Contractor or subcontractor at any tier.
(b) To the maximum extent practicable, the Contractor shall incorporate, and require its subcontractors at all tiers to incorporate, commercial items or non-developmental items as components of items to be supplied under this contract.
(c)(1) The Contractor shall insert the following clauses in subcontracts for commercial items:
(i) 52.203-13, Contractor Code of Business Ethics and Conduct (Oct 2015) (41 U.S.C. 3509), if the subcontract exceeds $5.5 million and has a performance period of more than 120 days. In altering this clause to identify the appropriate parties, all disclosures of violation of the civil False Claims Act or of Federal criminal law shall be directed to the agency Office of the Inspector General, with a copy to the Contracting Officer.
(ii) 52.203-15, Whistleblower Protections Under the American Recovery and Reinvestment Act of 2009 (Jun 2010) (Section 1553 of Pub. L. 111-5), if the subcontract is funded under the Recovery Act.

(iii) 52.203-19, Prohibition on Requiring Certain Internal Confidentiality Agreements or Statements (JAN 2017).
(iv) 52.204–21, Basic Safeguarding of Covered Contractor Information Systems (June, 2016), other than subcontracts for commercially available off-the-shelf items, if flow down is required in accordance with paragraph (c) of FAR clause 52.204–21.
(v) 52.219-8, Utilization of Small Business Concerns (Nov 2014) (15 U.S.C. 637(d)(2) and (3)), if the subcontract offers further subcontracting opportunities. If the subcontract (except subcontracts to small business concerns) exceeds $700,000 ($1.5 million for construction of any public facility), the subcontractor must include 52.219-8 in lower tier subcontracts that offer subcontracting opportunities.
(vi) 52.222-21 Prohibition of Segregated Facilities (Apr 2015)
(vii) 52.222-26, Equal Opportunity (Apr 2015) (E.O. 11246).
(viii) 52.222-35, Equal Opportunity for Veterans (Oct 2015) (38 U.S.C. 4212(a).
(ix) 52.222-36, Equal Opportunity for Workers with Disabilities (Jul 2014) (29 U.S.C. 793).
(x) 52.222-37, Employment Reports on Veterans (Feb 2016) (38 U.S.C. 4212).
(xi) 52.222-40, Notification of Employee Rights Under the National Labor Relations Act (Dec 2010) (E.O. 13496), if flow down is required in accordance with paragraph (f) of FAR clause 52.222-40.
(xii)(A) 52.222-50, Combating Trafficking in Persons (Mar 2015) (22 U.S.C. chapter 78 and E.O. 13627).
(B) Alternate I (MAR 2015) of 52.222-50 (22 U.S.C. chapter 78 and E.O. 13627).
(xiii) 52.222-55, Minimum Wages under Executive Order 13658 (Dec 2015), if flow down is required in accordance with paragraph (k) of FAR clause 52.222-55.
(xiv) 52.222-62, Paid Sick Leave Under Executive Order 13706 (Jan 2017) (E.O. 13706), if flowdown is required in accordance with paragraph (m) of FAR clause 52.222-62.
(xv)(A) 52.224-3, Privacy Training (Jan 2017) (5 U.S.C. 552a) if flow down is required in accordance with 52.224-3(f).
(B) Alternate I (Jan 2017) of 52.224-3, if flow down is required in accordance with 52.224-3(f) and the agency specifies that only its agency-provided training is acceptable).
(xvi) 52.225-26, Contractors Performing Private Security Functions Outside the United States (Oct 2016) (Section 862, as amended, of the National Defense Authorization Act for Fiscal Year 2008; 10 U.S.C. 2302 Note).
(xvii) 52.232-40, Providing Accelerated Payments to Small Business Subcontractors (Dec 2013), if flow down is required in accordance with paragraph (c) of FAR clause 52.232-40.
(xviii) 52.247-64, Preference for Privately Owned U.S.-Flag Commercial Vessels (Feb 2006) (46 U.S.C. App. 1241 and 10 U.S.C. 2631), if flow down is required in accordance with paragraph (d) of FAR clause 52.247-64).
(2) While not required, the Contractor may flow down to subcontracts for commercial items a minimal number of additional clauses necessary to satisfy its contractual obligations.
(d) The Contractor shall include the terms of this clause, including this paragraph (d), in subcontracts awarded under this contract.

5. <u>Section 5.63 System for Award Management</u>

Subsections (a), (b), and (c) were amended in accordance to the October 2016 FAR Clause 52.204-7. The System for Awards Management has revised the numbers used for contractors' unique entity identifier.

SECTION 5.63
SYSTEM FOR AWARD MANAGEMENT (OCT 2016) (FAR 52.204-7)

(a) Definitions. As used in this provision—
"Electronic Funds Transfer (EFT) indicator" means a four-character suffix to the unique entity identifier. The suffix is assigned at the discretion of the commercial, nonprofit, or Government entity to establish additional System for Award Management records for identifying alternative EFT accounts (see subpart 32.11) for the same entity.
"Registered in the System for Award Management (SAM) database" means that—
(1) The Offeror has entered all mandatory information, including the unique entity identifier and the EFT indicator, if applicable, the Commercial and Government Entity (CAGE) code, as well as data required by the Federal Funding Accountability and Transparency Act of 2006 (see subpart 4.14) into the SAM database;
(2) The Offeror has completed the Core, Assertions, and Representations and Certifications, and Points of Contact sections of the registration in the SAM database;
(3) The Government has validated all mandatory data fields, to include validation of the Taxpayer Identification Number (TIN) with the Internal Revenue Service (IRS). The Offeror will be required to provide consent for TIN validation to the Government as a part of the SAM registration process; and
(4) The Government has marked the record "Active".
"Unique entity identifier" means a number or other identifier used to identify a specific commercial, nonprofit, or Government entity. See www.sam.gov for the designated entity for establishing unique entity identifiers.
(b)(1) By submission of an offer, the Offeror acknowledges the requirement that a prospective awardee shall be registered in the SAM database prior to award, during performance, and through final payment of any contract, basic agreement, basic ordering agreement, or blanket purchasing agreement resulting from this solicitation.
(2) The Offeror shall enter, in the block with its name and address on the cover page of its offer, the annotation "Unique Entity Identifier" followed by the unique entity identifier that identifies the Offeror's name and address exactly as stated in the offer. The Offeror also shall enter its EFT indicator, if applicable. The unique entity identifier will be used by the Contracting Officer to verify that the Offeror is registered in the SAM database.
(c) If the Offeror does not have a unique entity identifier, it should contact the entity designated at www.sam.gov for establishment of the unique entity identifier directly to obtain one.
The Offeror should be prepared to provide the following information:
(1) Company legal business name.
(2) Tradestyle, doing business, or other name by which your entity is commonly recognized.
(3) Company Physical Street Address, City, State, and Zip Code.
(4) Company Mailing Address, City, State and Zip Code (if separate from physical).
(5) Company telephone number.
(6) Date the company was started.
(7) Number of employees at your location.
(8) Chief executive officer/key manager.
(9) Line of business (industry).
(10) Company Headquarters name and address (reporting relationship within your entity).

(d) If the Offeror does not become registered in the SAM database in the time prescribed by the Contracting Officer, the Contracting Officer will proceed to award to the next otherwise successful registered Offeror.
(e) Processing time, which normally takes 48 hours, should be taken into consideration when registering. Offerors who are not registered should consider applying for registration immediately upon receipt of this solicitation.
(f) Offerors may obtain information on registration at https://www.acquisition.gov.

6. **Section 5.73 Prohibition on Requiring Certain Internal Confidentiality Agreements or Statements**

OPM is adding this contract section to Carrier contracts to prohibit restrictions on whistleblowing to the Federal Government and to facilitate flow down into Carrier subcontracts as required by FAR clause 52.244-6.

SECTION 5.73
PROHIBITION ON REQUIRING CERTAIN INTERNAL CONFIDENTIALITY AGREEMENTS OR STATEMENTS (JAN 2017) (FAR 52.203-19)

(a) *Definitions*. As used in this clause–

"Internal confidentiality agreement or statement" means a confidentiality agreement or any other written statement that the contractor requires any of its employees or subcontractors to sign regarding nondisclosure of contractor information, except that it does not include confidentiality agreements arising out of civil litigation or confidentiality agreements that contractor employees or subcontractors sign at the behest of a Federal agency.

"Subcontract" means any contract as defined in subpart 2.1 entered into by a subcontractor to furnish supplies or services for performance of a prime contract or a subcontract. It includes but is not limited to purchase orders, and changes and modifications to purchase orders.

"Subcontractor" means any supplier, distributor, vendor, or firm (including a consultant) that furnishes supplies or services to or for a prime contractor or another subcontractor.

(b) The Contractor shall not require its employees or subcontractors to sign or comply with internal confidentiality agreements or statements prohibiting or otherwise restricting such employees or subcontractors from lawfully reporting waste, fraud, or abuse related to the performance of a Government contract to a designated investigative or law enforcement representative of a Federal department or agency authorized to receive such information (*e.g.*, agency Office of the Inspector General).

(c) The Contractor shall notify current employees and subcontractors that prohibitions and restrictions of any preexisting internal confidentiality agreements or statements covered by this clause, to the extent that such prohibitions and restrictions are inconsistent with the prohibitions of this clause, are no longer in effect.

(d) The prohibition in paragraph (b) of this clause does not contravene requirements applicable to Standard Form 312 (Classified Information Nondisclosure Agreement), Form

4414 (Sensitive Compartmented Information Nondisclosure Agreement), or any other form issued by a Federal department or agency governing the nondisclosure of classified information.

(e) In accordance with section 743 of Division E, Title VII, of the Consolidated and Further Continuing Appropriations Act, 2015, (Pub. L. 113-235), and its successor provisions in subsequent appropriations acts (and as extended in continuing resolutions) use of funds appropriated (or otherwise made available) is prohibited, if the Government determines that the Contractor is not in compliance with the provisions of this clause.

(f) The Contractor shall include the substance of this clause, including this paragraph (f), in subcontracts under such contracts.

Part IV-SPECIAL PROVISIONS is deleted and replaced with the following:

SECTION 4.1
ALTERATIONS IN CONTRACT (JAN 2014) (FAR 52.252-4)

Portions of this contract are altered as follows:

(a) Section 1.6 Confidentiality of Records. The following subsection is added:

(d) Local Blue Cross and/or Blue Shield Plans may combine the personal data and medical records of Federal subscribers, and information relating thereto, with the same information of other individuals who have health benefits coverage under the Local Blue Cross and/or Blue Shield Plan. This combined data may only be used and disclosed for the Plan's health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501). Such activities include, but are not limited to: care management; prevention, detection, and recovery of funds subject to fraud and abuse; and negotiation of provider contracts.

(e) As used in subsection (b)(1) of this section, "administration of this contract" means health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501).

(b) Section 1.9 Plan Performance—Experience-Rated FFS Contracts.

The Carrier may use the appropriate systems for measurement and/or collection of data on the quality of the health care services as described in subparagraph 1.9(b).

(c) Section 1.14, Misleading, Deceptive, or Unfair Advertising, is amended by removing the reference to the NAIC Advertisements of Accident and Sickness Insurance Model Regulation (Appendix D-b). Carrier should continue to use the FEHB Supplemental Literature Guidelines (now at the renumbered Appendix C) along with FEHBAR 1603.7002.

(d) Section 1.15 Renewal and Withdrawal of Approval (FEHBAR). The following subsections are added:

(d) If the agency suspends payment of the subscription charges for any reason, the Carrier may (1) suspend making benefit payments until payment of all subscription charges due is fully restored; or (2) terminate the contract without prior notice.

(e) Section 1.21 Patient Bill of Rights. For the purpose of compliance with this Section, the Carrier will conduct the following minimum activities: (1) the Carrier will provide subscribers with a Fact Sheet that includes information about the disenrollment rate in the Blue Cross and Blue Shield Service Benefit Plan, as well as Local Plan-specific information including compliance with Federal and State financial requirements, public corporate information, years in existence, and accreditation status; (2) Provider

Directories will include language advising subscribers to contact their providers directly to obtain information about the providers, including but not limited to board certifications, languages spoken, availability of interpreters, facility accessibility, and whether the provider is accepting new patients.

(f) Section 1.30 Health Information Technology Privacy and Security. Subsections (b) and (c) of Section 1.30 are amended to read as follows:

(b) The Carrier will promote consumer transparency by ensuring that at the point where the Federal member enters the subcontractor's, large provider's, or vendor's website or web portal the link to the subcontractor's, large provider's, or vendor's notice of privacy practices and/or privacy policies is displayed on the bottom, or prominently displayed elsewhere, on the website or web portal.

(c) Notice of privacy practices and/or privacy policies disclosures must describe the uses of individually identifiable protected health information and any potential disclosure to other entities as described in the HIPAA Privacy Rule.

(g) Section 2.2 Benefits Provided. The following paragraph is added to subsection 2.2(a):

(4) The Carrier may pay the Preferred Provider Organization level of benefits under this contract to ease the hardship of members affected by natural disasters such as earthquakes, floods, etc., when because of the natural disaster members have difficulty gaining access to Preferred network providers. The Carrier may pay the Preferred level of benefits without regard to the provider's contractual relationship with the Carrier and will determine an appropriate time frame based on local conditions during which the provision of this paragraph will apply. Benefits provided under this paragraph will be made available to all members similarly affected by the natural disaster.

(h) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Notwithstanding subsection (f) of Section 2.3, benefits provided under the contract are not assignable by the Member to any person without express written approval of the carrier, and in the absence of such approval, any such assignment shall be void. Notwithstanding such approval, no assignment of benefits may be made in any case prior to the time that a valid claim for benefits arises.

(i) Section 2.3 Payment of Benefits and Provision of Services and Supplies. The introductory paragraph of Subsection 2.3(g) is amended to read as follows:

(g) *Erroneous Payments*.

(i) If the Carrier or OPM determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider; the recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment under 48 C.F.R. 1631.201-70(h) regardless of any time period limitations in the written agreement with the provider.

(ii) The Carrier shall be deemed to have satisfied the requirements of

Subsection (g) (i) above by complying with Subsections (ii), (iii), and (iv). Local Blue Cross and Blue Shield Plans which have time period limitations in their provider contracts which prevent the Plan from recovering erroneous benefit payments made to providers will participate in an action plan. The action plan shall be developed by the Blue Cross and Blue Shield Association by December 31, 2008 and agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield Association and the Contracting Officer shall utilize standards of commercial reasonableness and neither shall unreasonably withhold agreement. The action plan shall be designed to reduce the occurrence of erroneous benefit payments, to identify and recover erroneous benefit payments within the time limits stipulated in their provider contracts, and to demonstrate due diligence in making an attempt to identify and recover within that provider contract timeframe such erroneous benefit payments.

(iii) The Blue Cross and Blue Shield Association shall be responsible for monitoring and determining whether each Blue Cross and Blue Shield Plan participating in the action plan is complying with its obligations under the action plan.

(iv) A Blue Cross and Blue Shield Plan which is in compliance with its obligations under the action plan shall be found to be in compliance with its obligation under this Section 2.3(g) to make a prompt and diligent effort to recover erroneous benefit payments. In the event that any Plan with such time period limitations is determined to be not in substantial compliance with the action plan, and that Plan is determined not to have pursued material benefit payments with promptness and diligence, then the Plan shall return the erroneous benefit payments to the Program.

(v) The Carrier shall follow general business practices and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall—

(j) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(7)(ii) of Section 2.3 is amended to read as follows:

Notwithstanding (g)(7)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that caused erroneous benefit payments) when the errors are egregious and repeated. These costs are deemed to be unreasonable and unallowable under Section 3.2(b). The term "repeated" in the previous sentence does not apply to situations in which a claims processing system error causes multiple erroneous payments or to situations that involve audit findings on errors that are endemic to the provision of insurance and claims processing.

(k) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(10) of Section 2.3 is amended to read as follows:

(10) In compliance with the Contracts Disputes Act, the Carrier shall return to the

Program an amount equal to the uncollected erroneous benefit payment where the Contracting Officer determines that the Carrier failed to make a prompt and diligent effort, as that term is described above, to recover the erroneous benefit payment. This provision applies to benefit payments which have been paid in error for any reason (except in the case of fraud or abuse).

(l) Section 2.4 Termination of Coverage and Conversion Privileges. The conversion contract set forth in Section 2.4(c) may be a contract that is regularly offered by the local Blue Cross and/or Blue Shield Plan.

(m) Section 2.5 Subrogation. The following subsections are added:

(c) To the extent that a Member has received benefits for covered services under this contract for an injury or illness caused by a third party, the Carrier shall have the right to be subrogated and succeed to any rights of recovery against any person or organization from whom the Member is legally entitled to receive all or part of those same benefits, including insurers of individuals (non-group) policies of liability insurance that are issued to and in the name of the Member. The obligation of the Carrier to recover amounts through subrogation is limited to making a reasonable effort to seek recovery of amounts to which it is entitled to recover in cases which are brought to its attention. The Carrier shall not be required to recover any amounts from any person or organization who causes an injury or illness for which the Member makes claims for benefits.

(d) The Carrier may also recover directly from the Member all amounts received by the Member by suit, settlement, or otherwise from any third party or its insurer, or the Member's insurer under an individual policy or liability insurance, for benefits which have also been paid under this contract.

(e) The Member shall take such action, furnish such information and assistance, and execute such papers as the Carrier or its representative believes are necessary to facilitate enforcement of its rights, and shall take no action which would prejudice the interests of the Carrier to subrogation.

(f) Effective January 1, 1997, all Participating Plans shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under the contract.

(n) Section 2.6 Coordination of Benefits (FEHBAR). The following subsections are added:

(g) The benefits payable by this Plan shall be determined, on a claim by claim basis, only for those claims in excess of $100, except where Medicare is the primary payer of benefits, claims in excess of $50.

(h) Whenever payments which should have been made under this contract in accordance with this provision have been made under any other group health coverage, the Carrier shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amount it shall determine to be

warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this contract and, to the extent of such payments discharged from liability under the contract.

(o) Section 3.1 Payments (FEHBAR). The following sentence is added to the end of Section 3.1(a):

OPM will withhold from the subscription charges amounts for other obligations due under the contract only to the extent that OPM and the Carrier have agreed in writing to specific deductions for such other obligations.

(p) Section 3.1 Payments (FEHBAR). The following subsection is added:

(g) Except as required pursuant to Sections 1.25 and 2.12, in the event this contract is terminated or not renewed, the agency shall be liable for all sums due and unpaid, including subscription charges, for the period up to the last day of the Member's entitlement to benefits.

(q) Section 3.2 Accounting and Allowable Cost (FEHBAR). Section 3.2(b)(2)(ii) of this contract is amended to comply with 5 U.S.C. 8909(f) as follows:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(r) Section 3.2 Accounting and Allowable Cost (FEHBAR). The provision in Section 3.2 (b)(2)(iv)(A) is supplemented as follows:

Charges for mandatory statutory reserves (Section 3.2(b)(2)(iv)(A)) to satisfy mandatory statutory reserve requirements of Participating Plans are allowable to the extent that such requirements exceed that portion of the service charge at Appendix B, Subscription Rates, Charges, Allowances and Limitations applicable to such Plans.

(s) Section 3.2 Accounting and Allowable Cost (FEHBAR). This section is modified as follows:

The Carrier, as required by the Blue Cross and Blue Shield Service Benefit Plan Workplan, shall furnish OPM an accounting of its operations under the contract not less than 120 days after the end of the calendar year contract period.

(t) Section 3.3 Special Reserve. The provision in Section 3.3(a) is supplemented as follows:

The Special reserve held by or on behalf of the Carrier is to be used only for payment of charges against this contract, including advance payments to Participating Plans and to hospitals.

(u) Section 3.10, Audit, Financial, and Other Information. Compliance by the Carrier and Participating Blue Cross and Blue Shield Plans with the Blue Cross Blue Shield Service Benefit Plan Workplan, as agreed upon between the Carrier and OPM, will constitute compliance with the Audit Guide referred to in Sections 3.2 and 3.10.

SECTION 4.2
HOSPITAL (FACILITY) BENEFIT PAYMENTS AND CONDITIONS (JAN 1991)

(a) Benefits described in the agreed upon brochure text shall be provided to the extent practicable in the form of services rendered by hospitals, freestanding ambulatory facilities, and home health care agencies, and payment, therefore, by or on behalf of the carrier shall constitute a complete discharge of their obligations under this contract to the extent of services rendered in accordance with the terms and conditions of the contract.

(b) Benefits for inpatient hospital care shall be available only to a Member admitted to the hospital on the recommendation, and while under the active medical supervision of a duly licensed physician or alternative provider as described in section 8902(k)(1) of title 5 U.S.C. who is a member of the staff of, or acceptable to, the hospital selected.

(c) Hospital service is subject to all the rules and regulations of the hospital selected including rules governing admissions.

(d) While a Member may elect to be hospitalized in any hospital, the Carrier does not undertake to guarantee the admission of such Member to the hospital, nor the availability of any accommodations or services therein requested by the Member or his physician.

SECTION 4.3
DEFINITION OF CARRIER (JAN 1991)

The Carrier is the Blue Cross and Blue Shield Association, an Illinois not-for-profit corporation, acting on behalf of participating Blue Cross and Blue Shield Plans and pursuant to authority specified in Exhibit A for and in behalf of the organizations specified in Exhibit A (hereinafter sometimes referred to as "Participating Plans").

SECTION 4.4
AUDIT DISPUTES (JAN 2000)

(a) Any questioned costs or issues documented by or on behalf of OPM's Office of the Inspector General (OIG) in draft or final audit reports examining the Carrier's and Participating Plans' performance under this contract, that are provided to the Carrier and that were initially raised in the timeframe set forth in subsection (c) below, remain open until resolved. Audit issues related to monetary findings for which extensions of the

waiver period for the issuance of final decisions and processing of prior period adjustments were obtained in previous contract terms also remain open until resolved.

(b) Resolution of a questioned cost or issue can be the result of a resolution letter or the issuance of a final decision by the Contracting Officer, or by the processing of a prior period adjustment, an adjustment to the Special reserve, or submission of a claim to OPM (as appropriate) by the Carrier or Participating Plan. A prior period adjustment intended to partially or fully resolve an audit finding will not be considered closed until properly reported on the calendar year Annual Accounting Statement.

(c) A claim seeking, as a matter of right, the payment of money, in a sum certain, pursuant to 48 CFR section 52.233-1, shall not be made more than five years following the last day prescribed by the contract for filing the calendar year Annual Accounting Statement for the year with respect to which the claim arises. A claim includes, in the case of the carrier, a charge against the contract.

SECTION 4.5
ASSOCIATION DUES (JAN 2004)

A Participating local Blue Cross and Blue Shield Plan may charge to this contract Association Dues, with the exception of dues related to those lobbying costs and Special Assessments determined to be unallowable. In calculating the unallowable portion of dues related to lobbying costs for a contract year, the Blue Cross and Blue Shield Plan will rely on the percentage of dues, less any special assessments, as determined by the BCBSA for IRS purposes, to be not tax deductible from the previous contract year.

SECTION 4.6
TRAVEL COSTS (JAN 1996)

The Carrier may charge and account for travel expenses related to administration of the contract on a per diem basis, subject to the maximums prescribed by the Federal Travel Regulations. For those travel costs for each contract term that are subject to the Federal per diem rates set forth at 48 CFR section 31.205-46, the Carrier shall charge to the contract an amount equal to the lesser of:

(i) the actual aggregate charges for those costs, or
(ii) the aggregate charges calculated using the per diem rates set forth in the Federal Travel Regulations.

SECTION 4.7
MARKET RESEARCH COSTS (JAN 1996)

(a) Costs of market research surveys or studies are generally allowable if the survey or study is:

1. directed to current Members and Members who left the Blue Cross and Blue Shield Service Benefit Plan in the most recent Open season, or
2. focused on long-range planning, industry state-of-the-art developments, or product development issues for which a direct benefit or potential benefit to the FEHB Program

can be identified, or
3. pre-approved by the Contracting Officer.

(b) Costs of market research surveys or studies are generally not allowable if the primary purpose is to survey or study an otherwise unallowable cost item, such as: to determine the effectiveness of advertising or sales strategies; to evaluate image effectiveness or ways to achieve image enhancement; or to perform a competitive analysis with other carriers in the FEHB Program. Such costs are unallowable, regardless of who receives the research surveys or studies.

(c) This provision does not supersede other contract requirements, such as prior approval for subcontracts under Section 1.16 Subcontracts (FEHBAR 1652.244-70).

SECTION 4.8
PRESCRIPTION DRUG BENEFITS WAIVER PROVISIONS (JAN 2009)

(a) For the purposes of applying the special provisions in this section, the Standard Option Mail Service Prescription Drug Program service standards are:

(1) When a prescription order is placed that does not require additional information or clarification (i.e., a clean or non-diverted prescription), the prescription order shall be dispensed within three business days from the date of receipt so the enrollee may expect to receive the medication within 7 calendar days.

(2) When a prescription order is placed that does require additional information, clarification or resolution of payment issues (i.e., a diverted prescription), the prescription order shall be dispensed within seven business days from the date of receipt so the enrollee may expect to receive the medication within 14 calendar days. However the following situations will not be considered a diverted prescription for the purposes of this section:

(i) Prescriptions for refrigerated products that require prior arrangements between the mail order pharmacy and a Member before the Member can receive the Prescription;

(ii) Prescriptions requiring specific counseling obligations imposed by the pharmaceutical manufacturer, distributor or the FDA;

(iii) Prescriptions requiring "registration" with a pharmaceutical manufacturer.

(b) The special provisions described in paragraphs (c)(1), (2), and (3) shall become effective automatically when less than 98 percent of the prescriptions are filled within the service standards described in either paragraph (a)(1) or (a)(2) for 7 consecutive business days. The special provisions shall terminate when for 7 consecutive business days 98 percent or more of the prescriptions are filled within the service standards described in paragraphs (a)(1) and (a)(2) of this section.

(c) The special provisions are:

(1) The Carrier shall waive during the effective periods in paragraph (b) the coinsurance for a 21 day prescription filled at a Preferred retail pharmacy when the Mail Service Prescription Drug Program vendor is unable to fill the prescription within the service standards. This waiver of the coinsurance shall be in effect for 14 calendar days after notice to the enrollee as described in paragraph (c)(2) below.

(2) The Carrier shall deliver to the enrollee a written or telephone notice no later than 5 days from the date of receipt for clean or non-diverted prescriptions and no later than 12 days from the date of receipt for diverted prescriptions.
This notice shall:

(i) advise the enrollee that the Mail Service Prescription Drug Program may not be able to fill the prescription(s) within the service standard timeframes;

(ii) advise the enrollee that any applicable coinsurance will be waived for a 21 day supply of the medication(s) when filled at a Preferred retail pharmacy;

(iii) provide the enrollee with instructions on how to use the waiver, and

(iv) advise the enrollee when the waiver will expire.

(3) The Carrier may use next day delivery service at no additional cost to the enrollee in order to meet the service standards in (a)(1) and (a)(2).

SECTION 4.9
SMALL BUSINESS SUBCONTRACTING PLAN (JAN 2002) (FAR 52.219-9) (AS AMENDED)

An amended clause 52.219-9, Small Business Subcontracting Plan, is attached to Appendix E.

SECTION 4.10
LETTER OF CREDIT (JAN 1997)

As of January 1, 1997, OPM will administer Letter of Credit drawdowns directly with the local Plans.

SECTION 4.11
PILOTING OF COST CONTAINMENT PROGRAMS (JAN 2001)

Upon approval by the Contracting Officer, the Carrier may design and implement pilot programs in one or more local Plan areas that test the feasibility and examine the impact of various managed care initiatives. The Carrier shall brief the Contracting Officer on a pilot program prior to its implementation, advise the Contracting Officer of the progress of the pilot program and provide a written evaluation at the conclusion of the pilot program. The evaluation of the pilot program shall, at a minimum, assess the cost effectiveness, effect on quality of care and/or quality of life, and customer satisfaction, and recommend whether the pilot program should be continued or expanded.

SECTION 4.12
TRANSITION COSTS FOR PLAN TERMINATIONS (JAN 1999)

In the event a Participating Plan's license to use the Blue Cross and/or Blue Shield service marks is terminated, thereby rendering it ineligible to participate in this Contract, the costs of transitioning the terminated Plan's Service Benefit Plan subscribers to a successor Plan shall be subject to advance approval. The Carrier shall submit to OPM a proposed transition plan, together with a detailed estimate of costs, prior to the incurrence of any significant transition costs. OPM and the Carrier shall negotiate an advance agreement pursuant to FAR 31.109 that covers the extent of allowable transition costs.

SECTION 4.13
PAYMENT BY ELECTRONIC FUNDS TRANSFER-CENTRAL CONTRACTOR REGISTRATION (MAY 1999) (FAR 52.232-33)

The references to the Central Contractor Registration in FAR 52.232-33 are not applicable to this contract.

SECTION 4.14
FEDERAL INCOME TAX RELATED TO HEALTH INSURANCE PROVIDERS' FEE (JANUARY 2015)

(a) Notwithstanding FAR 31.205-41(b)(1) and this Contract Section 3.2(b)(1)(ii), a charge for an incremental amount of Federal income tax liability incurred as the result of compliance with the Health Insurance Providers Fee (HIP Fee) provision of the Affordable Care Act section 9010 (hereafter referred to as the "HIP Tax Cost") by a participating local plan (Local Plan) that administers the Service Benefit Plan on behalf of the Blue Cross and Blue Shield Association (Carrier), and that is a covered entity within the meaning of 26 CFR Part 57, is an allowable cost to the Carrier under this contract under the criteria set forth below.

(1) The allowable cost to the Carrier for a year is the sum of the HIP Tax Cost for each Local Plan. The HIP Tax Cost for each Local Plan equals:
the amount reimbursed by OPM to the Carrier for the HIP Fee attributable to the Local Plan (Local Plan HIP Fee) for the year, divided by one minus the tax rate for the Local Plan specified under section (2) below, (Local Plan Tax Rate), less the Local Plan HIP Fee. In mathematical terms, the allowable charge to the Carrier for the HIP Tax Cost is the sum of each Local Plan's application of the formula below:

$$\left[\frac{\text{Local Plan HIP Fee}}{1 - \text{Local Plan Tax Rate}}\right] - \text{Local Plan HIP Fee}$$

(2) The Local Plan Tax Rate for purposes of the formula specified in section (1) is the lowest of the following:
(a) the rate specified at 26 USC §11 (b) (1) (D),
(b) the rate specified at 26 USC § 55(b)(1)(B)(i), for any year in which the Local Plan is entitled to the special deduction under 26 USC § 833(a)(2), or
(c) zero, for any year in which the Local Plan experiences a Net Operating Loss or other circumstance resulting in no tax liability. For a year in which the Local Plan experiences a Net Operating Loss resulting in no tax liability, the Carrier will charge the HIP Tax Cost attributable to the Local Plan in the first subsequent year in which the Local Plan's tax liability is greater than zero. The Local Plan will calculate the HIP Tax Cost in this circumstance by applying the formula using the HIP Fee for the year of the loss and the Local Plan Tax Rate for the year in which the tax liability is greater than zero. This charge by the Carrier is in addition to the charge allowed by the Carrier for the Local Plan Tax Cost for the year in which the tax liability is greater than zero.

(d) If the Local Plan Tax Rate reflected on the Local Plan's tax return actually filed for the contract year (which normally occurs the following year) differs from the Local Plan Tax Rate that was anticipated when the costs were drawn down by the Carrier for the contract year as allowable administrative expenses, the Carrier will make a commensurate adjustment to its current year drawdown of administrative expenses.

(b) The Contracting Officer or an authorized representative of the Contracting Officer shall have the right to examine and audit all books and records, including tax filings, relating to the calculation of the HIP Tax Cost charge for each Local Plan.

Part IV - Attachment I
SECTION 4.14
FEDERAL INCOME TAX RELATED TO HEALTH INSURER'S PROVIDER FEE

Examples of Allowable 9010 Tax Cost:

C is an experience rated FEHB carrier consisting of participating Local Plans F and G who underwrite and administer C in different geographic areas.

In 2015, F reports $900 on IRS Form 8963 and pays $500 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the $500 HIP Fee, F's Form 8963 reflects that $300 is attributable to F's FEHBP business.

Also in 2015, G reports $950 on IRS Form 8963 and pays $550 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the $550 HIP Fee, G's Form 8963 reflects that $325 is attributable to G's FEHBP business.

In 2015, C draws down a 2015 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2014 health risks, which is calculated as the sum of F and G's HIP Fee, or $300 +325 = $725, which is an allowable cost, from its FEHB letter of credit account (LOCA). C reimburses F for its HIP Fee of 300 and G for its HIP Fee of 325.

F records income of $300 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by $300. F records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, F pays quarterly payments to the IRS for its' 2015 tax liability. F's 2015 tax rate is 35 percent.

G records income of $325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by $325. G records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, G pays quarterly payments to the IRS for its' 2015 tax liability. Because G claims a special deduction under 26 USC § 833(a)(2), G's 2015 tax rate is 20 percent.

In 2015, C also draws down from its LOCA a 2015 HIP Tax Cost reimbursement for the 2015 income tax expense accrued and paid by F & G in 2015. C's 2015 HIP Tax cost reimbursement is calculated as follows:

Local Plan F HIP Tax Cost: ($300/1-.35)-$300 = $162
Local Plan G HIP Tax Cost: ($325/1-.20)-$325 = $81
Sum which is C's allowable HIP Tax Cost for 2015 = $243

In 2016, F & G report the same HIP Fee expense for 2015 health risks.

In 2016, F experiences the same tax rate as for 2015, but G incurs a net operating loss, resulting in a zero percent tax rate for 2016.

In 2016, C draws down a 2016 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2015 health risks of 300 + 325 = $725, which is an allowable cost, from C's FEHB letter of credit account (LOCA). C reimburses F for 300 and G for 325.

In 2016, F proceeds as in 2015 and C may charge 162 as an allowable HIP Tax Cost attributable to F in 2016.

In 2016 G records income of $325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by $325. Because G determines that its 2016 tax liability will be zero as it will have a Net Operating Loss for 2016, C does not incur an allowable 2016 HIP Tax Cost attributable to G. C must refund any such amounts drawn down during 2016.

Local Plan F HIP Tax Cost for 2016 = 162
Local Plan G HIP Tax Cost for 2016 = 0
Reimbursement attributable to G = adjustment for amounts drawn down by C, if any
Sum = C's allowable HIP Tax Cost for 2016 = 162 less adjustment.

In 2017, F proceeds as in 2015. C's allowable 2017 HIP Tax Cost includes $162 attributable to F. In 2017, G has an operating gain and reports the same HIP Fee amount and experiences the same 20% tax rate as in 2015. C's allowable 2017 HIP Tax Cost includes $81 attributable to G.

In addition, in 2017, because G's operating gain results in a tax rate higher than zero, G incurs economic disadvantage. This is because the 2016 HIP Fee reimbursement of $325 has reduced G's otherwise applicable Net Operating Loss carry-forward amount. G calculates the economic disadvantage as the difference between its 2017 tax liability with and without the 2016 HIP Fee reimbursement. This disadvantage is included in the Carrier's 2017 charge as an allowable HIP Tax Cost with respect to 2016. This is calculated as $325 (2016 HIP Fee) divided by 1-20% (application of 2017 Local Plan Tax Rate), less $325.]

Local Plan F HIP Tax Cost for 2017 = 162
Local Plan G HIP Tax Cost for 2017 = 81
Local Plan G HIP Tax Cost for 2017 due to 2016 HIP Fee reimbursement = apply formula using 2016 Fee Reimbursement amount and 2017 tax rate of 20% =81
Sum = C's allowable HIP Tax Cost for 2017 = 162 + 81 + 81 = $324

APPENDIX A

ATTACH

2018 FEHB BROCHURE

APPENDIX B

SUBSCRIPTION RATES, CHARGES, ALLOWANCES AND LIMITATIONS

Fee-For-Service Carrier

(Blue cross and Blue Shield Service Benefit Plan)
CONTRACT NO. CS 1039
Effective January 1, 2018

(a) Biweekly net-to-carrier rates, with appropriate adjustments for Enrollees paid on other than a biweekly basis, are as follows:

Standard Option		Basic Option	
Self Only	$329.24	Self Only	$283.56
Self Plus One	$720.01	Self Plus One	$637.35
Self and Family	$763.01	Self and Family	$675.54

(b) The amount of administrative expenses and charges to be included in the Annual Accounting Statement required by Section 3.2 shall be as set out in the schedule below:

Item	*Amount*
(i) Administrative Expenses	Actual, but not to exceed the Contractual Expense Limitation for 2018,* plus an amount sufficient to cover the costs needed to pay the Plan's Independent Public Accountant to undertake the audits and agreed upon procedures required in the "FEHBP Experienced-Rated Carrier and Service Organization Audit Guide."
(ii) Taxes	Actual (except that premium taxes as defined are not allowable).
(iii) Service Charge**	[redacted]

**The Contractual Expense Limitation for 2018 is [redacted] Notwithstanding Section 3.2 (b) of this Contract, costs of "activities that improve healthcare quality" as determined in accordance with the medical loss ratio provision of the Affordable Care Act

(Section 2718 of the Public Health Service Act; 42 U.S.C. 300gg-18, and its implementing regulations), are accounted for as benefits and not counted toward the Contractual Expense Limit.

Actual Affordable Care Act health insurer's provider fees and the related federal income tax impact related to the reimbursement of the health insurer's provider fee (calculated in accordance with Section 4.14) will be reimbursed and will remain outside the contractual expense limitation for 2018.

** The Service Charge for the 2018 contract year is based on the Overall Performance Score calculated in accordance with the 2017 Appendix F. The Service Charge for the 2019 contract year will be based on the Overall Performance Score calculated in accordance with the 2018 Appendix F.

Appendix E

Subsections (b), (c), (d), (e), (f), (g), (i), (j), (k), and (l) were amended in accordance to the January 2017 CFR 52.219-9. The text of the CFR has been edited consistent with the FEHBP's exception to the requirement that contractors report to eSRS.

APPENDIX E
Small Business Subcontracting Plan (JAN 2017)

(a) This clause does not apply to small business concerns.

(b) *Definitions*. As used in this clause—

"Alaska Native Corporation (ANC)" means any Regional Corporation, Village Corporation, Urban Corporation, or Group Corporation organized under the laws of the State of Alaska in accordance with the Alaska Native Claims Settlement Act, as amended (43 U.S.C. 1601, et seq.) and which is considered a minority and economically disadvantaged concern under the criteria at 43 U.S.C. 1626(e)(1). This definition also includes ANC direct and indirect subsidiary corporations, joint ventures, and partnerships that meet the requirements of 43 U.S.C. 1626(e)(2).

"Commercial item" means a product or service that satisfies the definition of commercial item in section 2.101 of the Federal Acquisition Regulation.

"Commercial plan" means a subcontracting plan (including goals) that covers the Offeror's fiscal year and that applies to the entire production of commercial items sold by either the entire company or a portion thereof (*e.g.,* division, plant, or product line).

"Indian tribe" means any Indian tribe, band, group, pueblo, or community, including native villages and native groups (including corporations organized by Kenai, Juneau, Sitka, and Kodiak) as defined in the Alaska Native Claims Settlement Act (43 U.S.C.A. 1601 et seq.), that is recognized by the Federal Government as eligible for services from the Bureau of Indian Affairs in accordance with 25 U.S.C. 1452(c). This definition also includes Indian-owned economic enterprises that meet the requirements of 25 U.S.C. 1452(e).

"Individual subcontracting plan" means a subcontracting plan that covers the entire contract period (including option periods), applies to a specific contract, and has goals that are based on the Offeror's planned subcontracting in support of the specific contract, except that indirect costs incurred for common or joint purposes may be allocated on a prorated basis to the contract.

"Master subcontracting plan" means a subcontracting plan that contains all the required elements of an individual subcontracting plan, except goals, and may be incorporated into individual subcontracting plans, provided the master subcontracting plan has been approved.

"Reduced payment" means a payment that is for less than the amount agreed upon in a subcontract in accordance with its terms and conditions, for supplies and services for which the Government has paid the prime contractor.

"Subcontract" means any agreement (other than one involving an employer-employee relationship) entered into by a Federal Government prime Contractor or subcontractor calling for supplies or services required for performance of the contract or subcontract.

"Total contract dollars" means the final anticipated dollar value, including the dollar value of all options.
"Untimely payment" means a payment to a subcontractor that is more than 90 days past due under the terms and conditions of a subcontract for supplies and services for which the Government has paid the prime contractor.
(c)(1) The Offeror, upon request by the Contracting Officer, shall submit and negotiate a subcontracting plan, where applicable, that separately addresses subcontracting with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns. If the Offeror is submitting an individual subcontracting plan, the plan must separately address subcontracting with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns, with a separate part for the basic contract and separate parts for each option (if any). The subcontracting plan shall be included in and made a part of the resultant contract. The subcontracting plan shall be negotiated within the time specified by the Contracting Officer. Failure to submit and negotiate the subcontracting plan shall make the Offeror ineligible for award of a contract.
(2)(i) The Contractor may accept a subcontractor's written representations of its size and socioeconomic status as a small business, small disadvantaged business, veteran-owned small business, service-disabled veteran-owned small business, or a women-owned small business if the subcontractor represents that the size and socioeconomic status representations with its offer are current, accurate, and complete as of the date of the offer for the subcontract.
(ii) The Contractor may accept a subcontractor's representations of its size and socioeconomic status as a small business, small disadvantaged business, veteran-owned small business, service-disabled veteran-owned small business, or a women-owned small business in the System for Award Management (SAM) if–
(A) The subcontractor is registered in SAM; and
(B) The subcontractor represents that the size and socioeconomic status representations made in SAM are current, accurate and complete as of the date of the offer for the subcontract.
(iii) The Contractor may not require the use of SAM for the purposes of representing size or socioeconomic status in connection with a subcontract.
(iv) In accordance with 13 CFR 121.411, 124.1015, 125.29, 126.900, and 127.700, a contractor acting in good faith is not liable for misrepresentations made by its subcontractors regarding the subcontractor's size or socioeconomic status.
(d) The Offeror's subcontracting plan shall include the following:
(1) Separate goals, expressed in terms of total dollars subcontracted, and as a percentage of total planned subcontracting dollars, for the use of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns as subcontractors. For individual subcontracting plans, and if required by the Contracting Officer, goals shall also be expressed in terms of percentage of total contract dollars, in addition to the goals expressed as a percentage of total subcontract dollars. The Offeror shall include all subcontracts that contribute to contract performance, and may include a proportionate share of products and services that are normally allocated as indirect costs. In accordance with 43 U.S.C. 1626–

(i) Subcontracts awarded to an ANC or Indian tribe shall be counted towards the subcontracting goals for small business and small disadvantaged business concerns, regardless of the size or Small Business Administration certification status of the ANC or Indian tribe; and
(ii) Where one or more subcontractors are in the subcontract tier between the prime Contractor and the ANC or Indian tribe, the ANC or Indian tribe shall designate the appropriate Contractor(s) to count the subcontract towards its small business and small disadvantaged business subcontracting goals.
(A) In most cases, the appropriate Contractor is the Contractor that awarded the subcontract to the ANC or Indian tribe.
(B) If the ANC or Indian tribe designates more than one Contractor to count the subcontract toward its goals, the ANC or Indian tribe shall designate only a portion of the total subcontract award to each Contractor. The sum of the amounts designated to various Contractors cannot exceed the total value of the subcontract.
(C) The ANC or Indian tribe shall give a copy of the written designation to the Contracting Officer, the prime Contractor, and the subcontractors in between the prime Contractor and the ANC or Indian tribe within 30 days of the date of the subcontract award.
(D) If the Contracting Officer does not receive a copy of the ANC's or the Indian tribe's written designation within 30 days of the subcontract award, the Contractor that awarded the subcontract to the ANC or Indian tribe will be considered the designated Contractor.
(2) A statement of—
(i) Total dollars planned to be subcontracted for an individual subcontracting plan; or the Offeror's total projected sales, expressed in dollars, and the total value of projected subcontracts to support the sales for a commercial plan;
(ii) Total dollars planned to be subcontracted to small business concerns (including ANC and Indian tribes); and
(iii) Total dollars planned to be subcontracted to veteran-owned small business concerns;
(iv) Total dollars planned to be subcontracted to service-disabled veteran-owned small business;
(v) Total dollars planned to be subcontracted to HUBZone small business concerns;
(vi) Total dollars planned to be subcontracted to small disadvantaged business concerns; and
(vii) Total dollars planned to be subcontracted to women-owned small business concerns.
(3) A description of the principal types of supplies and services to be subcontracted, and an identification of the types planned for subcontracting to—
(i) Small business concerns;
(ii) Veteran-owned small business concerns;
(iii) Service-disabled veteran-owned small business concerns;
(iv) HUBZone small business concerns;
(v) Small disadvantaged business concerns; and
(vi) Women-owned small business concerns.
(4) A description of the method used to develop the subcontracting goals in paragraph (d)(1) of this clause.
(5) A description of the method used to identify potential sources for solicitation purposes (*e.g.,* existing company source lists, SAM, veterans service organizations, the National Minority Purchasing Council Vendor Information Service, the Research and Information Division of the Minority Business Development Agency in the Department of Commerce, or small, HUBZone, small disadvantaged, and women-owned small business trade associations). A firm may rely on the information contained in SAM, as an accurate representation of a concern's size and

ownership characteristics for the purposes of maintaining a small, veteran-owned small, service-disabled veteran-owned small, HUBZone small, small disadvantaged, and women-owned small business source list. Use of SAM, as its source list does not relieve a firm of its responsibilities (*e.g.,* outreach, assistance, counseling, or publicizing subcontracting opportunities) in this clause.
(6) A statement as to whether or not the Offeror included indirect costs in establishing subcontracting goals, and a description of the method used to determine the proportionate share of indirect costs to be incurred with—
(i) Small business concerns (including ANC and Indian tribes);
(ii) Veteran-owned small business concerns;
(iii) Service-disabled veteran-owned small business concerns;
(iv) HUBZone small business concerns;
(v) Small disadvantaged business concerns (including ANC and Indian tribes); and
(vi) Women-owned small business concerns.
(7) The name of the individual employed by the Offeror who will administer the Offeror's subcontracting program, and a description of the duties of the individual.
(8) A description of the efforts the Offeror will make to assure that small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns have an equitable opportunity to compete for subcontracts.
(9) Assurances that the Offeror will include the clause of this contract entitled "Utilization of Small Business Concerns" in all subcontracts that offer further subcontracting opportunities, and that the Offeror will require all subcontractors (except small business concerns) that receive subcontracts in excess of $700,000 ($1.5 million for construction of any public facility) with further subcontracting possibilities to adopt a subcontracting plan that complies with the requirements of this clause.
(10) Assurances that the Offeror will—
(i) Cooperate in any studies or surveys as may be required;
(ii) Submit periodic reports so that the Government can determine the extent of compliance by the Offeror with the subcontracting plan;
(iii) Submit Standard Form (SF) 294 Subcontracting Report for Individual Contract in accordance with paragraph (l) of this clause. Submit the Summary Subcontract Report (SSR), in accordance with paragraph (l) of this clause. The reports shall provide information on subcontract awards to small business concerns (including ANCs and Indian tribes that are not small businesses), veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns (including ANCs and Indian tribes that have not been certified by the Small Business Administration as small disadvantaged businesses), women-owned small business concerns, and for NASA only, Historically Black Colleges and Universities and Minority Institutions. Reporting shall be in accordance with this clause, or as provided in agency regulations; and
(iv) Ensure that its subcontractors with subcontracting plans agree to submit the SF 294 in accordance with paragraph (l) of this clause. Ensure that its subcontractors with subcontracting plans agree to submit the SSR in accordance with paragraph (l) of this clause.
(vi) [RESERVED]; and
(vii) Require that each subcontractor with a subcontracting plan provide the prime contract number, its own DUNS number, and the e-mail address of the subcontractor's official

responsible for acknowledging receipt of or rejecting the ISRs, to its subcontractors with subcontracting plans.
(11) A description of the types of records that will be maintained concerning procedures that have been adopted to comply with the requirements and goals in the plan, including establishing source lists; and a description of the Offeror's efforts to locate small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns and award subcontracts to them. The records shall include at least the following (on a plant-wide or company-wide basis, unless otherwise indicated):
(i) Source lists (*e.g.,* SAM), guides, and other data that identify small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns.
(ii) Organizations contacted in an attempt to locate sources that are small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, or women-owned small business concerns.
(iii) Records on each subcontract solicitation resulting in an award of more than $150,000, indicating—
(A) Whether small business concerns were solicited and, if not, why not;
(B) Whether veteran-owned small business concerns were solicited and, if not, why not;
(C) Whether service-disabled veteran-owned small business concerns were solicited and, if not, why not;
(D) Whether HUBZone small business concerns were solicited and, if not, why not;
(E) Whether small disadvantaged business concerns were solicited and, if not, why not;
(F) Whether women-owned small business concerns were solicited and, if not, why not; and
(G) If applicable, the reason award was not made to a small business concern.
(iv) Records of any outreach efforts to contact—
(A) Trade associations;
(B) Business development organizations;
(C) Conferences and trade fairs to locate small, HUBZone small, small disadvantaged, service-disabled veteran-owned, and women-owned small business sources; and
(D) Veterans service organizations.
(v) Records of internal guidance and encouragement provided to buyers through—
(A) Workshops, seminars, training, etc.; and
(B) Monitoring performance to evaluate compliance with the program's requirements.
(vi) On a contract-by-contract basis, records to support award data submitted by the Offeror to the Government, including the name, address, and business size of each subcontractor. Contractors having commercial plans need not comply with this requirement.
(12) Assurances that the Offeror will make a good faith effort to acquire articles, equipment, supplies, services, or materials, or obtain the performance of construction work from the small business concerns that it used in preparing the bid or proposal, in the same or greater scope, amount, and quality used in preparing and submitting the bid or proposal. Responding to a request for a quote does not constitute use in preparing a bid or proposal. The Offeror used a small business concern in preparing the bid or proposal if–
(i) The Offeror identifies the small business concern as a subcontractor in the bid or proposal or associated small business subcontracting plan, to furnish certain supplies or perform a portion of the subcontract; or

(ii) The Offeror used the small business concern's pricing or cost information or technical expertise in preparing the bid or proposal, where there is written evidence of an intent or understanding that the small business concern will be awarded a subcontract for the related work if the Offeror is awarded the contract.
(13) Assurances that the Contractor will provide the Contracting Officer with a written explanation if the Contractor fails to acquire articles, equipment, supplies, services or materials or obtain the performance of construction work as described in (d)(12) of this clause. This written explanation must be submitted to the Contracting Officer within 30 days of contract completion.
(14) Assurances that the Contractor will not prohibit a subcontractor from discussing with the Contracting Officer any material matter pertaining to payment to or utilization of a subcontractor.
(15) Assurances that the Offeror will pay its small business subcontractors on time and in accordance with the terms and conditions of the underlying subcontract, and notify the contracting officer when the prime contractor makes either a reduced or an untimely payment to a small business subcontractor (see 52.242-5).
(e) In order to effectively implement this plan to the extent consistent with efficient contract performance, the Contractor shall perform the following functions:
(1) Assist small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns by arranging solicitations, time for the preparation of bids, quantities, specifications, and delivery schedules so as to facilitate the participation by such concerns. Where the Contractor's lists of potential small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business subcontractors are excessively long, reasonable effort shall be made to give all such small business concerns an opportunity to compete over a period of time.
(2) Provide adequate and timely consideration of the potentialities of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns in all "make-or-buy" decisions.
(3) Counsel and discuss subcontracting opportunities with representatives of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business firms.
(4) Confirm that a subcontractor representing itself as a HUBZone small business concern is certified by SBA as a HUBZone small business concern in accordance with 52.219-8(d)(2).
(5) Provide notice to subcontractors concerning penalties and remedies for misrepresentations of business status as small, veteran-owned small business, HUBZone small, small disadvantaged, or women-owned small business for the purpose of obtaining a subcontract that is to be included as part or all of a goal contained in the Contractor's subcontracting plan.
(6) For all competitive subcontracts over the simplified acquisition threshold in which a small business concern received a small business preference, upon determination of the successful subcontract Offeror, prior to award of the subcontract the Contractor must inform each unsuccessful small business subcontract Offeror in writing of the name and location of the apparent successful Offeror and if the successful subcontract Offeror is a small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, or women-owned small business concern.

(7) Assign each subcontract the NAICS code and corresponding size standard that best describes the principal purpose of the subcontract.
(f) A master subcontracting plan on a plant or division-wide basis that contains all the elements required by paragraph (d) of this clause, except goals, may be incorporated by reference as a part of the subcontracting plan required of the Offeror by this clause; provided—
(1) The master subcontracting plan has been approved;
(2) The Offeror ensures that the master subcontracting plan is updated as necessary and provides copies of the approved master subcontracting plan, including evidence of its approval, to the Contracting Officer; and
(3) Goals and any deviations from the master subcontracting plan deemed necessary by the Contracting Officer to satisfy the requirements of this contract are set forth in the individual subcontracting plan.
(g) A commercial plan is the preferred type of subcontracting plan for contractors furnishing commercial items. The commercial plan shall relate to the Offeror's planned subcontracting generally, for both commercial and Government business, rather than solely to the Government contract. Once the Contractor's commercial plan has been approved, the Government will not require another subcontracting plan from the same Contractor while the plan remains in effect, as long as the product or service being provided by the Contractor continues to meet the definition of a commercial item. A Contractor with a commercial plan shall comply with the reporting requirements stated in paragraph (d)(10) of this clause by submitting one SSR for all contracts covered by its commercial plan. This report shall be acknowledged or rejected by the Contracting Officer who approved the plan. This report shall be submitted within 30 days after the end of the Government's fiscal year.
(h) Prior compliance of the Offeror with other such subcontracting plans under previous contracts will be considered by the Contracting Officer in determining the responsibility of the Offeror for award of the contract.
(i) A contract may have no more than one subcontracting plan. When a contract modification exceeds the subcontracting plan threshold in 19.702(a), or an option is exercised, the goals of the existing subcontracting plan shall be amended to reflect any new subcontracting opportunities. When the goals in a subcontracting plan are amended, these goal changes do not apply retroactively.
(j) Subcontracting plans are not required from subcontractors when the prime contract contains the clause at 52.212-5, Contract Terms and Conditions Required to Implement Statutes or Executive Orders—Commercial Items, or when the subcontractor provides a commercial item subject to the clause at 52.244-6, Subcontracts for Commercial Items, under a prime contract.
(k)The failure of the Contractor or subcontractor to comply in good faith with—
(1) the clause of this contract entitled "Utilization Of Small Business Concerns,"or
(2) an approved plan required by this clause, shall be a material breach of the contract and may be considered in any past performance evaluation of the Contractor.
(l) The Contractor shall submit a SF 294. The Contractor shall submit SSRs. Purchases from a corporation, company, or subdivision that is an affiliate of the Contractor or subcontractor are not included in these reports. Subcontract awards by affiliates shall be treated as subcontract awards by the Contractor. Subcontract award data reported by the Contractor and subcontractors shall be limited to awards made to their immediate next-tier subcontractors. Credit cannot be taken for awards made to lower tier subcontractors, unless the Contractor or subcontractor has been designated to receive a small business or small disadvantaged business credit from an ANC

or Indian tribe. Only subcontracts involving performance in the U.S. or its outlying areas should be included in these reports with the exception of subcontracts under a contract awarded by the State Department or any other agency that has statutory or regulatory authority to require subcontracting plans for subcontracts performed outside the United States and its outlying areas.
(1) SF 294. This report is not required for commercial plans. The report is required for each contract containing an individual subcontracting plan. For Contractors the report shall be submitted to the Contracting Officer, or as specified elsewhere in this contract. In the case of a subcontract with a subcontracting plan, the report shall be submitted to the entity that awarded the subcontract.
(i) The report shall be submitted semi-annually during contract performance for the periods ending March 31 and September 30. A report is also required for each contract within 30 days of contract completion. Reports are due 30 days after the close of each reporting period, unless otherwise directed by the Contracting Officer. Reports are required when due, regardless of whether there has been any subcontracting activity since the inception of the contract or the previous reporting period. When a Contracting Officer rejects a report, the Contractor shall submit a revised report within 30 days of receiving the notice of report rejection.
(ii) (A) When a subcontracting plan contains separate goals for the basic contract and each option, as prescribed by FAR 19.704(c), the dollar goal inserted on this report shall be the sum of the base period through the current option; for example, for a report submitted after the second option is exercised, the dollar goal would be the sum of the goals for the basic contract, the first option, and the second option.
(B) If a subcontracting plan has been added to the contract pursuant to 19.702(a)(3) or 19.301-2(e), the Contractor's achievements must be reported in the report on a cumulative basis from the date of incorporation of the subcontracting plan into the contract.
(2) SSR. (i) Reports submitted under individual contract plans.
(A) This report encompasses all subcontracting under prime contracts and subcontracts with an executive agency, regardless of the dollar value of the subcontracts. This report also includes indirect costs on a prorated basis when the indirect costs are excluded from the subcontracting goals.
(B) The report may be submitted on a corporate, company or subdivision (e.g., plant or division operating as a separate profit center) basis, unless otherwise directed by the agency.
(C) If the Contractor and/or a subcontractor is performing work for more than one executive agency, a separate report shall be submitted to each executive agency covering only that agency's contracts, provided at least one of that agency's contracts is over $700,000 (over $1.5 million for construction of a public facility) and contains a subcontracting plan. For DoD, a consolidated report shall be submitted for all contracts awarded by military departments/agencies and/or subcontracts awarded by DoD prime contractors.
(D) The report shall be submitted annually by October 30, for the twelve month period ending September 30. When a Contracting Officer rejects an SSR, the Contractor is required to submit a revised SSR within 30 days of receiving the notice of report rejection.
(E) Subcontract awards that are related to work for more than one executive agency shall be appropriately allocated.
(F) The authority to acknowledge or reject SSRs, including SSRs submitted by subcontractors with subcontracting plans, resides with the Government agency awarding the prime contracts unless stated otherwise in the contract.
(ii) Reports submitted under a commercial plan.

(A) The report shall include all subcontract awards under the commercial plan in effect during the Government's fiscal year and all indirect costs.
(B) The report shall be submitted annually, within 30 days after the end of the Government's fiscal year.
(C) If a Contractor has a commercial plan and is performing work for more than one executive agency, the Contractor shall specify the percentage of dollars attributable to each agency.
(D) The authority to acknowledge or reject SSRs for commercial plans resides with the Contracting Officer who approved the commercial plan.

APPENDIX F
Measures and contributions to performance areas and scores for 2018 Performance and 2019 Service Charge

To be performed in accordance with the 2018 FEHB Plan Performance Assessment Procedure Manual and the FEHB Plan Performance Assessment – Consolidated Methodology Carrier Letter (CL 2017-15). The Service Charge for the 2019 contract year will be based on the Overall Performance Score calculated in accordance with this Appendix F.

1. Performance Area Contributions to Overall Performance Score (OPS)

Performance Area	Contribution to Overall Performance Score
Clinical Quality, Customer Service, and Resource Use	65%
Contract Oversight	35%

2. Clinical Quality, Customer Service, and Resource Use (QCR) Performance Area Measures

Performance Area	Measure	Priority Level	Measure Weight
Clinical Quality	Breast Cancer Screening	2	1.25
	Prenatal and Postpartum Care (Timeliness)	1	2.50
	Well Child Visits in the First 15 Months of Life	2	1.25
	Flu Vaccinations for Adults Ages 18-64	2	1.25
	Cervical Cancer Screening	2	1.25
	Controlling High Blood Pressure	1	2.50
	Comprehensive Diabetes Care – HbA1C <8% - Control	2	1.25
	Asthma Medication Ratio	2	1.25
	Medication Management for People with Asthma (75%)	2	1.25
	Avoidance of Antibiotics in Adults with Acute Bronchitis	2	1.25
	Follow-up After Hospitalization for Mental Illness (7-day or 30-day)	2	1.25
Customer Service	Plan Information on Costs	3	1.00
	Getting Needed Care	3	1.00
	Getting Care Quickly	3	1.00
	Claims Processing	3	1.00
	Overall Health Plan Rating	3	1.00

	Coordination of Care	3	1.00
	Overall Personal Doctor Rating	3	1.00
	Customer Service	3	1.00
Resource Use	Plan All Cause Readmissions	1	2.50
	Use of Imaging Studies for Low Back Pain	2	1.25

EXHIBIT D

2019A Amendment to Contract No. CS 1039*

Between the U.S. Office of Personnel Management and the Blue Cross and Blue Shield Association on Behalf of, and as Agent for, Participating Blue Cross and/or Blue Shield Plans

*In 2013, OPM consolidated prior amendments to Contract No. CS 1039 into one single restated contract.

AMENDMENT TO CONTRACT CS 1039

CONTRACT NO: 1039
EFFECTIVE: January 1, 1960

AMENDMENT NO. 2019A
EFFECTIVE: January 1, 2019

BETWEEN: THE UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
hereafter called the OPM, the Agency, or the Government

Address: 1900 E Street, NW
Washington, DC 20415-3610

AND

CONTRACTOR: Blue Cross and Blue Association
hereafter also called the Carrier

Address: 1310 G. Street, NW, Suite 900
Washington, DC 20005

In consideration of payment by the Agency of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract, including Appendix A.

FOR THE CARRIER

William A. Breskin
Name of Person Authorized to Execute Contract (Type or print)

Senior Vice President, Government Programs
Title

Signature

12/19/18
Date Signed

FOR THE GOVERNMENT

Sylvia V. Pulley
Name of Contracting Officer (Type or print)

Contracting Officer
FEHB I
Title

Sylvia V. Pulley
Signature

12/19/2018
Date Signed

1. **Section 1.9 Plan Performance—Fee-For-Service Contracts**

We amended Subsection (f) to align quality assurance standards among Carriers and to provide clarity for the measures and standards. Subparagraph (f)(4) *Coordination of Benefits* was moved to its own subsection in Section 1.9(j) because it is a more appropriate location for the requirement. Subsections (j) and (k) were renamed (k) and (l) respectively and references to them were changed accordingly. In amended Subparagraphs (f)(4) *Claims Timeliness* and (f)(6) *Member Inquiries*, the time period for reporting was clarified. In amended Subparagraph (f)(10)(i) *Call Answer Timeliness*, the required standard is set at 85% of calls answered by a live voice (during operating hours) within 30 seconds. In amended Subparagraph (f)(11) *Responsiveness to FEHB Member Requests for Reconsideration*, the reportable calculation is described. The required quality assurance standards are otherwise unchanged in these amendments. Subparagraph (g)(2) *Coordination of Benefits* was moved to its own subsection in Section 1.9(k) because it is a more appropriate location for the requirement; the language was also edited for clarity

SECTION 1.9
PLAN PERFORMANCE—FEE-FOR-SERVICE CONTRACTS (JAN 2019)

* * * * *

(f) Contract Quality Assurance. The Carrier shall develop and apply a quality assurance program specifying procedures for assuring contract quality over the contract period. The Carrier shall meet the following standards and submit an annual report to OPM on these standards by July 1 of the following contract period:

(1) *Claims Processing Accuracy* - the number of FEHB claims processed accurately divided by the total number of FEHB claims processed.

REQUIRED STANDARD: The Carrier shall accurately process at least 95 percent of FEHB claims.

(2) *Claims Coding Accuracy* - the number of FEHB claims coded accurately divided by the total number of FEHB claims coded.

REQUIRED STANDARD: The Carrier shall accurately code at least 98 percent of FEHB claims.

(3) *Recovery of Erroneous Payments* - the average number of working days it takes for the Carrier to begin collection action against an FEHB provider or member following identification of an erroneous payment, including overpayments.

REQUIRED STANDARD: The Carrier shall average no more than 30 working days from the date it identifies an FEHB erroneous payment to the date it begins the collection action.

(4) *Claims Timeliness* - the number of FEHB claims adjudicated (paid, denied, or a request for further information is sent out) within 30 working days from the date the Carrier received the claim, divided by the total number of FEHB claims received.

REQUIRED STANDARD: The Carrier shall adjudicate at least 95 percent of claims within 30 working days.

(5) *Processing ID cards on change of plan or option* - the number of calendar days from the date the Carrier receives the enrollment from the Enrollee's agency, Tribal Employer, or retirement system to the date it issues the ID card.

REQUIRED STANDARD: The Carrier shall issue all ID cards within 15 calendar days after receiving the enrollment from the Enrollee's agency, Tribal Employer, or retirement system except that the Carrier shall issue ID cards resulting from an open season election within 15 calendar days or by December 15, whichever is later.

(6) *Member Inquiries* - the number of written inquiries responded to within 15 working days divided by the total number of written inquiries received.

REQUIRED STANDARD: The Carrier shall respond to at least 90 percent of inquiries within 15 working days.

(7) *Written Inquiries Accuracy* – the number of FEHB written inquiries answered accurately divided by the total number of FEHB written inquiries received.

REQUIRED STANDARD: the Carrier shall accurately answer at least 97 percent of FEHB written inquiries.

(8) *Telephone Inquiries Accuracy* – the number of FEHB telephone inquiries answered accurately divided by the total number of FEHB telephone inquiries received.

REQUIRED STANDARD: The Carrier shall accurately answer at least 97 percent of FEHB telephone inquiries.

(9) *Internet Inquiries Accuracy* – the number of FEHB Internet inquiries answered accurately divided by the total number of FEHB Internet inquiries received.

REQUIRED STANDARD: The Carrier shall accurately answer at least 97 percent of FEHB Internet inquiries.

(10) *Telephone Access* - the Carrier shall report on the following statistics concerning telephone access to the member services department (or its equivalent) for the given time period. Except that, if the Carrier does not have a computerized phone system, report results of periodic surveys on telephone access.

(i) Call Answer Timeliness - the percentage of calls answered by a live voice (during operating hours) within 30 seconds.

REQUIRED STANDARD: The Carrier shall answer 80% of telephone calls by a live voice (during operating hours) within 30 seconds.

(ii) Telephone Blockage Rate - the number of calls receiving a busy signal when calling the Carrier divided by the total number of calls received.

REQUIRED STANDARD: The Carrier shall ensure that no more than 5 percent of calls receive a busy signal.

(iii) Telephone Abandonment Rate - the number of calls attempted but not connected to a live voice divided by the total number of calls attempted.

REQUIRED STANDARD: The Carrier shall ensure that no more than 5 percent of calls are abandoned before connection to a live voice.

(*iv*) *Initial Call Resolution* – the number of initial calls that result in a resolution of the issue divided by the total number of initial calls for an issue.

REQUIRED STANDARD: The Carrier shall resolve the issue during the initial call at least 80 percent of the time.

(11) *Responsiveness to FEHB Member Requests for Reconsideration* - the number of times the Carrier responds (affirms the denial in writing to the FEHB member, pays the claim, provides or authorizes coverage of the service, or requests additional information reasonably necessary to make a determination) within 30 days to a request for reconsideration of a disputed claim divided by the total number of requests for reconsideration of disputed claims received.

REQUIRED STANDARD: The Carrier shall respond to 100 percent of written FEHB disputed claim requests within 30 days after receipt by the Carrier.

* * * * *

(j) The Carrier must demonstrate that it uses and shall use a statistically valid sampling technique to identify FEHB claims prior to or after processing that requires coordination of benefits with a third party payer or the Carrier shall pursue and provide evidence that it pursues all claims for coordination of benefits.

(k) Correction of Deficiencies. The Contracting Officer may order the correction of a deficiency in the Carrier's quality assurance program or fraud prevention program. The Carrier shall take the necessary action promptly to implement the Contracting Officer's order. If the Contracting Officer orders a modification of the Carrier's quality assurance program or fraud prevention program pursuant to this paragraph after the contract year has begun, the costs incurred to correct the deficiency may be excluded from the administrative expenses -- for the contract year -- that are subject to the administrative expenses limitation specified at Appendix B; provided

the Carrier demonstrates that the correction of the deficiency significantly increases the Carrier's liability under this contract.

(l) In order to allow sufficient implementation time, the Contracting Officer will notify the Carrier reasonably in advance of any new requirement(s) under paragraphs (a) through (k).

2. **Section 1.26 Standards for Pharmacy Benefit Management Company (PBM) Arrangements**

We amended Subsection (c) to update the references to Section 1.9, Subsection (f).

SECTION 1.26
STANDARDS FOR PHARMACY BENEFIT MANAGEMENT COMPANY (PBM) ARRANGEMENTS (JAN 2019)

* * * * *

(c) Performance Standards The Carrier will require that its PBM contractors develop and apply a quality assurance program specifying procedures for ensuring contract quality on the following standards at a minimum and submit reports to the Carrier on their performance. PBMs must meet, at minimum, the member inquiry, telephone customer service, paper claims processing, and other applicable standards set for Carriers at Section 1.9(f)(1), (2), (4), (6), and (10). All other standards discussed below will have specific target goals the PBM is expected to achieve. Carriers may permit PBMs to measure compliance using statistically valid samples for the PBM's book of business. Agreed to standards shall be provided to OPM for its review and comment. If OPM has concerns about a particular standard, the Carrier agrees to present OPM's concerns to the PBM and either revise the standard as requested by OPM or revise the standard to the extent feasible and present to OPM information demonstrating the problems associated with making the requested revisions in full.

* * * * *

3. **Section 1.30 Health Information Technology Privacy and Security**

We amended Subsection (d) to more clearly require Carriers to allow an authorized representative of the Contracting Officer to perform independent evaluations to ensure information systems that directly process FEHBP data and information systems that are in the same general IT control environment are securely configured and are up to date.

SECTION 1.30
HEALTH INFORMATION TECHNOLOGY PRIVACY AND SECURITY (JAN 2019)

(a) Any Carrier subcontractor, large provider, or vendor, that administers a personal health record or quality and cost or price transparency software applications for Members that collect, create, receive, store or transmit individually identifiable protected health information of

Members that does not qualify as a covered entity or business associate under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or regulations will be required by the Carrier to, at a minimum, comply with equivalent privacy and security policies as are required of a "covered entity" under the HIPAA Privacy and Security regulations.

(b) The Carrier will provide for consumer transparency including, but not limited to, the posting of the subcontractor's, large provider's, or vendor's notice of privacy practices prominently at the point where the Member enters the subcontractor's, large provider's, vendor's or other entity's website or web portal.

(c) Notices of privacy practices disclosures must describe the uses of individually identifiable protected health information and any potential disclosure to other entities as described in the HIPAA Privacy Rule.

(d) The Carrier must allow the Contracting Officer or an authorized representative of the Contracting Officer to independently perform credentialed vulnerability scans and configuration compliance audits (using administrator accounts) against the Carrier's information systems and environments described in this subsection to determine whether the Carrier has controls in place to ensure its information systems are securely configured and patches are timely applied and up to date based on the level of risk in the environment.

(1) NIST SP 800-53 (or its current equivalent) may be used as a benchmark for conducting audits of Carrier information systems. The Contracting Officer or an authorized representative of the Contracting Officer may recommend that the Carrier adopt a best practice drawn from NIST SP 800-53 (or its current equivalent) to the following Carrier information systems:

(i) Information systems that directly process FEHBP data for contract purposes; and

(ii) All other information systems operating in the same general information technology control environment (i.e. any resources in the same physical or logical environment) as the information systems in subparagraph (i) above.

(2) In a written response to such a recommendation, the Carrier shall do one of the following:

(i) Agree to adopt the recommendation,

(ii) Explain that it is already in compliance with the recommendation, or

(iii) Explain why maintaining its current practice is compliant with Section 1.22, captioned Administrative Simplification -- HIPAA and is equally, if not more, appropriate for its business purposes than the recommended best practice from (1) above.

(3) Upon request of the Contracting Officer or an authorized representative of the Contracting Officer, the Carrier agrees to demonstrate to the requestor its compliance with either a recommended best practice from (1) or an alternative current practice from subparagraph (2)(iii) that the Carrier has adopted. Evidence submitted pursuant to (2) that the Carrier and Contracting Officer agree is extremely sensitive may, at the Carrier's request and the Contracting Officer's concurrence, be reviewed on the Carrier's premises.

(4) If the Carrier agrees to adopt a best practice recommendation made pursuant to (1) above, the Contracting Officer will allow reasonable time for the Carrier to implement the best practice before making any request under (3) above.

Part IV-SPECIAL PROVISIONS is deleted and replaced with the following:

SECTION 4.1
ALTERATIONS IN CONTRACT (JAN 2019) (FAR 52.252-4)

Portions of this contract are altered as follows:

(a) Section 1.6 Confidentiality of Records. The following subsection is added:

(d) Local Blue Cross and/or Blue Shield Plans may combine the personal data and medical records of Federal subscribers, and information relating thereto, with the same information of other individuals who have health benefits coverage under the Local Blue Cross and/or Blue Shield Plan. This combined data may only be used and disclosed for the Plan's health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501). Such activities include, but are not limited to: care management; prevention, detection, and recovery of funds subject to fraud and abuse; and negotiation of provider contracts.

(e) As used in subsection (b)(1) of this section, "administration of this contract" means health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501).

(b) Section 1.9 Plan Performance—Experience-Rated FFS Contracts.

The Carrier may use the appropriate systems for measurement and/or collection of data on the quality of the health care services as described in subparagraph 1.9(b).

(c) Section 1.14, Misleading, Deceptive, or Unfair Advertising, is amended by removing the reference to the NAIC Advertisements of Accident and Sickness Insurance Model Regulation (Appendix D-b). Carrier should continue to use the FEHB Supplemental Literature Guidelines (now at the renumbered Appendix C) along with FEHBAR 1603.7002.

(d) Section 1.15 Renewal and Withdrawal of Approval (FEHBAR). The following subsections are added:

(d) If the agency suspends payment of the subscription charges for any reason, the Carrier may (1) suspend making benefit payments until payment of all subscription charges due is fully restored; or (2) terminate the contract without prior notice.

(e) Section 1.21 Patient Bill of Rights. For the purpose of compliance with this Section, the Carrier will conduct the following minimum activities: (1) the Carrier will provide subscribers with a Fact Sheet that includes information about the disenrollment rate in the Blue Cross and Blue Shield Service Benefit Plan, as well as Local Plan-specific information including compliance with Federal and State financial requirements, public corporate information, years in existence, and accreditation status; (2) Provider

Directories will include language advising subscribers to contact their providers directly to obtain information about the providers, including but not limited to board certifications, languages spoken, availability of interpreters, facility accessibility, and whether the provider is accepting new patients.

(f) Section 1.30 Health Information Technology Privacy and Security. Subsections (b), (c) and the introductory paragraph of Subsection (d) of Section 1.30 are amended to read as follows:

(b) The Carrier will promote consumer transparency by ensuring that at the point where the Federal member enters the subcontractor's, large provider's, or vendor's website or web portal the link to the subcontractor's, large provider's, or vendor's notice of privacy practices and/or privacy policies is displayed on the bottom, or prominently displayed elsewhere, on the website or web portal.

(c) Notice of privacy practices and/or privacy policies disclosures must describe the uses of individually identifiable protected health information and any potential disclosure to other entities as described in the HIPAA Privacy Rule.

(d) The Carrier will participate with the Contracting Officer or an authorized representative of the Contracting Officer in credential vulnerability scans and configuration compliance audits conducted in accordance with rules of engagement agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The rules of engagement will include the software and hardware used for vulnerability scanning; the specific process used to conduct vulnerability scanning; precautions taken to prevent negative disruption on the systems being scanned; restrictions on the release of documents and artifacts; and how the results of the scanning will be reviewed and reported.

(g) Section 2.2 Benefits Provided. The following paragraph is added to subsection 2.2(a):

(4) The Carrier may pay the Preferred Provider Organization level of benefits under this contract to ease the hardship of members affected by natural disasters such as earthquakes, floods, etc., when because of the natural disaster members have difficulty gaining access to Preferred network providers. The Carrier may pay the Preferred level of benefits without regard to the provider's contractual relationship with the Carrier and will determine an appropriate time frame based on local conditions during which the provision of this paragraph will apply. Benefits provided under this paragraph will be made available to all members similarly affected by the natural disaster.

(h) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Notwithstanding subsection (f) of Section 2.3, benefits provided under the contract are not assignable by the Member to any person without express written approval of the carrier, and in the absence of such approval, any such assignment shall be void. Notwithstanding such approval, no assignment of benefits may be made in any case prior to the time that a valid claim for benefits arises.

(i) Section 2.3 Payment of Benefits and Provision of Services and Supplies. The introductory paragraph of Subsection 2.3(g) is amended to read as follows:

(g) *Erroneous Payments.*

(i) If the Carrier or OPM determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider; the recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment under 48 C.F.R. 1631.201-70(h) regardless of any time period limitations in the written agreement with the provider.

(ii) The Carrier shall be deemed to have satisfied the requirements of Subsection (g) (i) above by complying with Subsections (ii), (iii), and (iv). Local Blue Cross and Blue Shield Plans which have time period limitations in their provider contracts which prevent the Plan from recovering erroneous benefit payments made to providers will participate in an action plan. The action plan shall be developed by the Blue Cross and Blue Shield Association by December 31, 2008 and agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield Association and the Contracting Officer shall utilize standards of commercial reasonableness and neither shall unreasonably withhold agreement. The action plan shall be designed to reduce the occurrence of erroneous benefit payments, to identify and recover erroneous benefit payments within the time limits stipulated in their provider contracts, and to demonstrate due diligence in making an attempt to identify and recover within that provider contract timeframe such erroneous benefit payments.

(iii) The Blue Cross and Blue Shield Association shall be responsible for monitoring and determining whether each Blue Cross and Blue Shield Plan participating in the action plan is complying with its obligations under the action plan.

(iv) A Blue Cross and Blue Shield Plan which is in compliance with its obligations under the action plan shall be found to be in compliance with its obligation under this Section 2.3(g) to make a prompt and diligent effort to recover erroneous benefit payments. In the event that any Plan with such time period limitations is determined to be not in substantial compliance with the action plan, and that Plan is determined not to have pursued material benefit payments with promptness and diligence, then the Plan shall return the erroneous benefit payments to the Program.

(v) The Carrier shall follow general business practices and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall—

(j) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(7)(ii) of Section 2.3 is amended to read as follows:

Notwithstanding (g)(7)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that

caused erroneous benefit payments) when the errors are egregious and repeated. These costs are deemed to be unreasonable and unallowable under Section 3.2(b). The term "repeated" in the previous sentence does not apply to situations in which a claims processing system error causes multiple erroneous payments or to situations that involve audit findings on errors that are endemic to the provision of insurance and claims processing.

(k) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(10) of Section 2.3 is amended to read as follows:

(10) In compliance with the Contracts Disputes Act, the Carrier shall return to the Program an amount equal to the uncollected erroneous benefit payment where the Contracting Officer determines that the Carrier failed to make a prompt and diligent effort, as that term is described above, to recover the erroneous benefit payment. This provision applies to benefit payments which have been paid in error for any reason (except in the case of fraud or abuse).

(l) Section 2.4 Termination of Coverage and Conversion Privileges. The conversion contract set forth in Section 2.4(c) may be a contract that is regularly offered by the local Blue Cross and/or Blue Shield Plan.

(m) Section 2.5 Subrogation. The following subsections are added:

(c) To the extent that a Member has received benefits for covered services under this contract for an injury or illness caused by a third party, the Carrier shall have the right to be subrogated and succeed to any rights of recovery against any person or organization from whom the Member is legally entitled to receive all or part of those same benefits, including insurers of individuals (non-group) policies of liability insurance that are issued to and in the name of the Member. The obligation of the Carrier to recover amounts through subrogation is limited to making a reasonable effort to seek recovery of amounts to which it is entitled to recover in cases which are brought to its attention. The Carrier shall not be required to recover any amounts from any person or organization who causes an injury or illness for which the Member makes claims for benefits.

(d) The Carrier may also recover directly from the Member all amounts received by the Member by suit, settlement, or otherwise from any third party or its insurer, or the Member's insurer under an individual policy or liability insurance, for benefits which have also been paid under this contract.

(e) The Member shall take such action, furnish such information and assistance, and execute such papers as the Carrier or its representative believes are necessary to facilitate enforcement of its rights, and shall take no action which would prejudice the interests of the Carrier to subrogation.

(f) Effective January 1, 1997, all Participating Plans shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under the contract.

(n) Section 2.6 Coordination of Benefits (FEHBAR). The following subsections are added:

(g) The benefits payable by this Plan shall be determined, on a claim by claim basis, only for those claims in excess of $100, except where Medicare is the primary payer of benefits, claims in excess of $50.

(h) Whenever payments which should have been made under this contract in accordance with this provision have been made under any other group health coverage, the Carrier shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amount it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this contract and, to the extent of such payments discharged from liability under the contract.

(o) Section 3.1 Payments (FEHBAR). The following sentence is added to the end of Section 3.1(a):

OPM will withhold from the subscription charges amounts for other obligations due under the contract only to the extent that OPM and the Carrier have agreed in writing to specific deductions for such other obligations.

(p) Section 3.1 Payments (FEHBAR). The following subsection is added:

(g) Except as required pursuant to Sections 1.25 and 2.12, in the event this contract is terminated or not renewed, the agency shall be liable for all sums due and unpaid, including subscription charges, for the period up to the last day of the Member's entitlement to benefits.

(q) Section 3.2 Accounting and Allowable Cost (FEHBAR). Section 3.2(b)(2)(ii) of this contract is amended to comply with 5 U.S.C. 8909(f) as follows:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(r) Section 3.2 Accounting and Allowable Cost (FEHBAR). The provision in Section 3.2 (b)(2)(iv)(A) is supplemented as follows:

Charges for mandatory statutory reserves (Section 3.2(b)(2)(iv)(A)) to satisfy mandatory

statutory reserve requirements of Participating Plans are allowable to the extent that such requirements exceed that portion of the service charge at Appendix B, Subscription Rates, Charges, Allowances and Limitations applicable to such Plans.

(s) Section 3.2 Accounting and Allowable Cost (FEHBAR). This section is modified as follows:

The Carrier, as required by the Blue Cross and Blue Shield Service Benefit Plan Workplan, shall furnish OPM an accounting of its operations under the contract not less than 120 days after the end of the calendar year contract period.

(t) Section 3.3 Special Reserve. The provision in Section 3.3(a) is supplemented as follows:

The Special reserve held by or on behalf of the Carrier is to be used only for payment of charges against this contract, including advance payments to Participating Plans and to hospitals.

(u) Section 3.10, Audit, Financial, and Other Information. Compliance by the Carrier and Participating Blue Cross and Blue Shield Plans with the Blue Cross Blue Shield Service Benefit Plan Workplan, as agreed upon between the Carrier and OPM, will constitute compliance with the Audit Guide referred to in Sections 3.2 and 3.10.

SECTION 4.2
HOSPITAL (FACILITY) BENEFIT PAYMENTS AND CONDITIONS (JAN 1991)

(a) Benefits described in the agreed upon brochure text shall be provided to the extent practicable in the form of services rendered by hospitals, freestanding ambulatory facilities, and home health care agencies, and payment, therefore, by or on behalf of the carrier shall constitute a complete discharge of their obligations under this contract to the extent of services rendered in accordance with the terms and conditions of the contract.

(b) Benefits for inpatient hospital care shall be available only to a Member admitted to the hospital on the recommendation, and while under the active medical supervision of a duly licensed physician or alternative provider as described in section 8902(k)(1) of title 5 U.S.C. who is a member of the staff of, or acceptable to, the hospital selected.

(c) Hospital service is subject to all the rules and regulations of the hospital selected including rules governing admissions.

(d) While a Member may elect to be hospitalized in any hospital, the Carrier does not undertake to guarantee the admission of such Member to the hospital, nor the availability of any accommodations or services therein requested by the Member or his physician.

SECTION 4.3
DEFINITION OF CARRIER (JAN 1991)

The Carrier is the Blue Cross and Blue Shield Association, an Illinois not-for-profit corporation, acting on behalf of participating Blue Cross and Blue Shield Plans and

pursuant to authority specified in Exhibit A for and in behalf of the organizations specified in Exhibit A (hereinafter sometimes referred to as "Participating Plans").

SECTION 4.4
AUDIT DISPUTES (JAN 2000)

(a) Any questioned costs or issues documented by or on behalf of OPM's Office of the Inspector General (OIG) in draft or final audit reports examining the Carrier's and Participating Plans' performance under this contract, that are provided to the Carrier and that were initially raised in the timeframe set forth in subsection (c) below, remain open until resolved. Audit issues related to monetary findings for which extensions of the waiver period for the issuance of final decisions and processing of prior period adjustments were obtained in previous contract terms also remain open until resolved.

(b) Resolution of a questioned cost or issue can be the result of a resolution letter or the issuance of a final decision by the Contracting Officer, or by the processing of a prior period adjustment, an adjustment to the Special reserve, or submission of a claim to OPM (as appropriate) by the Carrier or Participating Plan. A prior period adjustment intended to partially or fully resolve an audit finding will not be considered closed until properly reported on the calendar year Annual Accounting Statement.

(c) A claim seeking, as a matter of right, the payment of money, in a sum certain, pursuant to 48 CFR section 52.233-1, shall not be made more than five years following the last day prescribed by the contract for filing the calendar year Annual Accounting Statement for the year with respect to which the claim arises. A claim includes, in the case of the carrier, a charge against the contract.

SECTION 4.5
ASSOCIATION DUES (JAN 2004)

A Participating local Blue Cross and Blue Shield Plan may charge to this contract Association Dues, with the exception of dues related to those lobbying costs and Special Assessments determined to be unallowable. In calculating the unallowable portion of dues related to lobbying costs for a contract year, the Blue Cross and Blue Shield Plan will rely on the percentage of dues, less any special assessments, as determined by the BCBSA for IRS purposes, to be not tax deductible from the previous contract year.

SECTION 4.6
TRAVEL COSTS (JAN 1996)

The Carrier may charge and account for travel expenses related to administration of the contract on a per diem basis, subject to the maximums prescribed by the Federal Travel Regulations. For those travel costs for each contract term that are subject to the Federal per diem rates set forth at 48 CFR section 31.205-46, the Carrier shall charge to the contract an amount equal to the lesser of:

(i) the actual aggregate charges for those costs, or
(ii) the aggregate charges calculated using the per diem rates set forth in the Federal Travel Regulations.

SECTION 4.7
MARKET RESEARCH COSTS (JAN 1996)

(a) Costs of market research surveys or studies are generally allowable if the survey or study is:

1. directed to current Members and Members who left the Blue Cross and Blue Shield Service Benefit Plan in the most recent Open season, or
2. focused on long-range planning, industry state-of-the-art developments, or product development issues for which a direct benefit or potential benefit to the FEHB Program can be identified, or
3. pre-approved by the Contracting Officer.

(b) Costs of market research surveys or studies are generally not allowable if the primary purpose is to survey or study an otherwise unallowable cost item, such as: to determine the effectiveness of advertising or sales strategies; to evaluate image effectiveness or ways to achieve image enhancement; or to perform a competitive analysis with other carriers in the FEHB Program. Such costs are unallowable, regardless of who receives the research surveys or studies.

(c) This provision does not supersede other contract requirements, such as prior approval for subcontracts under Section 1.16 Subcontracts (FEHBAR 1652.244-70).

SECTION 4.8
PRESCRIPTION DRUG BENEFITS WAIVER PROVISIONS (JAN 2009)

(a) For the purposes of applying the special provisions in this section, the Standard Option Mail Service Prescription Drug Program service standards are:

(1) When a prescription order is placed that does not require additional information or clarification (i.e., a clean or non-diverted prescription), the prescription order shall be dispensed within three business days from the date of receipt so the enrollee may expect to receive the medication within 7 calendar days.

(2) When a prescription order is placed that does require additional information, clarification or resolution of payment issues (i.e., a diverted prescription), the prescription order shall be dispensed within seven business days from the date of receipt so the enrollee may expect to receive the medication within 14 calendar days. However the following situations will not be considered a diverted prescription for the purposes of this section:

(i) Prescriptions for refrigerated products that require prior arrangements between the mail order pharmacy and a Member before the Member can receive the Prescription;

(ii) Prescriptions requiring specific counseling obligations imposed by the pharmaceutical manufacturer, distributor or the FDA;

(iii) Prescriptions requiring "registration" with a pharmaceutical manufacturer.

(b) The special provisions described in paragraphs (c)(1), (2), and (3) shall become effective automatically when less than 98 percent of the prescriptions are filled within the

service standards described in either paragraph (a)(1) or (a)(2) for 7 consecutive business days. The special provisions shall terminate when for 7 consecutive business days 98 percent or more of the prescriptions are filled within the service standards described in paragraphs (a)(1) and (a)(2) of this section.

(c) The special provisions are:

(1) The Carrier shall waive during the effective periods in paragraph (b) the coinsurance for a 21 day prescription filled at a Preferred retail pharmacy when the Mail Service Prescription Drug Program vendor is unable to fill the prescription within the service standards. This waiver of the coinsurance shall be in effect for 14 calendar days after notice to the enrollee as described in paragraph (c)(2) below.

(2) The Carrier shall deliver to the enrollee a written or telephone notice no later than 5 days from the date of receipt for clean or non-diverted prescriptions and no later than 12 days from the date of receipt for diverted prescriptions.

This notice shall:

(i) advise the enrollee that the Mail Service Prescription Drug Program may not be able to fill the prescription(s) within the service standard timeframes;

(ii) advise the enrollee that any applicable coinsurance will be waived for a 21 day supply of the medication(s) when filled at a Preferred retail pharmacy;

(iii) provide the enrollee with instructions on how to use the waiver, and

(iv) advise the enrollee when the waiver will expire.

(3) The Carrier may use next day delivery service at no additional cost to the enrollee in order to meet the service standards in (a)(1) and (a)(2).

SECTION 4.9
SMALL BUSINESS SUBCONTRACTING PLAN (JAN 2002) (FAR 52.219-9) (AS AMENDED)

An amended clause 52.219-9, Small Business Subcontracting Plan, is attached to Appendix E.

SECTION 4.10
LETTER OF CREDIT (JAN 1997)

As of January 1, 1997, OPM will administer Letter of Credit drawdowns directly with the local Plans.

SECTION 4.11
PILOTING OF COST CONTAINMENT PROGRAMS (JAN 2001)

Upon approval by the Contracting Officer, the Carrier may design and implement pilot programs in one or more local Plan areas that test the feasibility and examine the impact of various managed care initiatives. The Carrier shall brief the Contracting Officer on a pilot program prior to its implementation, advise the Contracting Officer of the progress of the pilot program and provide a written evaluation at the conclusion of the pilot program. The evaluation of the pilot program shall, at a minimum, assess the cost effectiveness, effect on quality of care and/or quality of life, and customer satisfaction, and recommend whether the pilot program should be continued or expanded.

SECTION 4.12
TRANSITION COSTS FOR PLAN TERMINATIONS (JAN 1999)

In the event a Participating Plan's license to use the Blue Cross and/or Blue Shield service marks is terminated, thereby rendering it ineligible to participate in this Contract, the costs of transitioning the terminated Plan's Service Benefit Plan subscribers to a successor Plan shall be subject to advance approval. The Carrier shall submit to OPM a proposed transition plan, together with a detailed estimate of costs, prior to the incurrence of any significant transition costs. OPM and the Carrier shall negotiate an advance agreement pursuant to FAR 31.109 that covers the extent of allowable transition costs.

SECTION 4.13
PAYMENT BY ELECTRONIC FUNDS TRANSFER-CENTRAL CONTRACTOR REGISTRATION (MAY 1999) (FAR 52.232-33)

The references to the Central Contractor Registration in FAR 52.232-33 are not applicable to this contract.

SECTION 4.14
FEDERAL INCOME TAX RELATED TO HEALTH INSURANCE PROVIDERS' FEE (JANUARY 2015)

(a) Notwithstanding FAR 31.205-41(b)(1) and this Contract Section 3.2(b)(1)(ii), a charge for an incremental amount of Federal income tax liability incurred as the result of compliance with the Health Insurance Providers Fee (HIP Fee) provision of the Affordable Care Act section 9010 (hereafter referred to as the "HIP Tax Cost") by a participating local plan (Local Plan) that administers the Service Benefit Plan on behalf of the Blue Cross and Blue Shield Association (Carrier), and that is a covered entity within the meaning of 26 CFR Part 57, is an allowable cost to the Carrier under this contract under the criteria set forth below.

(1) The allowable cost to the Carrier for a year is the sum of the HIP Tax Cost for each Local Plan. The HIP Tax Cost for each Local Plan equals:
the amount reimbursed by OPM to the Carrier for the HIP Fee attributable to the Local Plan (Local Plan HIP Fee) for the year, divided by one minus the tax rate for the Local Plan specified under section (2) below, (Local Plan Tax Rate), less the Local Plan HIP Fee. In mathematical terms, the allowable charge to the Carrier for the HIP Tax Cost is the sum of each Local Plan's application of the formula below:

$$\left[\frac{\text{Local Plan HIP Fee}}{1 - \text{Local Plan Tax Rate}}\right] - \text{Local Plan HIP Fee}$$

(2) The Local Plan Tax Rate for purposes of the formula specified in section (1) is the lowest of the following:
(a) the rate specified at 26 USC §11 (b) (1) (D),

(b) the rate specified at 26 USC § 55(b)(1)(B)(i), for any year in which the Local Plan is entitled to the special deduction under 26 USC § 833(a)(2), or
(c) zero, for any year in which the Local Plan experiences a Net Operating Loss or other circumstance resulting in no tax liability. For a year in which the Local Plan experiences a Net Operating Loss resulting in no tax liability, the Carrier will charge the HIP Tax Cost attributable to the Local Plan in the first subsequent year in which the Local Plan's tax liability is greater than zero. The Local Plan will calculate the HIP Tax Cost in this circumstance by applying the formula using the HIP Fee for the year of the loss and the Local Plan Tax Rate for the year in which the tax liability is greater than zero. This charge by the Carrier is in addition to the charge allowed by the Carrier for the Local Plan Tax Cost for the year in which the tax liability is greater than zero.

(d) If the Local Plan Tax Rate reflected on the Local Plan's tax return actually filed for the contract year (which normally occurs the following year) differs from the Local Plan Tax Rate that was anticipated when the costs were drawn down by the Carrier for the contract year as allowable administrative expenses, the Carrier will make a commensurate adjustment to its current year drawdown of administrative expenses.

(b) The Contracting Officer or an authorized representative of the Contracting Officer shall have the right to examine and audit all books and records, including tax filings, relating to the calculation of the HIP Tax Cost charge for each Local Plan.

Part IV - Attachment I
SECTION 4.14
FEDERAL INCOME TAX RELATED TO HEALTH INSURER'S PROVIDER FEE

Examples of Allowable 9010 Tax Cost:

C is an experience rated FEHB carrier consisting of participating Local Plans F and G who underwrite and administer C in different geographic areas.

In 2015, F reports $900 on IRS Form 8963 and pays $500 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the $500 HIP Fee, F's Form 8963 reflects that $300 is attributable to F's FEHBP business.

Also in 2015, G reports $950 on IRS Form 8963 and pays $550 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the $550 HIP Fee, G's Form 8963 reflects that $325 is attributable to G's FEHBP business.

In 2015, C draws down a 2015 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2014 health risks, which is calculated as the sum of F and G's HIP Fee, or $300 +325 = $725, which is an allowable cost, from its FEHB letter of credit account (LOCA). C reimburses F for its HIP Fee of 300 and G for its HIP Fee of 325.

F records income of $300 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by $300. F records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, F pays quarterly payments to the IRS for its' 2015 tax liability. F's 2015 tax rate is 35 percent.

G records income of $325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by $325. G records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, G pays quarterly payments to the IRS for its' 2015 tax liability. Because G claims a special deduction under 26 USC § 833(a)(2), G's 2015 tax rate is 20 percent.

In 2015, C also draws down from its LOCA a 2015 HIP Tax Cost reimbursement for the 2015 income tax expense accrued and paid by F & G in 2015. C's 2015 HIP Tax cost reimbursement is calculated as follows:

Local Plan F HIP Tax Cost: ($300/1-.35)-$300 = $162
Local Plan G HIP Tax Cost: ($325/1-.20)-$325 = $81
Sum which is C's allowable HIP Tax Cost for 2015 = $243

In 2016, F & G report the same HIP Fee expense for 2015 health risks.

In 2016, F experiences the same tax rate as for 2015, but G incurs a net operating loss, resulting in a zero percent tax rate for 2016.

In 2016, C draws down a 2016 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2015 health risks of 300 + 325 = $725, which is an allowable cost, from C's FEHB letter of credit account (LOCA). C reimburses F for 300 and G for 325.

In 2016, F proceeds as in 2015 and C may charge 162 as an allowable HIP Tax Cost attributable to F in 2016.

In 2016 G records income of $325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by $325. Because G determines that its 2016 tax liability will be zero as it will have a Net Operating Loss for 2016, C does not incur an allowable 2016 HIP Tax Cost attributable to G. C must refund any such amounts drawn down during 2016.

Local Plan F HIP Tax Cost for 2016 = 162
Local Plan G HIP Tax Cost for 2016 = 0
Reimbursement attributable to G = adjustment for amounts drawn down by C, if any
Sum = C's allowable HIP Tax Cost for 2016 = 162 less adjustment.

In 2017, F proceeds as in 2015. C's allowable 2017 HIP Tax Cost includes $162 attributable to F. In 2017, G has an operating gain and reports the same HIP Fee amount and experiences the same 20% tax rate as in 2015. C's allowable 2017 HIP Tax Cost includes $81 attributable to G.

In addition, in 2017, because G's operating gain results in a tax rate higher than zero, G incurs economic disadvantage. This is because the 2016 HIP Fee reimbursement of $325 has reduced G's otherwise applicable Net Operating Loss carry-forward amount. G calculates the economic disadvantage as the difference between its 2017 tax liability with and without the 2016 HIP Fee reimbursement. This disadvantage is included in the Carrier's 2017 charge as an allowable HIP Tax Cost with respect to 2016. This is calculated as $325 (2016 HIP Fee) divided by 1-20% (application of 2017 Local Plan Tax Rate), less $325.]

Local Plan F HIP Tax Cost for 2017 = 162
Local Plan G HIP Tax Cost for 2017 = 81
Local Plan G HIP Tax Cost for 2017 due to 2016 HIP Fee reimbursement = apply formula using 2016 Fee Reimbursement amount and 2017 tax rate of 20% =81
Sum = C's allowable HIP Tax Cost for 2017 = 162 + 81 + 81 = $324

APPENDIX A

2019

Brochure Text

For a copy of the 2009 brochure, please go to
https://bluewebportal.bcbs.com/

APPENDIX B

SUBSCRIPTION RATES, CHARGES, ALLOWANCES AND LIMITATIONS

Fee-For-Service Carrier

Blue Cross and Blue Shield Service Benefit Plan
CONTRACT NO. CS 1039
Effective January 1, 2019

(a) Biweekly net-to-Carrier rates, with appropriate adjustments for Enrollees paid on other than a biweekly basis, are as follows:

Basic Option:	$283.56 Self, $637.35 Self Plus One, and $675.54 Self and Family
Standard Option:	$329.24 Self, $720.01 Self Plus One, and $763.01 Self and Family
FEP Blue Focus:	$204.40 Self, $439.44 Self Plus One, and $483.37 Self and Family

(b) The amount of administrative expenses and charges to be included in the Annual Accounting Statement required by Section 3.2 shall be as set out in the schedule below:

Item	Amount
(i) Administrative Expenses	Actual, but not to exceed the Contractual Expense Limitation for 2019,* plus an amount sufficient to cover the costs needed to pay the Plan's Independent Public Accountant to undertake the audits and agreed upon procedures required in the "FEHBP Experienced-Rated Carrier and Service Organization Audit Guide."
(ii) Taxes	Actual (except that premium taxes as defined are not allowable).
(iii) Service Charge**	Redacted

*The Contractual Expense Limitation for 2019 is Redacted Notwithstanding Section 3.2(b) of this Contract, costs of "activities that improve healthcare quality" as determined in accordance with the medical loss ratio provision of the Affordable Care Act (Section 2718 of the

Public Health Service act; 42 U.S.C. 300gg-18 and its implementing regulations), are accounted for as benefits and not counted toward the Contractual Expense Limit.

** The Service Charge for the 2019 contract year is based on the Overall Performance Score calculated in accordance with the 2018 Appendix F. The Service Charge for the 2020 contract year will be based on the Overall Performance Score calculated in accordance with the 2019 Appendix F.

APPENDIX D
RULES FOR COORDINATION OF BENEFITS

Model Regulation Service--October 2013
National Association of Insurance Commissioners

When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows:

A. (1) The primary plan shall pay or provide its benefits as if the secondary plan or plans did not exist.

(2) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(3) When multiple contracts providing coordinated coverage are treated as a single plan under this regulation, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one Carrier pays or provides benefits under the plan, the Carrier designated as primary within the plan shall be responsible for the plan's compliance with this regulation.

(4) If a person is covered by more than one secondary plan, the order of benefit determination rules of this regulation decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the rules of this regulation, has its benefits determined before those of that secondary plan.

B. (1) Except as provided in Paragraph (2), a plan that does not contain order of benefit determination provisions that are consistent with this regulation is always the primary plan unless the provisions of both plans, regardless of the provisions of this paragraph, state that the complying plan is primary.

Drafting Note: The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts (often referred to as "med pay"), which is included in the definition of "plan" under Section 3K(3) of this model regulation, does not normally contain order of benefit determinations provisions. As such, unless state law or regulation specifies otherwise, in accordance with paragraph (1), such coverage would be primary. Med pay coverage is not liability coverage and is not dependent upon fault.

(2) Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverage's that are superimposed over base plan hospital and surgical benefits, and insurance type coverage's that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A plan may take into consideration the benefits paid or provided by another plan only when, under the rules of this regulation, it is secondary to that other plan.

D. Order of Benefit Determination

Each plan determines its order of benefits using the first of the following rules that applies:

(1) Non-Dependent or Dependent

(a) Subject to Subparagraph (b) of this paragraph, the plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

(b) (i) If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(I) Secondary to the plan covering the person as a dependent; and

(II) Primary to the plan covering the person as other than a dependent (e.g. a retired employee),

(ii) Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

Drafting Note: The provisions of Subparagraph (b) address the situation where federal law requires Medicare to be secondary with respect to group health plans in certain situations despite state law order of benefit determination provisions to the contrary. One example of this type of situation arises when a person, who is a Medicare beneficiary, is also covered under his or her own group health plan as a retiree and under a group health plan as a dependent of an active employee. In this situation, each of the three plans is secondary to the other as the following illustrates: (1)

Medicare is secondary to the group health plan covering the person as a dependent of an active employee as required pursuant to the Medicare secondary payer rules; (2) the group health plan covering the person as a dependent of an active employee is secondary to the group health plan covering the person as a retiree, as required under Subparagraph (a); and (3) the group health plan covering the claimant as retiree is secondary to Medicare because the plan is designed to supplement Medicare when Medicare is the primary plan. Subparagraph (b) resolves this problem by making the group health plan covering the person as a dependent of an active employee the primary plan. The dependent coverage pays before the non-dependent coverage even though under state law order of benefit determination provisions in the absence of Subparagraph (b), the non-dependent coverage (e.g. retiree coverage) would be expected to pay before the dependent coverage. Therefore, in cases that involve Medicare, generally, the dependent coverage pays first as the primary plan, Medicare pays second as the secondary plan, and the non-dependent coverage (e.g. retiree coverage) pays third.

The reason why Subparagraph (b) provides for this order of benefits making the plan covering the person as dependent of an active employee primary is because Medicare will not be primary in most situations to any coverage that a dependent has on the basis of active employment and, as such, Medicare will not provide any information as to what Medicare would have paid had it been primary. The plan covering the person as a retiree cannot determine its payment as a secondary plan unless it has information about what the primary plan paid. The plan covering the person as a dependent of an active employee could be subject to penalties under the Medicare secondary payer rules if it refuses to pay its benefits. The plan covering the person as a retiree is not subject to the same penalties because, in this particular situation, as described above, which does not involve a person eligible for Medicare based on end-stage renal disease (ESRD), the plan can never be primary to Medicare. As such, out of the three plans providing coverage to the person, the plan covering the person as a dependent of an active employee can determine its benefits most easily.

(2) Dependent Child Covered Under More Than One Plan

Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(ii) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

(b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;

(ii)If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(I) The plan covering the custodial parent;

(II) The plan covering the custodial parent's spouse;

(III) The plan covering the non-custodial parent; and then

(IV) The plan covering the non-custodial parent's spouse.

(c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph (a) or (b) of this paragraph as if those individuals were parents of the child.

Drafting Note: Subparagraph (c) addresses the situation where individuals other than the parents of a child are responsible for the child's health care expenses or provide health care coverage for the child under each of their plans. In this situation, for the purpose of determining the order of

benefits under this paragraph, Subparagraph (c) requires that these individuals be treated in the same manner as parents of the child.

(d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in Paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the dependent child's parents(s) and the dependent's spouse.

Drafting Note: Subparagraph (d) is intended to address the situation created by the enactment of Section 2714 of the Public Health Service Act, as that section was added by the federal Patient Protection and Affordable Care Act (Public Law 111-148) (ACA), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152). Section 2714 of the PHSA extended coverage for dependents to age 26 regardless of any dependency factors, such as support, residency, student status or marital status.

(3) Active Employee or Retired or Laid-Off Employee

(a) The plan that covers a person as an active employee that is, an employee who is neither laid off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

(b) If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

(c) This rule does not apply if the rule in Paragraph (1) can determine the order of benefits.

Drafting Note: This rule applies only in the situation when the same person is covered under two plans, one of which is provided on the basis of active employment and the other of which is provided to retired or laid-off employees. The rule in Paragraph (1) does not apply because the person is covered either as a non-dependent under both plans (i.e. the person is covered under one plan as an active employee and at the same time is covered as a retired or laid-off employee under the other plan) or as a dependent under both plans (i.e. the person is covered under one plan as a dependent of an active employee and at the same time is covered under the other plan as a dependent of a retired or laid-off employee). This rule does not apply when a person is covered under his or her own plan as an active employee or retired or laid-off employee and a dependent under a spouse's plan provided to the spouse on the basis of active employment. In this situation,

the rule in Paragraph (1) applies because the person is covered as a non-dependent under one plan (i.e. the person is covered as an active employee or retired or laid-off employee) and at the same time is covered as a dependent under the other plan (i.e. the person is covered as a dependent under a plan provided on the basis of active employment or a plan that is provided to retired or laid-off employees).

(4) COBRA or State Continuation Coverage

(a) If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

(b) If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(c) This rule does not apply if the rule in Paragraph (1) can determine the order of benefits

Drafting Note: COBRA originally provided that coverage under a new group health plan caused the COBRA coverage to end. An amendment passed as part of P.L. 101-239, the Omnibus Budget Reconciliation Act of 1989 (OBRA 89), allows the COBRA coverage to continue if the newly acquired group health plan contains any preexisting condition exclusion or limitation. In this instance two group health plans will cover the person, and the rule above will be used to determine which of the plans determines its benefits first. In addition, some states have continuation provisions comparable to COBRA.

Drafting Note: This rule applies only in the situation when a person has coverage pursuant to COBRA or under a right of continuation pursuant to state or other federal law and has coverage under another plan on the basis of employment. The rule under Paragraph (1) does not apply because the person is covered either: (a) as a non-dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as an employee or as a retired employee and is covered under his or her own plan as an employee, member, subscriber or retiree); or (b) as a dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as a dependent of an employee, member or subscriber or retired employee and is covered under the other plan as a dependent of an employee, member, subscriber or retiree). The rule under Paragraph (1) applies when the person is covered pursuant to COBRA or under a right of continuation pursuant to state or other federal law as a non-dependent and covered under the other plan as a

dependent of an employee, member, subscriber or retiree. The rule in this paragraph does not apply because the person is covered as a non-dependent under one of the plans and as a dependent under the other plan.

(5) Longer or Shorter Length of Coverage

(a) If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

(b) To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.

(c) The start of a new plan does not include:

(i) A change in the amount or scope of a plan's benefits;

(ii) A change in the entity that pays, provides or administers the plan's benefits; or

(iii) A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

(d) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

(6) If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.

APPENDIX F

Measures and contributions to performance areas and scores for 2019 Performance and 2020 Service Charge

To be performed in accordance with the 2019 FEHB Plan Performance Assessment Procedure Manual and the FEHB Plan Performance Assessment – Consolidated Methodology Carrier Letter (CL 2017-15). The Service Charge for the 2020 contract year will be based on the Overall Performance Score calculated in accordance with this Appendix F.

1. Performance Area Contributions to Overall Performance Score (OPS)

Performance Area	Contribution to Overall Performance Score
Clinical Quality, Customer Service, and Resource Use	65%
Contract Oversight	35%

2. Clinical Quality, Customer Service, and Resource Use (QCR) Performance Area Measures

Performance Area	Measure	Priority Level	Measure Weight
Clinical Quality	Controlling High Blood Pressure	1	2.50
	Prenatal Care (Timeliness)	1	2.50
	Breast Cancer Screening	2	1.25
	Well Child Visits in the First 15 Months of Life (6 visits)	2	1.25
	Flu Vaccinations for Adults (18-64)	2	1.25
	Cervical Cancer Screening	2	1.25
	Comprehensive Diabetes Care – HbA1C <8% - Control	2	1.25
	Asthma Medication Ratio	2	1.25
	Avoidance of Antibiotics in Adults with Acute Bronchitis	2	1.25
	Follow-up After Hospitalization for Mental Illness (7-day or 30-day)	2	1.25
	Statin Therapy for Patients with Cardiovascular Disease (Adherence)	2	1.25
Customer Service	Plan Information on Costs	3	1.00
	Getting Care Quickly	3	1.00
	Getting Needed Care	3	1.00
	Claims Processing	3	1.00
	Overall Health Plan Rating	3	1.00
	Coordination of Care	3	1.00

	Overall Personal Doctor Rating	3	1.00
	Customer Service	3	1.00
Resource Use	Plan All Cause Readmissions	1	2.50
	Emergency Department Utilization	2	1.25
	Use of Imaging Studies for Low Back Pain	2	1.25

EXHIBIT E

2020A Amendment to Contract No. CS 1039

Between the U.S. Office of Personnel Management and the Blue Cross and Blue Shield Association on Behalf of, and as Agent for, Participating Blue Cross and/or Blue Shield Plans

AMENDMENT TO CONTRACT CS XXXX

CONTRACT NO: 1039
EFFECTIVE: January 1, 1960

AMENDMENT NO. 2020A
EFFECTIVE: January 1, 2020

BETWEEN: THE UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
hereafter called the OPM, the Agency, or the Government

Address: 1900 E Street, NW
Washington, DC 20415-3610

AND

CONTRACTOR: Blue Cross and Blue Shield Association
hereafter also called the Carrier

Address: 1310 G. Street. NW, Suite 900
Washington, DC 20005

In consideration of payment by the Agency of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract, including Appendix A.

FOR THE CARRIER

William A. Breskin
Name of Person Authorized to Execute Contract (Type or print)

Senior Vice President, Government Programs
Title

Signature

12/16/19
Date Signed

FOR THE GOVERNMENT

Sylvia V. Pulley
Name of Contracting Officer (Type or print)

Contracting Officer
FEHB I
Title

Signature

12/17/2019
Date Signed

1. **Section 1.9 Plan Performance**

We amended the last sentence in subsection (b) to clarify that the referenced costs are allowable administrative expenses, subject to the administrative cost limitation.

SECTION 1.9 PLAN PERFORMANCE--EXPERIENCE-RATED FFS CONTRACTS (JAN 2020)

* * * * *

(b) Clinical Care Measures. The Carrier shall measure and/or collect data on the quality of the health care services it provides to its members as requested by OPM. Measurement/data collection efforts may include performance measurement systems such as Healthcare Effectiveness Data and Information Set (HEDIS), measures developed by the Pharmacy Quality Alliance (PQA), and similar measures developed by accrediting organizations such as, but not limited to, the Association for Ambulatory Health Care (AAAHC), the National Committee for Quality Assurance (NCQA), and URAC or endorsed by the National Quality Forum. Costs incurred by the Carrier for collecting or contracting with a vendor to collect quality measures/data are allowable administrative expenses, subject to the administrative cost limitation.

* * * * *

2. **Section 1.26 FFS Standards For Pharmacy Benefit Management Company (PBM) Arrangements**

We amended the language in this section to better align the contract with industry standards. The title was updated to reflect the updated terminology and changes were made based on the March 2013 conversion. This section was amended to make it generally applicable to any vendor providing PBM services. In subsection (a) definitions were added. Subsection (b)(2)(i) was amended to mitigate matters with aggregate pricing/reimbursement. Subsection 4 was amended to ensure that disclosure of fees is not limited to administrative fees. Subsection (b)(7) was amended to ensure that OPM is able to request reports or information about PBMs through the Carrier if the Carrier does not have requested information. Subsection (c) was amended to include all integrity standards related to a Carrier PBM contract. Subsection (d) was amended to remove paragraph-level cross-references to section 1.9, given that some text does not correspond to all listed cross-references. Technical edits were made in subsection (e) to replace "physician" with "Prescriber" as other providers may be able to write prescriptions. Subsection (f) was added to allow for prior approval. Subsection (g) was amended to track the URAC standard.

SECTION 1.26 STANDARDS FOR ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS (JAN 2020)

The Carrier will ensure and report that the following standards are included in new, renewing or amended contracts with Pharmacy Benefit Managers (PBMs) providing services to Enrollees and family members effective on or after January 1, 2020. Notwithstanding the foregoing, the revisions to Section 1.26 shall not take effect before the expiration of the Carrier's current

contract (including the exercise of an existing option to extend the term by not more than one year at a time) but not later than January 2023. The PBM includes all entities that have a majority ownership interest in or majority control over the PBM. The PBM also includes any other subsidiary of the entity that has majority ownership or control over the PBM.

All PBMs must adhere to the provisions of this Section 1.26.

If the Carrier's PBM arrangement is with an Underwriter rather than with the Carrier, then all references to the Carrier and Plan appearing in this Section 1.26 shall be deemed to be references to the Underwriter.

(a) Definitions Under This Section

(1) "Expedited request" means a request initiated by the Prescriber or member when the time limit for standard utilization management review for the prescribed medication could seriously jeopardize the patient's life, health, or ability to regain maximum function.

(2) "Licensed pharmacist" means an individual currently licensed by the appropriate jurisdiction to engage in the practice of pharmacy consistent with that jurisdiction's laws and regulations.

(3) "Manufacturer payment" means any and all compensation, financial benefits, or remuneration the PBM receives from a pharmaceutical manufacturer for any dispensing or distribution channel, including but not limited to, discounts, credits, rebates (regardless of how categorized), market share incentives, chargebacks, commissions, administrative or management fees, and any fees received for sales of utilization data to a pharmaceutical manufacturer.

(4) "Net revenue" means the total dollar sales of prescription drugs at the prescription price negotiated with clients and associated administrative fees, either through retail networks or PBM-owned or controlled mail order pharmacies, that is allocable to the Plan for the reporting period.

(5) "Network pharmacy," means any retail, mail order, specialty, or licensed pharmacy provider that contracts with the PBM.

(6) "Pass through transparent pricing" means drug pricing in which the Carrier receives the full value of the PBM's negotiated discounts, rebates, credits, or other financial benefits.

(7) "Pharmacy Benefit Manager" or "PBM" means the combination of

(i) a business or other entity that, pursuant to a contract with the Carrier, either directly or through an intermediary, manages the prescription drug benefit provided by the Carrier including, but not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs; and

(ii) all entities that have a majority ownership interest in, or majority control over, the business or other entity that is in contract with the Carrier referenced in (i).

(8) "Prescriber" means any licensed, certified or otherwise legally authorized health care professional authorized by law to prescribe a prescription drug.

(9) "Total product revenue" means the total dollar sales of prescription drugs to clients, either through retail networks or PBM-owned or controlled mail order pharmacies, with respect to the PBM's entire client base, for the reporting period.

(b) Transparency Standards

(1) The PBM shall not be majority-owned or majority-controlled by a pharmaceutical manufacturing company. The PBM must disclose to the Carrier and OPM the name of any entity that has a majority ownership interest in or majority control over the PBM.

(2) The PBM shall agree to provide pass-through transparent pricing based on the PBM's cost for drugs (as described below).

(i) The PBM shall charge the Carrier no more than the amount paid to the retail pharmacy for each drug plus a dispensing fee.

(ii) The PBM shall charge the Carrier the cost of drugs dispensed by a specialty and/or a mail order pharmacy that is owned by the PBM based on the pharmacy's actual acquisition cost, plus a dispensing fee. Costs shall not be based on industry benchmarks; for example, Average Acquisition Cost (AAC) or Wholesale Acquisition Cost (WAC).

(iii) The PBM, or any other entity that negotiates and collects Manufacturer Payments allocable to the Carrier, agrees to credit to the Carrier either as a price reduction or by cash refund the value of all Manufacturer Payments properly allocated to the Carrier.

(3) The PBM must identify sources of profit to the Carrier and OPM as it relates to the FEHB contract.

(4) All of the PBM's fees, including, but not limited to, administrative or dispensing fees, must be clearly identified to retail claims, mail claims, specialty claims, and clinical or other programs, if applicable. The PBM must agree to disclose each fee to the Carrier and OPM.

(5) The PBM, or any other entity that negotiates and collects Manufacturer Payments allocable to the Plan, will provide the Carrier with quarterly and annual Manufacturer Payment Reports identifying the following information. This information shall be presented for both the total of all prescription drugs dispensed through the PBM, acting as a mail order pharmacy, and its retail network and in the aggregate for the 25 brand name drugs that represent the greatest cost to the Carrier or such number of brand name drugs that together represent 75 percent of the total cost to the Carrier, whichever is the greater number:

(i) the dollar amount of Total Product Revenue;

(ii) the dollar amount of total drug expenditures for the Plan;

(iii)the dollar amount of all Manufacturer Payments earned by the PBM for the reporting period;

(iv) the Manufacturer Payments that have been (1) earned but not billed (2) billed and (3) paid to the PBM based on the drugs dispensed to the Plan members during the past year.

(v) the percentage of all Manufacturer Payments earned by the PBM for the reporting period that were Manufacturer Formulary Payments, which are payments the PBM receives from a manufacturer in return for formulary placement and/or access, or payments that are characterized as "formulary" or "base" rebates or payments pursuant to the PBM's agreements with pharmaceutical manufacturers;

(vi)the percentage of all Manufacturer Payments received by the PBM during the reporting period that were Manufacturer Additional Payments, which are all Manufacturer Payments other than Manufacturer Formulary Payments.

(6) The PBM agrees to provide the Carrier, at least annually, with all financial and utilization information requested by the Carrier relating to the provision of benefits to eligible

Enrollees through the PBM and all financial and utilization information relating to services provided to the Carrier.

(7) The Carrier shall provide any information it receives from the PBM, including a copy of its contract with the PBM to OPM. At OPM's request, the Carrier must obtain from the PBM any reasonable information or reports and provide it to OPM. A PBM providing information to a Carrier under this subsection may designate that information as confidential commercial information. The Carrier in its contract with the PBM shall effectuate the PBM's consent to the disclosure of this information to OPM. OPM shall treat such designated information as confidential under 5 C.F.R. § 294.112.

(8) The Carrier will require that its PBM:

(i) Provide information to physicians, pharmacists, other health care professionals, consumers, and payers about the factors that affect formulary system decisions, including: cost containment measures; the procedures for obtaining non-formulary drugs; and the importance of formulary compliance to improving quality of care and restraining health care costs;

(ii) Provide consumer education that explains how formulary decisions are made and the roles and responsibilities of the consumer; and

(iii) Disclose the existence of formularies and have copies of the current formulary readily available and publicly accessible.

(9) In accordance with FEHBAR 1652.204-74, FAR 52.215-2 and FEHBAR 1652.246-70, all contracts and other documentation that support amounts charged and credited to the Carrier contract are fully disclosed to and auditable by the OPM Office of Inspector General (OPM OIG). The PBM must provide the OPM OIG upon request complete copies of all PBM records including, but not limited to:

(i) All PBM contracts with Participating Pharmacies, including invoices, receipts, and credits;

(ii) All PBM contracts with Pharmaceutical Manufacturers, including invoices, receipts, and credits;

(iii)All PBM contracts with third parties purchasing or using claims data;

(iv)All PBM transmittals in connection with sales of claims data to third parties; and

(v) All PBM Maximum Allowable Cost (MAC) price lists.

(c) Integrity Standards

(1) The Carrier will require that its PBM agree to adopt and adhere to a code of ethics promulgated by a national professional association, such as the most recent Code of Ethics of the American Pharmacists Association, for their employed pharmacists.

(2) The Carrier will require that its PBM be licensed as required by the appropriate jurisdiction's laws and regulations.

(3) The Carrier will require that its PBM only employ or contract with licensed pharmacists for roles that require such a license under the appropriate jurisdiction's laws and regulations.

(4) A PBM shall perform its duties with care, skill, prudence, diligence, and professionalism.

(5) A PBM shall notify the Carrier in writing of any activity, policy, or practice of the PBM that directly or indirectly presents any conflict of interest with the duties imposed in this subsection.

(6) A PBM, or Carrier, shall not enter into a contract with a pharmacy or pharmacist that prohibits or penalizes a pharmacy or pharmacist for disclosure of information to a member regarding:

(i) The cost of a prescription medication to the member; or

(ii) The availability of any therapeutically-equivalent alternative medications or alternative methods of purchasing the prescription medication, including but not limited to, paying a cash price that is less expensive to the member than the cost of the prescription under the Plan.

(d) Performance Standards

The Carrier will require that its PBM contractors develop and apply a quality assurance program specifying procedures for ensuring contract quality on the following standards at a minimum and submit reports to the Carrier on their performance. PBMs must meet, at minimum, the member inquiry, customer service, claims processing, and other applicable standards set for Carriers at Section 1.9(f). All other standards discussed below will have specific target goals the PBM is expected to achieve. Carriers may permit PBMs to measure compliance using statistically valid samples for the PBMs book of business. Agreed to standards shall be provided to OPM for its review and comment. If OPM has concerns about a particular standard, the Carrier agrees to present OPM's concerns to the PBM and either revise the standard as requested by OPM or revise the standard to the extent feasible and present to OPM information demonstrating the problems associated with making the requested revisions in full.

(1) Point of Service (POS) system response time. The PBM's network electronic transaction system provides rapid response to network pharmacies.

(2) POS system availability. The PBM's network electronic transaction system generally is available to, and accessible by, network pharmacies.

(3) Licensing. The PBM verifies the appropriate licensing of its network pharmacies. This includes DEA registration for U.S. pharmacies, and the equivalent, if one exists, for pharmacies outside of the U.S.

(4) Dispensing accuracy. The PBM dispenses its prescriptions to the correct patient and for the correct drug, drug strength and dosage in accordance with the prescription not less than 99.9 percent of the time.

(5) Mail service pharmacy turnaround time. The PBM promptly dispenses and ships at least 98 percent on average of all prescriptions not requiring intervention or clarification within 3 business days or meets an equivalent measure approved by OPM.

(6) Quality of Drug Therapy. The quality assurance program implemented by a Carrier's PBM contractor must include a process to measure the quality of its drug therapy provided to Enrollees. Specific areas to be addressed include achievement of quality targets measured by both internal and external metrics; identification and appropriate use of best practices; and application of evidence-based medicine, as appropriate.

(e) Alternative Drug Options – The Carrier will require that its PBM contractors, at a minimum, utilize the following protocols for PBM initiated drug interchanges (any change from the original prescription) other than generic substitutions:

(1) The PBM must treat the Prescriber, and not itself, as the ultimate decision-maker. Furthermore, to the extent appropriate under the circumstances, the PBM must allow the patient input into that decision-making process. At a minimum, the PBM must provide the

patient with a written notice in the package sent to the patient that the drug interchange has occurred with the approval of the Prescriber.
(2) The PBM will obtain authorization for a drug interchange only with the express, verifiable authorization from the Prescriber as communicated directly by the Prescriber, in writing or verbally, or by a licensed medical professional or other office staff member as authorized by the Prescriber.
(3) The PBM must memorialize in appropriate detail all conversations with patients and Prescribers in connection with drug interchanging requests, including the identity of the contact person at the Prescriber's office and the basis for his or her authority.
(4) The PBM will only interchange a patient's drug from a lower priced drug to a drug with a higher cost to the patient or Plan when authorized by the Carrier or the Plan.
(5) The PBM will permit pharmacists to express their professional judgment to both the PBM and Prescribers on the impact of drug interchanges and to answer Prescribers' questions. PBMs will not require pharmacists to, and will not penalize pharmacists for refusing to, initiate calls to Prescribers for drug interchanges that in their professional judgment should not be made.
(6) The PBM will offer to disclose, and if requested, will disclose to Prescribers, the Carrier, and patients (i) the reason(s) why it is suggesting a drug interchange and (ii) how the interchange will affect the PBM, the Plan, and the patients financially.

(f) Utilization Management Timeframe – The PBM must promptly review and respond to requests for prior approval for specific drugs and any other utilization management edits following receipt of all required information.
(1) For expedited requests, the PBM must review and respond within 24 hours.
(2) For other, non-expedited requests, the PBM must review and respond within 72 hours.

(g) Patient Safety Standard - The Carrier will require that its PBM contractors establish drug utilization management, formulary process and procedures that have distinct systems for identifying and rectifying consumer safety issues including:

(i) A system for identifying and communicating drug and consumer safety issues at point-of-service;
(ii) A system of drug utilization management tools, such as prospective and concurrent drug utilization management that identifies situations which may compromise the safety of the consumer;
(iii) A system/process for error reporting; and
(iv) A system/process for identifying/managing risk

(h) Safety and Accessibility for Consumers - The Carrier will require that its PBM meets the following standards related to pharmacy network management and consumer access to medications.

(1) The Carrier will require that its PBM contractor define the scope of its services with respect to:

(i) The distribution channels offered (e.g. pharmacy network, mail order pharmacies, or specialty pharmacies);
(ii) The types of pharmacy services offered within each distribution channel; and
(iii) The geographic area served by each distribution channel.

(2) The Carrier will require that for each distribution channel provided by its PBM contractor, the PBM contractor:

(i) Establishes criteria and measures actual performance in comparison to those criteria: and

(ii) Makes improvements where necessary to maintain the pharmacy network and meet contractual requirements.

(3) The Carrier will require that its PBM contractor establish a quality and safety mechanism for each distribution channel in order to identify and address concerns related to:

(i) Quality and safety of drug distribution; and

(ii) Quality of service.

(i) Contract Terms - The contract between the PBM and the Carrier must not exceed 3 years without re-competition unless the Contracting Officer approves an exception. The Carrier's PBM contract must allow for termination based on a material breach of any terms and conditions stated in the Carrier's PBM contract. The Carrier must provide sufficient written notice of the material breach to the PBM and the PBM must be given adequate time to respond and cure the material breach.

3. Section 2.2 Benefits Provided

This section is amended to reflect recognition of the fact that a number of judicial jurisdictions have determined section 501 to be the provision of the Rehabilitation Act of 1973 that is appropriately applicable to individuals covered under the FEHB Program.

SECTION 2.2 BENEFITS PROVIDED (JAN 2020)

* * * * *

(3) To offer in individual cases, after consultation with and concurrence by the Member and provider(s), a benefit alternative not ordinarily covered under this contract which will result in equally effective medical treatment at no greater benefit cost. An alternative benefit will be made available for a limited time period and is subject to the Carrier's ongoing review. Members must cooperate with the Carrier's review process.

(c)The decision to offer, deny, or withdraw coverage for a modified benefit provided in accordance with (b) above is solely within the Carrier's discretion (unless the Carrier and Member have entered into an alternative benefits agreement that expressly modifies this authority), and is not subject to OPM review under the disputed claims process.

(d) In each case when the Carrier provides a non-covered benefit in accordance with the authority of (b) above, the Carrier shall document in writing prior to the provision of such benefit the reasons and justification for its determination. The writing may be in the form of an alternative benefit agreement with the Member. Such payment or provision of services or supplies while a valid charge under the contract shall not be considered to be a precedent in the disposition of similar cases or extensions in the same case beyond the approved period.

(e) Except as provided for in (b) above, the Carrier shall provide benefits for services or supplies in accordance with Appendix A.

(f) The Carrier, subject to (g) below, shall determine whether in its judgment a service or supply is medically necessary or payable under this contract.

(g) The Carrier agrees to pay for or provide a health service or supply in an individual case if OPM finds that the Member is entitled thereto under the terms of the contract.

(h) (1) Notwithstanding (b) and (e) above, in accordance with the Rehabilitation Act of 1973, in the case of a Member who is a qualified individual with a disability, the Carrier shall pay for or provide a covered health service or supply as an alternative benefit appropriate to the Member's needs, when required by OPM following OPM consultation with the Carrier, pursuant to paragraph 2.2(g), above.

* * * * *

4. **Section 5.14 Utilization Of Small Business Concerns**

We have updated this section consistent with the updated FAR clause.

SECTION 5.14 UTILIZATION OF SMALL BUSINESS CONCERNS (OCT 2018) (FAR 52.219-8)

(a) Definitions. As used in this contract --

"HUBZone small business concern" means a small business concern, certified by the Small Business Administration, that appears on the List of Qualified HUBZone Small Business Concerns maintained by the Small Business Administration.

"Service-disabled veteran-owned small business concern"

(1) Means a small business concern--

(i) Not less than 51 percent of which is owned by one or more service-disabled veterans or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more service-disabled veterans; and

(ii) The management and daily business operations of which are controlled by one or more service-disabled veterans or, in the case of a service-disabled veteran with permanent and severe disability, the spouse or permanent caregiver of such veteran.

(2) Service-disabled veteran means a veteran, as defined in 38 U.S.C. 101(2), with a disability that is service-connected, as defined in 38 U.S.C. 101(16).

"Small business concern" means a small business as defined pursuant to Section 3 of the Small Business Act and relevant regulations promulgated pursuant thereto.

"Small disadvantaged business concern", consistent with 13 CFR 124.1002, means a small business concern under the size standard applicable to the acquisition, that--

(1) Is at least 51 percent unconditionally and directly owned (as defined at 13 CFR 124.105) by—

(i) One or more socially disadvantaged (as defined at 13 CFR 124.103) and economically disadvantaged (as defined at 13 CFR 124.104) individuals who are citizens of the United States; and

(ii) Each individual claiming economic disadvantage has a net worth not exceeding $750,000 after taking into account the applicable exclusions set forth at 13 CFR 124.104(c)(2); and

(2) The management and daily business operations of which are controlled (as defined at 13.CFR 124.106) by individuals, who meet the criteria in paragraphs (1)(i) and (ii) of this definition.

"Veteran-owned small business concern" means a small business concern–

(1) Not less than 51 percent of which is owned by one or more veterans (as defined at 38 U.S.C. 101(2)) or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more veterans; and

(2) The management and daily business operations of which are controlled by one or more veterans.

"Women-owned small business concern" means a small business concern–

(1) That is at least 51 percent owned by one or more women, or, in the case of any publicly owned business, at least 51 percent of the stock of which is owned by one or more women; and

(2) Whose management and daily business operations are controlled by one or more women.

(b) It is the policy of the United States that small business concerns, veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns, and women-owned small business concerns shall have the maximum practicable opportunity to participate in performing contracts let by any Federal agency, including contracts and subcontracts for subsystems, assemblies, components, and related services for major systems. It is further the policy of the United States that its prime contractors establish procedures to ensure the timely payment of amounts due pursuant to the terms of their subcontracts with small business concerns, veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns, and women-owned small business concerns.

(c) The Contractor hereby agrees to carry out this policy in the awarding of subcontracts to the fullest extent consistent with efficient contract performance. The Contractor further agrees to cooperate in any studies or surveys as may be conducted by the United States Small Business Administration or the awarding agency of the United States as may be necessary to determine the extent of the Contractor's compliance with this clause.

(d)(1) The Contractor may accept a subcontractor's written representations of its size and socioeconomic status as a small business, small disadvantaged business, a veteran-owned small business, service-disabled veteran-owned small business or a women-owned small business if the subcontractor represents that the size and socioeconomic status representations with its offer are current, accurate, and complete as of the date of the offer for the subcontract.

(2) The Contractor may accept a subcontractor's representations of its size and socioeconomic status as a small business, small disadvantaged business, veteran-owned small business, service-disabled veteran-owned small business, or a women-owned small business in the System for Award Management (SAM) if–

(i) The subcontractor is registered in SAM; and

(ii) The subcontractor represents that the size and socioeconomic status representations made in SAM are current, accurate and complete as of the date of the offer for the subcontract.

(3) The Contractor may not require the use of SAM for the purposes of representing size or socioeconomic status in connection with a subcontract.

(4) In accordance with 13 CFR 121.411, 124.1015, 125.29, 126.900, and 127.700, a contractor acting in good faith is not liable for misrepresentations made by its subcontractors regarding the subcontractor's size or socioeconomic status.

(5) The Contractor shall confirm that a subcontractor representing itself as a HUBZone small business concern is certified by SBA as a HUBZone small business concern by accessing the System for Award Management or by contacting the SBA. Options for contacting the SBA include—

(i) HUBZone small business database search application web page at http://dsbs.sba.gov/dsbs/search/dsp_searchhubzone.cfm; or http://www.sba.gov/hubzone;

(ii) In writing to the Director/HUB, U.S. Small Business Administration, 409 3rd Street, SW., Washington, DC 20416; or

The SBA HUBZone Help Desk at hubzone@sba.gov.

5. Section 5.18 Contract Work Hours And Safety Standards Act -- Overtime Compensation

We amended subsection (b) to remove specific dollar amounts for liability and provisions of the law which were added to provide guidance for monetary penalties of inflation.

SECTION 5.18 CONTRACT WORK HOURS AND SAFETY STANDARDS ACT -- OVERTIME COMPENSATION (MAY 2018) (FAR 52.222-4)

(a) *Overtime requirements*. No Contractor or subcontractor employing laborers or mechanics (see Federal Acquisition Regulation 22.300) shall require or permit them to work over 40 hours in any workweek unless they are paid at least 1 and ½ times the basic rate of pay for each hour worked over 40 hours.

(b) *Violation; liability for unpaid wages; liquidated damages*. The responsible Contractor and subcontractor are liable for unpaid wages if they violate the terms in paragraph (a) of this clause. In addition, the Contractor and subcontractor are liable for liquidated damages payable to the Government. The Contracting Officer will assess liquidated damages at the rate specified at 29 CFR 5.5(b)(2) per affected employee for each calendar day on which the employer required or permitted the employee to work in excess of the standard workweek of 40 hours without paying overtime wages required by the Contract Work Hours and Safety Standards statute (found at 40 U.S.C. chapter 37). In accordance with the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 Note), the Department of Labor adjusts this civil monetary penalty for inflation no later than January 15 each year.

(c) *Withholding for unpaid wages and liquidated damages.* The Contracting Officer will withhold from payments due under the contract sufficient funds required to satisfy any Contractor or subcontractor liabilities for unpaid wages and liquidated damages. If amounts withheld under the contract are insufficient to satisfy Contractor or subcontractor liabilities, the Contracting Officer will withhold payments from other Federal or Federally assisted contracts held by the same Contractor that are subject to the Contract Work Hours and Safety Standards statute.

(d) *Payrolls and basic records.* (1) The Contractor and its subcontractors shall maintain payrolls and basic payroll records for all laborers and mechanics working on the contract during the contract and shall make them available to the Government until 3 years after contract completion. The records shall contain the name and address of each employee, social security

number, labor classifications, hourly rates of wages paid, daily and weekly number of hours worked, deductions made, and actual wages paid. The records need not duplicate those required for construction work by Department of Labor regulations at 29 CFR 5.5(a)(3) implementing the Construction Wage Rate Requirements statute.

(2) The Contractor and its subcontractors shall allow authorized representatives of the Contracting Officer or the Department of Labor to inspect, copy, or transcribe records maintained under paragraph (d)(1) of this clause. The Contractor or subcontractor also shall allow authorized representatives of the Contracting Officer or Department of Labor to interview employees in the workplace during working hours.

(e) *Subcontracts*. The Contractor shall insert the provisions set forth in paragraphs (a) through (d) of this clause in subcontracts that may require or involve the employment of laborers and mechanics and require subcontractors to include these provisions in any such lower tier subcontracts. The Contractor shall be responsible for compliance by any subcontractor or lower-tier subcontractor with the provisions set forth in paragraphs (a) through (d) of this clause.

6. **Section 5.58 Payment By Electronic Funds Transfer–System For Award Management**

This section was updated to remove the word "database" when referring to accessing the System for Award Management (SAM).

SECTION 5.58 PAYMENT BY ELECTRONIC FUNDS TRANSFER–SYSTEM FOR AWARD MANAGEMENT (OCT 2018) (FAR 52.232-33)

(a) Method of payment.

(1) All payments by the Government under this contract shall be made by electronic funds transfer (EFT), except as provided in paragraph (a)(2) of this clause. As used in this clause, the term "EFT" refers to the funds transfer and may also include the payment information transfer.

(2) In the event the Government is unable to release one or more payments by EFT, the Contractor agrees to either—

(i) Accept payment by check or some other mutually agreeable method of payment; or

(ii) Request the Government to extend the payment due date until such time as the Government can make payment by EFT (but see paragraph (d) of this clause).

(b) *Contractor's EFT information.* The Government shall make payment to the Contractor using the EFT information contained in the System for Award Management (SAM). In the event that the EFT information changes, the Contractor shall be responsible for providing the updated information to SAM.

(c) *Mechanisms for EFT payment*. The Government may make payment by EFT through either the Automated Clearing House (ACH) network, subject to the rules of the National Automated Clearing House Association, or the Fedwire Transfer System. The rules governing Federal payments through the ACH are contained in 31 CFR Part 210.

(d) *Suspension of payment*. If the Contractor's EFT information in SAM is incorrect, then the Government need not make payment to the Contractor under this contract until correct EFT information is entered into SAM; and any invoice or contract financing request shall be deemed not to be a proper invoice for the purpose of prompt payment under this contract. The

prompt payment terms of the contract regarding notice of an improper invoice and delays in accrual of interest penalties apply.

(e) Liability for uncompleted or erroneous transfers.

(1) If an uncompleted or erroneous transfer occurs because the Government used the Contractor's EFT information incorrectly, the Government remains responsible for—

(i) Making a correct payment;

(ii) Paying any prompt payment penalty due; and

(iii) Recovering any erroneously directed funds.

(2) If an uncompleted or erroneous transfer occurs because the Contractor's EFT information was incorrect, or was revised within 30 days of Government release of the EFT payment transaction instruction to the Federal Reserve System, and—

(i) If the funds are no longer under the control of the payment office, the Government is deemed to have made payment and the Contractor is responsible for recovery of any erroneously directed funds; or

(ii) If the funds remain under the control of the payment office, the Government shall not make payment, and the provisions of paragraph (d) of this clause shall apply.

(f) *EFT and prompt payment*. A payment shall be deemed to have been made in a timely manner in accordance with the prompt payment terms of this contract if, in the EFT payment transaction instruction released to the Federal Reserve System, the date specified for settlement of the payment is on or before the prompt payment due date, provided the specified payment date is a valid date under the rules of the Federal Reserve System.

(g) *EFT and assignment of claims*. If the Contractor assigns the proceeds of this contract as provided for in the assignment of claims terms of this contract, the Contractor shall require as a condition of any such assignment, that the assignee shall register separately in SAM and shall be paid by EFT in accordance with the terms of this clause. Notwithstanding any other requirement of this contract, payment to an ultimate recipient other than the Contractor, or a financial institution properly recognized under an assignment of claims pursuant to Subpart 32.8, is not permitted. In all respects, the requirements of this clause shall apply to the assignee as if it were the Contractor. EFT information that shows the ultimate recipient of the transfer to be other than the Contractor, in the absence of a proper assignment of claims acceptable to the Government, is incorrect EFT information within the meaning of paragraph (d) of this clause.

(h) *Liability for change of EFT information by financial agent*. The Government is not liable for errors resulting from changes to EFT information made by the Contractor's financial agent.

(i) *Payment information*. The payment or disbursing office shall forward to the Contractor available payment information that is suitable for transmission as of the date of release of the EFT instruction to the Federal Reserve System. The Government may request the Contractor to designate a desired format and method(s) for delivery of payment information from a list of formats and methods the payment office is capable of executing. However, the Government does not guarantee that any particular format or method of delivery is available at any particular payment office and retains the latitude to use the format and delivery method most convenient to the Government. If the Government makes payment by check in accordance with paragraph (a) of this clause, the Government shall mail the payment information to the remittance address contained in SAM.

7. Section 5.60 Subcontracts For Commercial Items

We added subsections (b)(v) and (b)(vi) to include the Prohibition on Contracting for Hardware, Software, and Services Developed or Provided by Kaspersky Lab and Other Covered Entities, and the Prohibition on Contracting for Certain Telecommunications and Video Surveillance Services or Equipment. All other amendments are technical edits to keep the flow and order of the subsections and to update dates to referenced FAR Clauses.

SECTION 5.60 SUBCONTRACTS FOR COMMERCIAL ITEMS (AUG 2019) (FAR 52.244-6)

(a) Definitions. As used in this clause —

"Commercial item" and "commercially available off-the-shelf item" have the meanings contained in Federal Acquisition Regulation 2.101, Definitions.

"Subcontract" includes a transfer of commercial items between divisions, subsidiaries, or affiliates of the Contractor or subcontractor at any tier.

(b) To the maximum extent practicable, the Contractor shall incorporate, and require its subcontractors at all tiers to incorporate, commercial items or non-developmental items as components of items to be supplied under this contract.

(c)(1) The Contractor shall insert the following clauses in subcontracts for commercial items:

(i) 52.203-13, Contractor Code of Business Ethics and Conduct (Oct 2015) (41 U.S.C. 3509), if the subcontract exceeds $5.5 million and has a performance period of more than 120 days. In altering this clause to identify the appropriate parties, all disclosures of violation of the civil False Claims Act or of Federal criminal law shall be directed to the agency Office of the Inspector General, with a copy to the Contracting Officer.

(ii) 52.203-15, Whistleblower Protections Under the American Recovery and Reinvestment Act of 2009 (Jun 2010) (Section 1553 of Pub. L. 111-5), if the subcontract is funded under the Recovery Act.

(iii) 52.203-19, Prohibition on Requiring Certain Internal Confidentiality Agreements or Statements (JAN 2017).

(iv) 52.204–21, Basic Safeguarding of Covered Contractor Information Systems (June, 2016), other than subcontracts for commercially available off-the-shelf items, if flow down is required in accordance with paragraph (c) of FAR clause 52.204–21.

(v) 52.204-23, Prohibition on Contracting for Hardware, Software, and Services Developed or Provided by Kaspersky Lab and Other Covered Entities (Jul 2018) (Section 1634 of Pub. L. 115-91).

(vi) 52.204-25, Prohibition on Contracting for Certain Telecommunications and Video Surveillance Services or Equipment. (Aug 2019) (Section 889(a)(1)(A) of Pub. L. 115-232).

(vii) 52.219-8, Utilization of Small Business Concerns (Oct 2018) (15 U.S.C. 637(d)(2) and (3)), if the subcontract offers further subcontracting opportunities. If the subcontract (except subcontracts to small business concerns) exceeds $700,000 ($1.5 million for construction of any public facility), the subcontractor must include 52.219-8 in lower tier subcontracts that offer subcontracting opportunities.

(viii) 52.222-21 Prohibition of Segregated Facilities (Apr 2015).

(ix) 52.222-26, Equal Opportunity (Apr 2015) (E.O. 11246).

(x) 52.222-35, Equal Opportunity for Veterans (Oct 2015) (38 U.S.C. 4212(a).

(xi) 52.222-36, Equal Opportunity for Workers with Disabilities (Jul 2014) (29 U.S.C. 793).

(xii) 52.222-37, Employment Reports on Veterans (Feb 2016) (38 U.S.C. 4212).

(xiii) 52.222-40, Notification of Employee Rights Under the National Labor Relations Act (Dec 2010) (E.O. 13496), if flow down is required in accordance with paragraph (f) of FAR clause 52.222-40.

(xiv)(A) 52.222-50, Combating Trafficking in Persons (Jan 2019) (22 U.S.C. chapter 78 and E.O. 13627).

(B) Alternate I (MAR 2015) of 52.222-50 (22 U.S.C. chapter 78 and E.O. 13627).

(xv) 52.222-55 , Minimum Wages under Executive Order 13658 (Dec 2015), if flow down is required in accordance with paragraph (k) of FAR clause 52.222-55.

(xvi) 52.222-62, Paid Sick Leave Under Executive Order 13706 (Jan 2017) (E.O. 13706), if flowdown is required in accordance with paragraph (m) of FAR clause 52.222-62.

(xvii)(A) 52.224-3, Privacy Training (Jan 2017) (5 U.S.C. 552a) if flow down is required in accordance with 52.224-3(f).

(B) Alternate I (Jan 2017) of 52.224-3, if flow down is required in accordance with 52.224-3(f) and the agency specifies that only its agency-provided training is acceptable).

(xviii) 52.225-26, Contractors Performing Private Security Functions Outside the United States (Oct 2016) (Section 862, as amended, of the National Defense Authorization Act for Fiscal Year 2008; 10 U.S.C. 2302 Note).

(xvix) 52.232-40, Providing Accelerated Payments to Small Business Subcontractors (Dec 2013), if flow down is required in accordance with paragraph (c) of FAR clause 52.232-40.

(xx) 52.247-64, Preference for Privately Owned U.S.-Flag Commercial Vessels (Feb 2006) (46 U.S.C. App. 1241 and 10 U.S.C. 2631), if flow down is required in accordance with paragraph (d) of FAR clause 52.247-64).

(2) While not required, the Contractor may flow down to subcontracts for commercial items a minimal number of additional clauses necessary to satisfy its contractual obligations.
(d) The Contractor shall include the terms of this clause, including this paragraph (d), in subcontracts awarded under this contract.

8. Section 5.63 System For Award Management

We amended subsection (b)(1) to reflect the updated FAR Clause requiring registration in System for Award Management (SAM) when submitting an offer and the continuation of registration throughout the duration of the award.

SECTION 5.63 SYSTEM FOR AWARD MANAGEMENT (OCT 2018) (FAR 52.204-7)

(a) Definitions. As used in this provision—

"Electronic Funds Transfer (EFT) indicator" means a four-character suffix to the unique entity identifier. The suffix is assigned at the discretion of the commercial, nonprofit, or Government entity to establish additional System for Award Management records for identifying alternative EFT accounts (see subpart 32.11) for the same entity.

"Registered in the System for Award Management (SAM) database" means that—

(1) The Offeror has entered all mandatory information, including the unique entity identifier and the EFT indicator, if applicable, the Commercial and Government Entity (CAGE)

code, as well as data required by the Federal Funding Accountability and Transparency Act of 2006 (see subpart 4.14) into SAM;

(2) The offeror has completed the Core, Assertions, and Representations and Certifications, and Points of Contact sections of the registration in SAM;

(3) The Government has validated all mandatory data fields, to include validation of the Taxpayer Identification Number (TIN) with the Internal Revenue Service (IRS). The offeror will be required to provide consent for TIN validation to the Government as a part of SAM registration process; and

(4) The Government has marked the record "Active".

"Unique entity identifier" means a number or other identifier used to identify a specific commercial, nonprofit, or Government entity. See www.sam.gov for the designated entity for establishing unique entity identifiers.

(b)(1) An Offeror is required to be registered in SAM when submitting an offer or quotation, and shall continue to be registered until time of award, during performance, and through final payment of any contract, basic agreement, basic ordering agreement, or blanket purchasing agreement resulting from this solicitation.

(2) The Offeror shall enter, in the block with its name and address on the cover page of its offer, the annotation "Unique Entity Identifier" followed by the unique entity identifier that identifies the Offeror's name and address exactly as stated in the offer. The Offeror also shall enter its EFT indicator, if applicable. The unique entity identifier will be used by the Contracting Officer to verify that the Offeror is registered in SAM.

(c) If the Offeror does not have a unique entity identifier, it should contact the entity designated at www.sam.gov for establishment of the unique entity identifier directly to obtain one.

The Offeror should be prepared to provide the following information:

(1) Company legal business name.

(2) Tradestyle, doing business, or other name by which your entity is commonly recognized.

(3) Company Physical Street Address, City, State, and Zip Code.

(4) Company Mailing Address, City, State and Zip Code (if separate from physical).

(5) Company telephone number.

(6) Date the company was started.

(7) Number of employees at your location.

(8) Chief executive officer/key manager.

(9) Line of business (industry).

(10) Company Headquarters name and address (reporting relationship within your entity).

(d) If the Offeror does not become registered in SAM in the time prescribed by the Contracting Officer, the Contracting Officer will proceed to award to the next otherwise successful registered Offeror.

9. **Section 5.66 Updates Of Publically Available Information Regarding Responsibility Matters**

This section was updated to the October 2018 FAR clause which updated the System for Award Management website and removed the word "database."

SECTION 5.66 UPDATES OF PUBLICALLY AVAILABLE INFORMATION REGARDING RESPONSIBILITY MATTERS (OCT 2018) (FAR 52.209-9)

(a) The Contractor shall update the information in the Federal Awardee Performance and Integrity Information System (FAPIIS) on a semi-annual basis, throughout the life of the contract, by posting the required information in the System for Award Management via https://www.sam.gov.

(b) As required by section 3010 of the Supplemental Appropriations Act, 2010 (Pub. L. 111-212), all information posted in FAPIIS on or after April 15, 2011, except past performance reviews, will be publicly available. FAPIIS consists of two segments—

(1) The non-public segment, into which Government officials and the Contractor post information, which can only be viewed by—

(i) Government personnel and authorized users performing business on behalf of the Government; or

(ii) The Contractor, when viewing data on itself; and

(2) The publicly-available segment, to which all data in the non-public segment of FAPIIS is automatically transferred after a waiting period of 14 calendar days, except for—

(i) Past performance reviews required by subpart 42.15;

(ii) Information that was entered prior to April 15, 2011; or

(iii) Information that is withdrawn during the 14-calendar-day waiting period by the Government official who posted it in accordance with paragraph (c)(1) of this clause.

(c) The Contractor will receive notification when the Government posts new information to the Contractor's record.

(1) If the Contractor asserts in writing within 7 calendar days, to the Government official who posted the information, that some of the information posted to the non-public segment of FAPIIS is covered by a disclosure exemption under the Freedom of Information Act, the Government official who posted the information must within 7 calendar days remove the posting from FAPIIS and resolve the issue in accordance with agency Freedom of Information procedures, prior to reposting the releasable information. The contractor must cite 52.209-9 and request removal within 7 calendar days of the posting to FAPIIS.

(2) The Contractor will also have an opportunity to post comments regarding information that has been posted by the Government. The comments will be retained as long as the associated information is retained, i.e., for a total period of 6 years. Contractor comments will remain a part of the record unless the Contractor revises them.

(3) As required by section 3010 of Pub. L. 111-212, all information posted in FAPIIS on or after April 15, 2011, except past performance reviews, will be publicly available.

(d) Public requests for system information posted prior to April 15, 2011, will be handled under Freedom of Information Act procedures, including, where appropriate, procedures promulgated under E.O. 12600.

10. <u>Section 5.71 Combating Trafficking In Persons</u>

Section 5.71 was updated to reflect the January 2019 FAR clause changes which provide expanded regulations on Human Trafficking.

SECTION 5.71 COMBATING TRAFFICKING IN PERSONS (JAN 2019) (FAR 52.222-50)

(a) Definitions. As used in this clause—

"Agent" means any individual, including a director, an officer, an employee, or an independent contractor, authorized to act on behalf of the organization.

"Coercion" means—

(1) Threats of serious harm to or physical restraint against any person;

(2) Any scheme, plan, or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to or physical restraint against any person; or

(3) The abuse or threatened abuse of the legal process.

"Commercially available off-the-shelf (COTS) item" means-

(1) Any item of supply (including construction material) that is-

(i) A commercial item (as defined in paragraph (1) of the definition at FAR 2.101);

(ii) Sold in substantial quantities in the commercial marketplace; and

(iii) Offered to the Government, under a contract or subcontract at any tier, without modification, in the same form in which it is sold in the commercial marketplace; and

(2) Does not include bulk cargo, as defined in 46 U.S.C. 40102(4), such as agricultural products and petroleum products.

"Commercial sex act" means any sex act on account of which anything of value is given to or received by any person.

"Debt bondage" means the status or condition of a debtor arising from a pledge by the debtor of his or her personal services or of those of a person under his or her control as a security for debt, if the value of those services as reasonably assessed is not applied toward the liquidation of the debt or the length and nature of those services are not respectively limited and defined.

"Employee" means an employee of the Contractor directly engaged in the performance of work under the contract who has other than a minimal impact or involvement in contract performance.

"Forced labor" means knowingly providing or obtaining the labor or services of a person—

(1) By threats of serious harm to, or physical restraint against, that person or another person;

(2) By means of any scheme, plan, or pattern intended to cause the person to believe that, if the person did not perform such labor or services, that person or another person would suffer serious harm or physical restraint; or

(3) By means of the abuse or threatened abuse of law or the legal process.

"Involuntary servitude" includes a condition of servitude induced by means of—

(1) Any scheme, plan, or pattern intended to cause a person to believe that, if the person did not enter into or continue in such conditions, that person or another person would suffer serious harm or physical restraint; or

(2) The abuse or threatened abuse of the legal process.

"Recruitment fees" means fees of any type, including charges, costs, assessments, or other financial obligations, that are associated with the recruiting process, regardless of the time, manner, or location of imposition or collection of the fee.

(1) Recruitment fees include, but are not limited to, the following fees (when they are associated with the recruiting process) for—

(i) Soliciting, identifying, considering, interviewing, referring, retaining, transferring, selecting, training, providing orientation to, skills testing, recommending, or placing employees or potential employees;

(ii) Advertising;

(iii) Obtaining permanent or temporary labor certification, including any associated fees;

(iv) Processing applications and petitions;

(v) Acquiring visas, including any associated fees;

(vi) Acquiring photographs and identity or immigration documents, such as passports, including any associated fees;

(vii) Accessing the job opportunity, including required medical examinations and immunizations; background, reference, and security clearance checks and examinations; and additional certifications;

(viii) An employer's recruiters, agents or attorneys, or other notary or legal fees;

(ix) Language interpretation or translation, arranging for or accompanying on travel, or providing other advice to employees or potential employees;

(x) Government-mandated fees, such as border crossing fees, levies, or worker welfare funds;

(xi) Transportation and subsistence costs—

(A) While in transit, including, but not limited to, airfare or costs of other modes of transportation, terminal fees, and travel taxes associated with travel from the country of origin to the country of performance and the return journey upon the end of employment; and

(B) From the airport or disembarkation point to the worksite;

(xii) Security deposits, bonds, and insurance; and

(xiii) Equipment charges.

(2) A recruitment fee, as described in the introductory text of this definition, is a recruitment fee, regardless of whether the payment is—

(i) Paid in property or money;

(ii) Deducted from wages;

(iii) Paid back in wage or benefit concessions;

(iv) Paid back as a kickback, bribe, in-kind payment, free labor, tip, or tribute; or

(v) Collected by an employer or a third party, whether licensed or unlicensed, including, but not limited to—

(A) Agents;

(B) Labor brokers;

(C) Recruiters;

(D) Staffing firms (including private employment and placement firms);

(E) Subsidiaries/affiliates of the employer;

(F) Any agent or employee of such entities; and

(G) Subcontractors at all tiers.

"Severe forms of trafficking in persons" means—

(1) Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or

(2) The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

"Sex trafficking" means the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act.

(b) Policy. The United States Government has adopted a policy prohibiting trafficking in persons including the trafficking-related activities of this clause. Contractors, contractor employees, and their agents shall not—

(1) Engage in severe forms of trafficking in persons during the period of performance of the contract;

(2) Procure commercial sex acts during the period of performance of the contract; or

(3) Use forced labor in the performance of the contract.

(4) Destroy, conceal, confiscate, or otherwise deny access by an employee to the employee's identity or immigration documents, such as passports or drivers' licenses, regardless of issuing authority;

(5)(i) Use misleading or fraudulent practices during the recruitment of employees or offering of employment, such as failing to disclose, in a format and language understood by the employee or potential employee, basic information or making material misrepresentations during the recruitment of employees regarding the key terms and conditions of employment, including wages and fringe benefits, the location of work, the living conditions, housing and associated costs (if employer or agent provided or arranged), any significant costs to be charged to the employee or potential employee, and, if applicable, the hazardous nature of the work;

(ii) Use recruiters that do not comply with local labor laws of the country in which the recruiting takes place;

(6) Charge employees or potential employees recruitment fees;

(7)(i) Fail to provide return transportation or pay for the cost of return transportation upon the end of employment-

(A) For an employee who is not a national of the country in which the work is taking place and who was brought into that country for the purpose of working on a U.S. Government contract or subcontract (for portions of contracts performed outside the United States); or

(B) For an employee who is not a United States national and who was brought into the United States for the purpose of working on a U.S. Government contract or subcontract, if the payment of such costs is required under existing temporary worker programs or pursuant to a written agreement with the employee (for portions of contracts performed inside the United States); except that-

(ii) The requirements of paragraphs (b)(7)(i) of this clause shall not apply to an employee who is-

(A) Legally permitted to remain in the country of employment and who chooses to do so; or

(B) Exempted by an authorized official of the contracting agency from the requirement to provide return transportation or pay for the cost of return transportation;

(iii) The requirements of paragraph (b)(7)(i) of this clause are modified for a victim of trafficking in persons who is seeking victim services or legal redress in the country of employment, or for a witness in an enforcement action related to trafficking in persons. The contractor shall provide the return transportation or pay the cost of return transportation in a way that does not obstruct the victim services, legal redress, or witness activity. For example, the contractor shall not only offer return transportation to a witness at a time when the witness is still needed to testify. This paragraph does not apply when the exemptions at paragraph (b)(7)(ii) of this clause apply.

(8) Provide or arrange housing that fails to meet the host country housing and safety standards; or

(9) If required by law or contract, fail to provide an employment contract, recruitment agreement, or other required work document in writing. Such written work document shall be in a language the employee understands. If the employee must relocate to perform the work, the work document shall be provided to the employee at least five days prior to the employee

relocating. The employee's work document shall include, but is not limited to, details about work description, wages, prohibition on charging recruitment fees, work location(s), living accommodations and associated costs, time off, roundtrip transportation arrangements, grievance process, and the content of applicable laws and regulations that prohibit trafficking in persons.

(c) Contractor requirements. The Contractor shall—

(1) Notify its employees and agents of—

(i) The United States Government's policy prohibiting trafficking in persons, described in paragraph (b) of this clause; and

(ii) The actions that will be taken against employees or agents for violations of this policy. Such actions for employees may include, but are not limited to, removal from the contract, reduction in benefits, or termination of employment; and

(2) Take appropriate action, up to and including termination, against employees, agents, or subcontractors that violate the policy in paragraph (b) of this clause.

(d) *Notification.*

(1) The Contractor shall inform the Contracting Officer and the agency Inspector General immediately of—

(i)Any credible information it receives from any source (including host country law enforcement) that alleges a Contractor employee, subcontractor, subcontractor employee, or their agent has engaged in conduct that violates the policy; in in paragraph (b) of this clause (see also 18 U.S.C. 1351, Fraud in Foreign Labor Contracting, and 52.203-13(b)(3)(i)(A), if that clause is included in the solicitation or contract, which requires disclosure to the agency Office of the Inspector General when the Contractor has credible evidence of fraud) ; and

(ii) Any actions taken against a Contractor employee, subcontractor, or subcontractor employee, or their agent pursuant to this clause.

(2) If the allegation may be associated with more than one contract, the Contractor shall inform the contracting officer for the contract with the highest dollar value.

(e) *Remedies*. In addition to other remedies available to the Government, the Contractor's failure to comply with the requirements of paragraphs (c), (d), (g), (h) or (i) of this clause may result in—

(1) Requiring the Contractor to remove a Contractor employee or employees from the performance of the contract;

(2) Requiring the Contractor to terminate a subcontract;

(3) Suspension of contract payments until the Contractor has taken appropriate remedial action;

(4) Loss of award fee, consistent with the award fee plan, for the performance period in which the Government determined Contractor non-compliance;

(5) Declining to exercise available options under the contract;

(6) Termination of the contract for default or cause, in accordance with the termination clause of this contract; or

(7) Suspension or debarment.

(f) Mitigating and aggravating factors. When determining remedies, the Contracting Officer may consider the following:

(1) Mitigating factors. The Contractor had a Trafficking in Persons compliance plan or an awareness program at the time of the violation, was in compliance with the plan, and has

taken appropriate remedial actions for the violation, that may include reparation to victims for such violations.

(2) Aggravating factors. The Contractor failed to abate an alleged violation or enforce the requirements of a compliance plan, when directed by the Contracting Officer to do so.

(g) Full cooperation.

(1) The Contractor shall, at a minimum-

(i) Disclose to the agency Inspector General information sufficient to identify the nature and extent of an offense and the individuals responsible for the conduct;

(ii) Provide timely and complete responses to Government auditors' and investigators' requests for documents;

(iii) Cooperate fully in providing reasonable access to its facilities and staff (both inside and outside the U.S.) to allow contracting agencies and other responsible Federal agencies to conduct audits, investigations, or other actions to ascertain compliance with the Trafficking Victims Protection Act of 2000 (22 U.S.C. chapter 78), E.O. 13627, or any other applicable law or regulation establishing restrictions on trafficking in persons, the procurement of commercial sex acts, or the use of forced labor; and

(iv) Protect all employees suspected of being victims of or witnesses to prohibited activities, prior to returning to the country from which the employee was recruited, and shall not prevent or hinder the ability of these employees from cooperating fully with Government authorities.

(2) The requirement for full cooperation does not foreclose any Contractor rights arising in law, the FAR, or the terms of the contract. It does not-

(i) Require the Contractor to waive its attorney-client privilege or the protections afforded by the attorney work product doctrine;

(ii) Require any officer, director, owner, employee, or agent of the Contractor, including a sole proprietor, to waive his or her attorney client privilege or Fifth Amendment rights; or

(iii) Restrict the Contractor from-

(A) Conducting an internal investigation; or

(B) Defending a proceeding or dispute arising under the contract or related to a potential or disclosed violation.

(h) Compliance plan.

(1) This paragraph (h) applies to any portion of the contract that-

(i) Is for supplies, other than commercially available off-the-shelf items, acquired outside the United States, or services to be performed outside the United States; and

(ii) Has an estimated value that exceeds $500,000.

(2) The Contractor shall maintain a compliance plan during the performance of the contract that is appropriate-

(i) To the size and complexity of the contract; and

(ii) To the nature and scope of the activities to be performed for the Government, including the number of non-United States citizens expected to be employed and the risk that the contract or subcontract will involve services or supplies susceptible to trafficking in persons.

(3) Minimum requirements. The compliance plan must include, at a minimum, the following:

(i) An awareness program to inform contractor employees about the Government's policy prohibiting trafficking-related activities described in paragraph (b) of this clause, the activities prohibited, and the actions that will be taken against the employee for violations. Additional information about Trafficking in Persons and examples of awareness programs can

be found at the website for the Department of State's Office to Monitor and Combat Trafficking in Persons at http://www.state.gov/j/tip/.

(ii) A process for employees to report, without fear of retaliation, activity inconsistent with the policy prohibiting trafficking in persons, including a means to make available to all employees the hotline phone number of the Global Human Trafficking Hotline at 1-844-888-FREE and its email address at help@befree.org.

(iii) A recruitment and wage plan that only permits the use of recruitment companies with trained employees, prohibits charging recruitment fees to the employee or potential employees, and ensures that wages meet applicable host-country legal requirements or explains any variance.

(iv) A housing plan, if the Contractor or subcontractor intends to provide or arrange housing, that ensures that the housing meets host-country housing and safety standards.

(v) Procedures to prevent agents and subcontractors at any tier and at any dollar value from engaging in trafficking in persons (including activities in paragraph (b) of this clause) and to monitor, detect, and terminate any agents, subcontracts, or subcontractor employees that have engaged in such activities.

(4) Posting.

(i) The Contractor shall post the relevant contents of the compliance plan, no later than the initiation of contract performance, at the workplace (unless the work is to be performed in the field or not in a fixed location) and on the Contractor's Web site (if one is maintained). If posting at the workplace or on the Web site is impracticable, the Contractor shall provide the relevant contents of the compliance plan to each worker in writing.

(ii) The Contractor shall provide the compliance plan to the Contracting Officer upon request.

(5) Certification. Annually after receiving an award, the Contractor shall submit a certification to the Contracting Officer that-

(i) It has implemented a compliance plan to prevent any prohibited activities identified at paragraph (b) of this clause and to monitor, detect, and terminate any agent, subcontract or subcontractor employee engaging in prohibited activities; and

(ii) After having conducted due diligence, either-

(A) To the best of the Contractor's knowledge and belief, neither it nor any of its agents, subcontractors, or their agents is engaged in any such activities; or

(B) If abuses relating to any of the prohibited activities identified in paragraph (b) of this clause have been found, the Contractor or subcontractor has taken the appropriate remedial and referral actions.

(i) *Subcontracts*.

(1) The Contractor shall include the substance of this clause, including this paragraph (f), in all subcontracts and in all contracts with agents. The requirements in paragraph (h) of this clause apply only to any portion of the subcontract that-

(A) Is for supplies, other than commercially available off-the-shelf items, acquired outside the United States, or services to be performed outside the United States; and

(B) Has an estimated value that exceeds $500,000.

(2) If any subcontractor is required by this clause to submit a certification, the Contractor shall require submission prior to the award of the subcontract and annually thereafter. The certification shall cover the items in paragraph (h)(5) of this clause.

11. Section 5.74 Prohibition on Contracting for Hardware, Software, and Services Developed or Provided by Kaspersky Lab and Other Covered Entities

This is a new section added to the contract to provide rules on the Prohibition on Contracting for Hardware, Software, and Services Developed or Provided by Kaspersky Lab.

SECTION 5.74 PROHIBITION ON CONTRACTING FOR HARDWARE, SOFTWARE, AND SERVICES DEVELOPED OR PROVIDED BY KASPERSKY LAB AND OTHER COVERED ENTITIES (JUL 2018) (FAR 52.204-23).

(a) *Definitions*. As used in this clause—

"Covered article" means any hardware, software, or service that–

(1) Is developed or provided by a covered entity;

(2) Includes any hardware, software, or service developed or provided in whole or in part by a covered entity; or

(3) Contains components using any hardware or software developed in whole or in part by a covered entity.

"Covered entity" means–

(1) Kaspersky Lab;

(2) Any successor entity to Kaspersky Lab;

(3) Any entity that controls, is controlled by, or is under common control with Kaspersky Lab; or

(4) Any entity of which Kaspersky Lab has a majority ownership.

(b) *Prohibition.* Section 1634 of Division A of the National Defense Authorization Act for Fiscal Year 2018 (Pub. L. 115-91) prohibits Government use of any covered article. The Contractor is prohibited from—

(1) Providing any covered article that the Government will use on or after October 1, 2018; and

(2) Using any covered article on or after October 1, 2018, in the development of data or deliverables first produced in the performance of the contract.

(c) *Reporting requirement.*

(1) In the event the Contractor identifies a covered article provided to the Government during contract performance, or the Contractor is notified of such by a subcontractor at any tier or any other source, the Contractor shall report, in writing, to the Contracting Officer or, in the case of the Department of Defense, to the website at https://dibnet.dod.mil. For indefinite delivery contracts, the Contractor shall report to the Contracting Officer for the indefinite delivery contract and the Contracting Officer(s) for any affected order or, in the case of the Department of Defense, identify both the indefinite delivery contract and any affected orders in the report provided at https://dibnet.dod.mil.

(2) The Contractor shall report the following information pursuant to paragraph (c)(1) of this clause:

(i) Within 1 business day from the date of such identification or notification: the contract number; the order number(s), if applicable; supplier name; brand; model number (Original Equipment Manufacturer (OEM) number, manufacturer part number, or wholesaler number); item description; and any readily available information about mitigation actions undertaken or recommended.

(ii) Within 10 business days of submitting the report pursuant to paragraph (c)(1) of this clause: any further available information about mitigation actions undertaken or

recommended. In addition, the Contractor shall describe the efforts it undertook to prevent use or submission of a covered article, any reasons that led to the use or submission of the covered article, and any additional efforts that will be incorporated to prevent future use or submission of covered articles.

(d) Subcontracts. The Contractor shall insert the substance of this clause, including this paragraph (d), in all subcontracts, including subcontracts for the acquisition of commercial items.

12. Section 5.75 Prohibition on Contracting for Certain Telecommunications and Video Surveillance Services or Equipment

This is a new section added to the contract to provide rules on the Prohibition on Contracting for Certain Telecommunications and Video Surveillance Services or Equipment.

SECTION 5.75 PROHIBITION ON CONTRACTING FOR CERTAIN TELECOMMUNICATIONS AND VIDEO SURVEILLANCE SERVICES OR EQUIPMENT (AUG 2019) (FAR 52.204-25).

(a) *Definitions.* As used in this clause—

"Covered foreign country" means The People's Republic of China.

"Covered telecommunications equipment or services" means–

(1) Telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities);

(2) For the purpose of public safety, security of Government facilities, physical security surveillance of critical infrastructure, and other national security purposes, video surveillance and telecommunications equipment produced by Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities);

(3) Telecommunications or video surveillance services provided by such entities or using such equipment; or

(4) Telecommunications or video surveillance equipment or services produced or provided by an entity that the Secretary of Defense, in consultation with the Director of National Intelligence or the Director of the Federal Bureau of Investigation, reasonably believes to be an entity owned or controlled by, or otherwise connected to, the government of a covered foreign country.

"Critical technology" means–

(1) Defense articles or defense services included on the United States Munitions List set forth in the International Traffic in Arms Regulations under subchapter M of chapter I of title 22, Code of Federal Regulations;

(2) Items included on the Commerce Control List set forth in Supplement No. 1 to part 774 of the Export Administration Regulations under subchapter C of chapter VII of title 15, Code of Federal Regulations, and controlled-

(i) Pursuant to multilateral regimes, including for reasons relating to national security, chemical and biological weapons proliferation, nuclear nonproliferation, or missile technology; or

(ii) For reasons relating to regional stability or surreptitious listening;

(3) Specially designed and prepared nuclear equipment, parts and components, materials, software, and technology covered by part 810 of title 10, Code of Federal Regulations (relating to assistance to foreign atomic energy activities);

(4) Nuclear facilities, equipment, and material covered by part 110 of title 10, Code of Federal Regulations (relating to export and import of nuclear equipment and material);

(5) Select agents and toxins covered by part 331 of title 7, Code of Federal Regulations, part 121 of title 9 of such Code, or part 73 of title 42 of such Code; or

(6) Emerging and foundational technologies controlled pursuant to section 1758 of the Export Control Reform Act of 2018 (50 U.S.C. 4817).

"Substantial or essential component" means any component necessary for the proper function or performance of a piece of equipment, system, or service.

(b) *Prohibition.* Section 889(a)(1)(A) of the John S. McCain National Defense Authorization Act for Fiscal Year 2019 (Pub. L. 115-232) prohibits the head of an executive agency on or after August 13, 2019, from procuring or obtaining, or extending or renewing a contract to procure or obtain, any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system. The Contractor is prohibited from providing to the Government any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system, unless an exception at paragraph (c) of this clause applies or the covered telecommunication equipment or services are covered by a waiver described in Federal Acquisition Regulation 4.2104.

(c) *Exceptions.* This clause does not prohibit contractors from providing—

(1) A service that connects to the facilities of a third-party, such as backhaul, roaming, or interconnection arrangements; or

(2) Telecommunications equipment that cannot route or redirect user data traffic or permit visibility into any user data or packets that such equipment transmits or otherwise handles.

(d) Reporting requirement. (1)In the event the Contractor identifies covered telecommunications equipment or services used as a substantial or essential component of any system, or as critical technology as part of any system, during contract performance, or the Contractor is notified of such by a subcontractor at any tier or by any other source, the Contractor shall report the information in paragraph (d)(2) of this clause to the Contracting Officer, unless elsewhere in this contract are established procedures for reporting the information; in the case of the Department of Defense, the Contractor shall report to the website at https://dibnet.dod.mil. For indefinite delivery contracts, the Contractor shall report to the Contracting Officer for the indefinite delivery contract and the Contracting Officer(s) for any affected order or, in the case of the Department of Defense, identify both the indefinite delivery contract and any affected orders in the report provided at https://dibnet.dod.mil.

(2) The Contractor shall report the following information pursuant to paragraph (d)(1) of this clause

(i) Within one business day from the date of such identification or notification: the contract number; the order number(s), if applicable; supplier name; supplier unique entity identifier (if known); supplier Commercial and Government Entity (CAGE) code (if known); brand; model number (original equipment manufacturer number, manufacturer part number, or wholesaler number); item description; and any readily available information about mitigation actions undertaken or recommended.

(ii) Within 10 business days of submitting the information in paragraph (d)(2)(i) of this clause: any further available information about mitigation actions undertaken or recommended. In addition, the Contractor shall describe the efforts it undertook to prevent use or submission of covered telecommunications equipment or services, and any additional efforts that will be incorporated to prevent future use or submission of covered telecommunications equipment or services.

(e) *Subcontracts.* The Contractor shall insert the substance of this clause, including this paragraph (e), in all subcontracts and other contractual instruments, including subcontracts for the acquisition of commercial items.

Part IV-SPECIAL PROVISIONS is deleted and replaced with the following:

SECTION 4.1
ALTERATIONS IN CONTRACT (JAN 2019) (FAR 52.252-4)

Portions of this contract are altered as follows:

(a) Section 1.6 Confidentiality of Records. The following subsection is added:

(d) Local Blue Cross and/or Blue Shield Plans may combine the personal data and medical records of Federal subscribers, and information relating thereto, with the same information of other individuals who have health benefits coverage under the Local Blue Cross and/or Blue Shield Plan. This combined data may only be used and disclosed for the Plan's health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501). Such activities include, but are not limited to: care management; prevention, detection, and recovery of funds subject to fraud and abuse; and negotiation of provider contracts.

(e) As used in subsection (b)(1) of this section, "administration of this contract" means health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501).

(b) Section 1.9 Plan Performance—Experience-Rated FFS Contracts.

The Carrier may use the appropriate systems for measurement and/or collection of data on the quality of the health care services as described in subparagraph 1.9(b).

(c) Section 1.14, Misleading, Deceptive, or Unfair Advertising, is amended by removing the reference to the NAIC Advertisements of Accident and Sickness Insurance Model Regulation (Appendix D-b). Carrier should continue to use the FEHB Supplemental Literature Guidelines (now at the renumbered Appendix C) along with FEHBAR 1603.7002.

(d) Section 1.15 Renewal and Withdrawal of Approval (FEHBAR). The following subsections are added:

(d) If the agency suspends payment of the subscription charges for any reason, the Carrier may (1) suspend making benefit payments until payment of all subscription charges due is fully restored; or (2) terminate the contract without prior notice.

(e) Section 1.21 Patient Bill of Rights. For the purpose of compliance with this Section, the Carrier will conduct the following minimum activities: (1) the Carrier will provide subscribers with a Fact Sheet that includes information about the disenrollment rate in the Blue Cross and Blue Shield Service Benefit Plan, as well as Local Plan-specific information including compliance with Federal and State financial requirements, public corporate information, years in existence, and accreditation status; (2) Provider

Directories will include language advising subscribers to contact their providers directly to obtain information about the providers, including but not limited to board certifications, languages spoken, availability of interpreters, facility accessibility, and whether the provider is accepting new patients.

(f) Section 1.30 Health Information Technology Privacy and Security. Subsections (b), (c) and the introductory paragraph of Subsection (d) of Section 1.30 are amended to read as follows:

(b) The Carrier will promote consumer transparency by ensuring that at the point where the Federal member enters the subcontractor's, large provider's, or vendor's website or web portal the link to the subcontractor's, large provider's, or vendor's notice of privacy practices and/or privacy policies is displayed on the bottom, or prominently displayed elsewhere, on the website or web portal.

(c) Notice of privacy practices and/or privacy policies disclosures must describe the uses of individually identifiable protected health information and any potential disclosure to other entities as described in the HIPAA Privacy Rule.

(d) The Carrier will participate with the Contracting Officer or an authorized representative of the Contracting Officer in credential vulnerability scans and configuration compliance audits conducted in accordance with rules of engagement agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The rules of engagement will include the software and hardware used for vulnerability scanning; the specific process used to conduct vulnerability scanning; precautions taken to prevent negative disruption on the systems being scanned; restrictions on the release of documents and artifacts; and how the results of the scanning will be reviewed and reported.

(g) Section 2.2 Benefits Provided. The following paragraph is added to subsection 2.2(a):

(4) The Carrier may pay the Preferred Provider Organization level of benefits under this contract to ease the hardship of members affected by natural disasters such as earthquakes, floods, etc., when because of the natural disaster members have difficulty gaining access to Preferred network providers. The Carrier may pay the Preferred level of benefits without regard to the provider's contractual relationship with the Carrier and will determine an appropriate time frame based on local conditions during which the provision of this paragraph will apply. Benefits provided under this paragraph will be made available to all members similarly affected by the natural disaster.

(h) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Notwithstanding subsection (f) of Section 2.3, benefits provided under the contract are not assignable by the Member to any person without express written approval of the carrier, and in the absence of such approval, any such assignment shall be void. Notwithstanding such approval, no assignment of benefits may be made in any case prior to the time that a valid claim for benefits arises.

(i) Section 2.3 Payment of Benefits and Provision of Services and Supplies. The introductory paragraph of Subsection 2.3(g) is amended to read as follows:

(g) *Erroneous Payments*.

(i) If the Carrier or OPM determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider; the recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment under 48 C.F.R. 1631.201-70(h) regardless of any time period limitations in the written agreement with the provider.

(ii) The Carrier shall be deemed to have satisfied the requirements of Subsection (g) (i) above by complying with Subsections (ii), (iii), and (iv). Local Blue Cross and Blue Shield Plans which have time period limitations in their provider contracts which prevent the Plan from recovering erroneous benefit payments made to providers will participate in an action plan. The action plan shall be developed by the Blue Cross and Blue Shield Association by December 31, 2008 and agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield Association and the Contracting Officer shall utilize standards of commercial reasonableness and neither shall unreasonably withhold agreement. The action plan shall be designed to reduce the occurrence of erroneous benefit payments, to identify and recover erroneous benefit payments within the time limits stipulated in their provider contracts, and to demonstrate due diligence in making an attempt to identify and recover within that provider contract timeframe such erroneous benefit payments.

(iii) The Blue Cross and Blue Shield Association shall be responsible for monitoring and determining whether each Blue Cross and Blue Shield Plan participating in the action plan is complying with its obligations under the action plan.

(iv) A Blue Cross and Blue Shield Plan which is in compliance with its obligations under the action plan shall be found to be in compliance with its obligation under this Section 2.3(g) to make a prompt and diligent effort to recover erroneous benefit payments. In the event that any Plan with such time period limitations is determined to be not in substantial compliance with the action plan, and that Plan is determined not to have pursued material benefit payments with promptness and diligence, then the Plan shall return the erroneous benefit payments to the Program.

(v) The Carrier shall follow general business practices and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall—

(j) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(7)(ii) of Section 2.3 is amended to read as follows:

Notwithstanding (g)(7)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that

caused erroneous benefit payments) when the errors are egregious and repeated. These costs are deemed to be unreasonable and unallowable under Section 3.2(b). The term "repeated" in the previous sentence does not apply to situations in which a claims processing system error causes multiple erroneous payments or to situations that involve audit findings on errors that are endemic to the provision of insurance and claims processing.

(k) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(10) of Section 2.3 is amended to read as follows:

(10) In compliance with the Contracts Disputes Act, the Carrier shall return to the Program an amount equal to the uncollected erroneous benefit payment where the Contracting Officer determines that the Carrier failed to make a prompt and diligent effort, as that term is described above, to recover the erroneous benefit payment. This provision applies to benefit payments which have been paid in error for any reason (except in the case of fraud or abuse).

(l) Section 2.4 Termination of Coverage and Conversion Privileges. The conversion contract set forth in Section 2.4(c) may be a contract that is regularly offered by the local Blue Cross and/or Blue Shield Plan.

(m) Section 2.5 Subrogation. The following subsections are added:

(c) To the extent that a Member has received benefits for covered services under this contract for an injury or illness caused by a third party, the Carrier shall have the right to be subrogated and succeed to any rights of recovery against any person or organization from whom the Member is legally entitled to receive all or part of those same benefits, including insurers of individuals (non-group) policies of liability insurance that are issued to and in the name of the Member. The obligation of the Carrier to recover amounts through subrogation is limited to making a reasonable effort to seek recovery of amounts to which it is entitled to recover in cases which are brought to its attention. The Carrier shall not be required to recover any amounts from any person or organization who causes an injury or illness for which the Member makes claims for benefits.

(d) The Carrier may also recover directly from the Member all amounts received by the Member by suit, settlement, or otherwise from any third party or its insurer, or the Member's insurer under an individual policy or liability insurance, for benefits which have also been paid under this contract.

(e) The Member shall take such action, furnish such information and assistance, and execute such papers as the Carrier or its representative believes are necessary to facilitate enforcement of its rights, and shall take no action which would prejudice the interests of the Carrier to subrogation.

(f) Effective January 1, 1997, all Participating Plans shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under the contract.

(n) Section 2.6 Coordination of Benefits (FEHBAR). The following subsections are added:

(g) The benefits payable by this Plan shall be determined, on a claim by claim basis, only for those claims in excess of $100, except where Medicare is the primary payer of benefits, claims in excess of $50.

(h) Whenever payments which should have been made under this contract in accordance with this provision have been made under any other group health coverage, the Carrier shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amount it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this contract and, to the extent of such payments discharged from liability under the contract.

(o) Section 3.1 Payments (FEHBAR). The following sentence is added to the end of Section 3.1(a):

OPM will withhold from the subscription charges amounts for other obligations due under the contract only to the extent that OPM and the Carrier have agreed in writing to specific deductions for such other obligations.

(p) Section 3.1 Payments (FEHBAR). The following subsection is added:

(g) Except as required pursuant to Sections 1.25 and 2.12, in the event this contract is terminated or not renewed, the agency shall be liable for all sums due and unpaid, including subscription charges, for the period up to the last day of the Member's entitlement to benefits.

(q) Section 3.2 Accounting and Allowable Cost (FEHBAR). Section 3.2(b)(2)(ii) of this contract is amended to comply with 5 U.S.C. 8909(f) as follows:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(r) Section 3.2 Accounting and Allowable Cost (FEHBAR). The provision in Section 3.2 (b)(2)(iv)(A) is supplemented as follows:

Charges for mandatory statutory reserves (Section 3.2(b)(2)(iv)(A)) to satisfy mandatory

statutory reserve requirements of Participating Plans are allowable to the extent that such requirements exceed that portion of the service charge at Appendix B, Subscription Rates, Charges, Allowances and Limitations applicable to such Plans.

(s) Section 3.2 Accounting and Allowable Cost (FEHBAR). This section is modified as follows:

The Carrier, as required by the Blue Cross and Blue Shield Service Benefit Plan Workplan, shall furnish OPM an accounting of its operations under the contract not less than 120 days after the end of the calendar year contract period.

(t) Section 3.3 Special Reserve. The provision in Section 3.3(a) is supplemented as follows:

The Special reserve held by or on behalf of the Carrier is to be used only for payment of charges against this contract, including advance payments to Participating Plans and to hospitals.

(u) Section 3.10, Audit, Financial, and Other Information. Compliance by the Carrier and Participating Blue Cross and Blue Shield Plans with the Blue Cross Blue Shield Service Benefit Plan Workplan, as agreed upon between the Carrier and OPM, will constitute compliance with the Audit Guide referred to in Sections 3.2 and 3.10.

SECTION 4.2
HOSPITAL (FACILITY) BENEFIT PAYMENTS AND CONDITIONS (JAN 1991)

(a) Benefits described in the agreed upon brochure text shall be provided to the extent practicable in the form of services rendered by hospitals, freestanding ambulatory facilities, and home health care agencies, and payment, therefore, by or on behalf of the carrier shall constitute a complete discharge of their obligations under this contract to the extent of services rendered in accordance with the terms and conditions of the contract.

(b) Benefits for inpatient hospital care shall be available only to a Member admitted to the hospital on the recommendation, and while under the active medical supervision of a duly licensed physician or alternative provider as described in section 8902(k)(1) of title 5 U.S.C. who is a member of the staff of, or acceptable to, the hospital selected.

(c) Hospital service is subject to all the rules and regulations of the hospital selected including rules governing admissions.

(d) While a Member may elect to be hospitalized in any hospital, the Carrier does not undertake to guarantee the admission of such Member to the hospital, nor the availability of any accommodations or services therein requested by the Member or his physician.

SECTION 4.3
DEFINITION OF CARRIER (JAN 1991)

The Carrier is the Blue Cross and Blue Shield Association, an Illinois not-for-profit corporation, acting on behalf of participating Blue Cross and Blue Shield Plans and

pursuant to authority specified in Exhibit A for and in behalf of the organizations specified in Exhibit A (hereinafter sometimes referred to as "Participating Plans").

SECTION 4.4
AUDIT DISPUTES (JAN 2000)

(a) Any questioned costs or issues documented by or on behalf of OPM's Office of the Inspector General (OIG) in draft or final audit reports examining the Carrier's and Participating Plans' performance under this contract, that are provided to the Carrier and that were initially raised in the timeframe set forth in subsection (c) below, remain open until resolved. Audit issues related to monetary findings for which extensions of the waiver period for the issuance of final decisions and processing of prior period adjustments were obtained in previous contract terms also remain open until resolved.

(b) Resolution of a questioned cost or issue can be the result of a resolution letter or the issuance of a final decision by the Contracting Officer, or by the processing of a prior period adjustment, an adjustment to the Special reserve, or submission of a claim to OPM (as appropriate) by the Carrier or Participating Plan. A prior period adjustment intended to partially or fully resolve an audit finding will not be considered closed until properly reported on the calendar year Annual Accounting Statement.

(c) A claim seeking, as a matter of right, the payment of money, in a sum certain, pursuant to 48 CFR section 52.233-1, shall not be made more than five years following the last day prescribed by the contract for filing the calendar year Annual Accounting Statement for the year with respect to which the claim arises. A claim includes, in the case of the carrier, a charge against the contract.

SECTION 4.5
ASSOCIATION DUES (JAN 2004)

A Participating local Blue Cross and Blue Shield Plan may charge to this contract Association Dues, with the exception of dues related to those lobbying costs and Special Assessments determined to be unallowable. In calculating the unallowable portion of dues related to lobbying costs for a contract year, the Blue Cross and Blue Shield Plan will rely on the percentage of dues, less any special assessments, as determined by the BCBSA for IRS purposes, to be not tax deductible from the previous contract year.

SECTION 4.6
TRAVEL COSTS (JAN 1996)

The Carrier may charge and account for travel expenses related to administration of the contract on a per diem basis, subject to the maximums prescribed by the Federal Travel Regulations. For those travel costs for each contract term that are subject to the Federal per diem rates set forth at 48 CFR section 31.205-46, the Carrier shall charge to the contract an amount equal to the lesser of:

(i) the actual aggregate charges for those costs, or
(ii) the aggregate charges calculated using the per diem rates set forth in the Federal Travel Regulations.

SECTION 4.7
MARKET RESEARCH COSTS (JAN 1996)

(a) Costs of market research surveys or studies are generally allowable if the survey or study is:

1. directed to current Members and Members who left the Blue Cross and Blue Shield Service Benefit Plan in the most recent Open season, or
2. focused on long-range planning, industry state-of-the-art developments, or product development issues for which a direct benefit or potential benefit to the FEHB Program can be identified, or
3. pre-approved by the Contracting Officer.

(b) Costs of market research surveys or studies are generally not allowable if the primary purpose is to survey or study an otherwise unallowable cost item, such as: to determine the effectiveness of advertising or sales strategies; to evaluate image effectiveness or ways to achieve image enhancement; or to perform a competitive analysis with other carriers in the FEHB Program. Such costs are unallowable, regardless of who receives the research surveys or studies.

(c) This provision does not supersede other contract requirements, such as prior approval for subcontracts under Section 1.16 Subcontracts (FEHBAR 1652.244-70).

SECTION 4.8
PRESCRIPTION DRUG BENEFITS WAIVER PROVISIONS (JAN 2009)

(a) For the purposes of applying the special provisions in this section, the Standard Option Mail Service Prescription Drug Program service standards are:

(1) When a prescription order is placed that does not require additional information or clarification (i.e., a clean or non-diverted prescription), the prescription order shall be dispensed within three business days from the date of receipt so the enrollee may expect to receive the medication within 7 calendar days.

(2) When a prescription order is placed that does require additional information, clarification or resolution of payment issues (i.e., a diverted prescription), the prescription order shall be dispensed within seven business days from the date of receipt so the enrollee may expect to receive the medication within 14 calendar days. However the following situations will not be considered a diverted prescription for the purposes of this section:

(i) Prescriptions for refrigerated products that require prior arrangements between the mail order pharmacy and a Member before the Member can receive the Prescription;

(ii) Prescriptions requiring specific counseling obligations imposed by the pharmaceutical manufacturer, distributor or the FDA;

(iii) Prescriptions requiring "registration" with a pharmaceutical manufacturer.

(b) The special provisions described in paragraphs (c)(1), (2), and (3) shall become effective automatically when less than 98 percent of the prescriptions are filled within the

service standards described in either paragraph (a)(1) or (a)(2) for 7 consecutive business days. The special provisions shall terminate when for 7 consecutive business days 98 percent or more of the prescriptions are filled within the service standards described in paragraphs (a)(1) and (a)(2) of this section.

(c) The special provisions are:

(1) The Carrier shall waive during the effective periods in paragraph (b) the coinsurance for a 21 day prescription filled at a Preferred retail pharmacy when the Mail Service Prescription Drug Program vendor is unable to fill the prescription within the service standards. This waiver of the coinsurance shall be in effect for 14 calendar days after notice to the enrollee as described in paragraph (c)(2) below.

(2) The Carrier shall deliver to the enrollee a written or telephone notice no later than 5 days from the date of receipt for clean or non-diverted prescriptions and no later than 12 days from the date of receipt for diverted prescriptions.

This notice shall:

(i) advise the enrollee that the Mail Service Prescription Drug Program may not be able to fill the prescription(s) within the service standard timeframes;

(ii) advise the enrollee that any applicable coinsurance will be waived for a 21 day supply of the medication(s) when filled at a Preferred retail pharmacy;

(iii) provide the enrollee with instructions on how to use the waiver, and

(iv) advise the enrollee when the waiver will expire.

(3) The Carrier may use next day delivery service at no additional cost to the enrollee in order to meet the service standards in (a)(1) and (a)(2).

SECTION 4.9
SMALL BUSINESS SUBCONTRACTING PLAN (JAN 2002) (FAR 52.219-9) (AS AMENDED)

An amended clause 52.219-9, Small Business Subcontracting Plan, is attached to Appendix E.

SECTION 4.10
LETTER OF CREDIT (JAN 1997)

As of January 1, 1997, OPM will administer Letter of Credit drawdowns directly with the local Plans.

SECTION 4.11
PILOTING OF COST CONTAINMENT PROGRAMS (JAN 2001)

Upon approval by the Contracting Officer, the Carrier may design and implement pilot programs in one or more local Plan areas that test the feasibility and examine the impact of various managed care initiatives. The Carrier shall brief the Contracting Officer on a pilot program prior to its implementation, advise the Contracting Officer of the progress of the pilot program and provide a written evaluation at the conclusion of the pilot program. The evaluation of the pilot program shall, at a minimum, assess the cost effectiveness, effect on quality of care and/or quality of life, and customer satisfaction, and recommend whether the pilot program should be continued or expanded.

SECTION 4.12
TRANSITION COSTS FOR PLAN TERMINATIONS (JAN 1999)

In the event a Participating Plan's license to use the Blue Cross and/or Blue Shield service marks is terminated, thereby rendering it ineligible to participate in this Contract, the costs of transitioning the terminated Plan's Service Benefit Plan subscribers to a successor Plan shall be subject to advance approval. The Carrier shall submit to OPM a proposed transition plan, together with a detailed estimate of costs, prior to the incurrence of any significant transition costs. OPM and the Carrier shall negotiate an advance agreement pursuant to FAR 31.109 that covers the extent of allowable transition costs.

SECTION 4.13
PAYMENT BY ELECTRONIC FUNDS TRANSFER-CENTRAL CONTRACTOR REGISTRATION (MAY 1999) (FAR 52.232-33)

The references to the Central Contractor Registration in FAR 52.232-33 are not applicable to this contract.

SECTION 4.14
FEDERAL INCOME TAX RELATED TO HEALTH INSURANCE PROVIDERS' FEE (JANUARY 2015)

(a) Notwithstanding FAR 31.205-41(b)(1) and this Contract Section 3.2(b)(1)(ii), a charge for an incremental amount of Federal income tax liability incurred as the result of compliance with the Health Insurance Providers Fee (HIP Fee) provision of the Affordable Care Act section 9010 (hereafter referred to as the "HIP Tax Cost") by a participating local plan (Local Plan) that administers the Service Benefit Plan on behalf of the Blue Cross and Blue Shield Association (Carrier), and that is a covered entity within the meaning of 26 CFR Part 57, is an allowable cost to the Carrier under this contract under the criteria set forth below.

(1) The allowable cost to the Carrier for a year is the sum of the HIP Tax Cost for each Local Plan. The HIP Tax Cost for each Local Plan equals:
the amount reimbursed by OPM to the Carrier for the HIP Fee attributable to the Local Plan (Local Plan HIP Fee) for the year, divided by one minus the tax rate for the Local Plan specified under section (2) below, (Local Plan Tax Rate), less the Local Plan HIP Fee. In mathematical terms, the allowable charge to the Carrier for the HIP Tax Cost is the sum of each Local Plan's application of the formula below:

$$\left[\frac{\text{Local Plan HIP Fee}}{1 - \text{Local Plan Tax Rate}}\right] - \text{Local Plan HIP Fee}$$

(2) The Local Plan Tax Rate for purposes of the formula specified in section (1) is the lowest of the following:
(a) the rate specified at 26 USC §11 (b) (1) (D),

(b) the rate specified at 26 USC § 55(b)(1)(B)(i), for any year in which the Local Plan is entitled to the special deduction under 26 USC § 833(a)(2), or
(c) zero, for any year in which the Local Plan experiences a Net Operating Loss or other circumstance resulting in no tax liability. For a year in which the Local Plan experiences a Net Operating Loss resulting in no tax liability, the Carrier will charge the HIP Tax Cost attributable to the Local Plan in the first subsequent year in which the Local Plan's tax liability is greater than zero. The Local Plan will calculate the HIP Tax Cost in this circumstance by applying the formula using the HIP Fee for the year of the loss and the Local Plan Tax Rate for the year in which the tax liability is greater than zero. This charge by the Carrier is in addition to the charge allowed by the Carrier for the Local Plan Tax Cost for the year in which the tax liability is greater than zero.

(d) If the Local Plan Tax Rate reflected on the Local Plan's tax return actually filed for the contract year (which normally occurs the following year) differs from the Local Plan Tax Rate that was anticipated when the costs were drawn down by the Carrier for the contract year as allowable administrative expenses, the Carrier will make a commensurate adjustment to its current year drawdown of administrative expenses.

(b) The Contracting Officer or an authorized representative of the Contracting Officer shall have the right to examine and audit all books and records, including tax filings, relating to the calculation of the HIP Tax Cost charge for each Local Plan.

Part IV - Attachment I
SECTION 4.14
FEDERAL INCOME TAX RELATED TO HEALTH INSURER'S PROVIDER FEE

Examples of Allowable 9010 Tax Cost:

C is an experience rated FEHB carrier consisting of participating Local Plans F and G who underwrite and administer C in different geographic areas.

In 2015, F reports $900 on IRS Form 8963 and pays $500 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the $500 HIP Fee, F's Form 8963 reflects that $300 is attributable to F's FEHBP business.

Also in 2015, G reports $950 on IRS Form 8963 and pays $550 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the $550 HIP Fee, G's Form 8963 reflects that $325 is attributable to G's FEHBP business.

In 2015, C draws down a 2015 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2014 health risks, which is calculated as the sum of F and G's HIP Fee, or $300 +325 = $725, which is an allowable cost, from its FEHB letter of credit account (LOCA). C reimburses F for its HIP Fee of 300 and G for its HIP Fee of 325.

F records income of $300 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by $300. F records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, F pays quarterly payments to the IRS for its' 2015 tax liability. F's 2015 tax rate is 35 percent.

G records income of $325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by $325. G records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, G pays quarterly payments to the IRS for its' 2015 tax liability. Because G claims a special deduction under 26 USC § 833(a)(2), G's 2015 tax rate is 20 percent.

In 2015, C also draws down from its LOCA a 2015 HIP Tax Cost reimbursement for the 2015 income tax expense accrued and paid by F & G in 2015. C's 2015 HIP Tax cost reimbursement is calculated as follows:

Local Plan F HIP Tax Cost: ($300/1-.35)-$300 = $162
Local Plan G HIP Tax Cost: ($325/1-.20)-$325 = $81
Sum which is C's allowable HIP Tax Cost for 2015 = $243

In 2016, F & G report the same HIP Fee expense for 2015 health risks.

In 2016, F experiences the same tax rate as for 2015, but G incurs a net operating loss, resulting in a zero percent tax rate for 2016.

In 2016, C draws down a 2016 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2015 health risks of 300 + 325 = $725, which is an allowable cost, from C's FEHB letter of credit account (LOCA). C reimburses F for 300 and G for 325.

In 2016, F proceeds as in 2015 and C may charge 162 as an allowable HIP Tax Cost attributable to F in 2016.

In 2016 G records income of $325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by $325. Because G determines that its 2016 tax liability will be zero as it will have a Net Operating Loss for 2016, C does not incur an allowable 2016 HIP Tax Cost attributable to G. C must refund any such amounts drawn down during 2016.

Local Plan F HIP Tax Cost for 2016 = 162
Local Plan G HIP Tax Cost for 2016 = 0
Reimbursement attributable to G = adjustment for amounts drawn down by C, if any
Sum = C's allowable HIP Tax Cost for 2016 = 162 less adjustment.

In 2017, F proceeds as in 2015. C's allowable 2017 HIP Tax Cost includes $162 attributable to F. In 2017, G has an operating gain and reports the same HIP Fee amount and experiences the same 20% tax rate as in 2015. C's allowable 2017 HIP Tax Cost includes $81 attributable to G.

In addition, in 2017, because G's operating gain results in a tax rate higher than zero, G incurs economic disadvantage. This is because the 2016 HIP Fee reimbursement of $325 has reduced G's otherwise applicable Net Operating Loss carry-forward amount. G calculates the economic disadvantage as the difference between its 2017 tax liability with and without the 2016 HIP Fee reimbursement. This disadvantage is included in the Carrier's 2017 charge as an allowable HIP Tax Cost with respect to 2016. This is calculated as $325 (2016 HIP Fee) divided by 1-20% (application of 2017 Local Plan Tax Rate), less $325.]

Local Plan F HIP Tax Cost for 2017 = 162
Local Plan G HIP Tax Cost for 2017 = 81
Local Plan G HIP Tax Cost for 2017 due to 2016 HIP Fee reimbursement = apply formula using 2016 Fee Reimbursement amount and 2017 tax rate of 20% =81
Sum = C's allowable HIP Tax Cost for 2017 = 162 + 81 + 81 = $324

APPENDIX A

2020

FEP Brochures Text

For a copy of the 2020 FEP brochures, please go to www.fepblue.org.

APPENDIX B

SUBSCRIPTION RATES, CHARGES, ALLOWANCES AND LIMITATIONS

Fee-For-Service Carrier

Blue Cross and Blue Shield Service Benefit Plan
CONTRACT NO. CS 1039
Effective January 1, 2020

(a) Biweekly net-to-Carrier rates, with appropriate adjustments for Enrollees paid on other than a biweekly basis, are as follows:

Basic Option:	$292.10 Self, $656.47 Self Plus One, and $709.32 Self and Family
Standard Option:	$339.12 Self, $741.61 Self Plus One, and $801.16 Self and Family
FEP Blue Focus:	$204.40 Self, $439.44 Self Plus One, and $483.37 Self and Family

(b) The amount of administrative expenses and charges to be included in the Annual Accounting Statement required by Section 3.2 shall be as set out in the schedule below:

Item	Amount
(i) Administrative Expenses	Actual, but not to exceed the Contractual Expense Limitation for 2020,* plus an amount sufficient to cover the costs needed to pay the Plan's Independent Public Accountant to undertake the audits and agreed upon procedures required in the "FEHBP Experienced-Rated Carrier and Service Organization Audit Guide."
(ii) Taxes	Actual (except that premium taxes as defined are not allowable).
(iii) Service Charge**	REDACTED

*The Contractual Expense Limitation for 2020 is REDACTED Notwithstanding Section 3.2(b) of this Contract, costs of "activities that improve healthcare quality" as determined in accordance with the medical loss ratio provision of the Affordable Care Act (Section 2718 of the

Public Health Service act; 42 U.S.C. 300gg-18 and its implementing regulations), are accounted for as benefits and not counted toward the Contractual Expense Limit.

** The Service Charge for the 2020 contract year is based on the Overall Performance Score calculated in accordance with the 2019 Appendix F. The Service Charge for the 2021 contract year will be based on the Overall Performance Score calculated in accordance with the 2020 Appendix F.

APPENDIX F

Measures and contributions to performance areas and scores for 2020 Performance and 2021 Service Charge

To be performed in accordance with the 2020 FEHB Plan Performance Assessment Procedure Manual and the FEHB Plan Performance Assessment – Consolidated Methodology Carrier Letter (CL 2017-15). The Service Charge for the 2021 contract year will be based on the Overall Performance Score calculated in accordance with this Appendix F.

1. Performance Area Contributions to Overall Performance Score (OPS)

Performance Area	**Contribution to Overall Performance Score**
Clinical Quality, Customer Service, and Resource Use	65%
Contract Oversight	35%

2. Clinical Quality, Customer Service, and Resource Use (QCR) Performance Area Measures

Performance Area	**Measure**	**Priority Level**	**Measure Weight**
Clinical Quality	Controlling High Blood Pressure	1	2.50
	Prenatal Care (Timeliness)	1	2.50
	Comprehensive Diabetes Care HbA1C <8%	1	2.50
	Breast Cancer Screening	2	1.25
	Well Child Visits in the First 15 Months of Life (6 visits)	2	1.25
	Flu Vaccinations for Adults (18-64)	2	1.25
	Cervical Cancer Screening	2	1.25

	Asthma Medication Ratio	2	1.25
	Avoidance of Antibiotics in Adults with Acute Bronchitis	2	1.25
	Follow-up after Discharge from Emergency Department for Mental Illness (30 day)	2	1.25
	Follow-up after Discharge from Emergency Department for Alcohol or other Drug Dependence (30 Day)	2	1.25
	Statin Therapy for Patients with Cardiovascular Disease (Adherence)	2	1.25
	Colorectal Cancer Screening	2	1.25
Customer Service	Getting Care Quickly	3	1.00
	Getting Needed Care	3	1.00
	Claims Processing	3	1.00
	Overall Health Plan Rating	3	1.00
	Coordination of Care	3	1.00
	Overall Personal Doctor Rating	3	1.00
Resource Use	Emergency Department Utilization	2	1.25
	Use of Imaging Studies for Low Back Pain	1	2.50

EXHIBIT F

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Standard Contract Amendment

For

Fee-For-Service Carriers

2021

AMENDMENT TO CONTRACT CS 1039

CONTRACT NO: 1039
EFFECTIVE: January 1, 1960

AMENDMENT NO. 2021A
EFFECTIVE: January 1, 2021

BETWEEN: THE UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
hereafter called the OPM, the Agency, or the Government

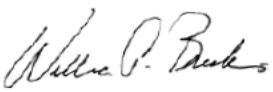
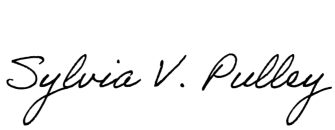
Address: 1900 E Street, NW
Washington, DC 20415-3610

AND

CONTRACTOR: Blue Cross and Blue Shield Association
hereafter also called the Carrier

Address: 1310 G. Street, NW
Washington, DC 20005

In consideration of payment by the Agency of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract, including Appendix A.

FOR THE CARRIER	FOR THE GOVERNMENT
William A. Breskin	Sylvia V. Pulley
Name of Person Authorized to Execute Contract (Type or print)	(Type or print)
Senior Vice President, Government Programs	Contracting Officer
Title	Title
	
Signature	Signature
12/24/2020	12/28/2020
Date Signed	*Date Signed*

1. **Section 1.7 Statistics and Specials Studies**

We added part (e) to this section to ensure Carriers notify OPM should they receive a Third-Party request about FEHB program data that is not related to the administration of the contract.

SECTION 1.7 STATISTICS AND SPECIAL STUDIES (JAN 2021)

(a) The Carrier shall maintain or cause to be maintained statistical records of its operations under the contract and shall furnish OPM, in the form prescribed by the Contracting Officer, the statistical reports reasonably necessary for the OPM to carry out its functions under Chapter 89 of title 5, United States Code.

(b) The Carrier shall furnish such other reasonable statistical data and reports of special studies as the Contracting Officer may from time to time request for the purpose of carrying out its functions under Chapter 89 of title 5, United States Code.

(c) The Carrier shall furnish the routine reports in the required number of copies in a format to be determined by the Contracting Officer as instructed by OPM.

(d) The Carrier shall notify the OPM Health Insurance Specialist (Contracts) immediately upon a change in the name or address of the Carrier's contracting official(s).

(e) The Carrier shall notify the OPM Health Insurance Specialist within 3 business days from the date of request if a third party requests FEHB program data for any purpose not related to administration of the contract.

2. **Section 1.9 Plan Performance – Experience-Rated FFS Contract**

We clarified the language for the Contract Quality Assurance metrics. The metrics themselves have not been modified.

SECTION 1.9 PLAN PERFORMANCE—EXPERIENCE-RATED FFS CONTRACTS (2021)

* * * * *

(d) Accreditation. To demonstrate its commitment to providing quality health care, the Carrier shall continue to pursue and maintain accreditation according to the steps and timeframes outlined by OPM. The Carrier shall submit accreditation changes and updates to its OPM Health Insurance Specialist (Contracts).

(e) Consumer Assessments of Healthcare Providers and Systems (CAHPS). In addition to any other means of surveying Plan members that the Carrier may develop, the Carrier shall participate in the Consumer Assessments of Healthcare Providers and Systems (CAHPS) 5.0 Survey to provide feedback to Enrollees on Enrollee experience with the various FEHBP plans. The Carrier shall take into account the published results of the survey, or other results as directed by OPM, in identifying areas for improvement as part of the Carrier's quality assurance program. Payment of survey charges will be in accordance with Section 3.11.

(f) Contract Quality Assurance. The Carrier shall develop and apply a quality assurance program specifying procedures for assuring contract quality over the contract period. The Carrier shall meet the required standards provided in this section. No later than July 1 of the

subsequent year, the Carrier shall submit to OPM an annual report of metrics on each specification provided in this section, using data for the contract period.

(1) *Claims Processing Accuracy*
SPECIFICATION: the number of FEHB claims processed accurately divided by the total number of FEHB claims processed.
REQUIRED STANDARD: The Carrier shall accurately process at least 95 percent of FEHB claims.
(2) *Claims Coding Accuracy*
SPECIFICATION: the number of FEHB claims coded accurately divided by the total number of FEHB claims.
REQUIRED STANDARD: The Carrier shall accurately code at least 98 percent of FEHB claims.
(3) *Recovery of Erroneous Payments*
SPECIFICATION: the average number of working days it takes for the Carrier to begin collection action against an FEHB provider or member following identification of an erroneous payment, including overpayments.
REQUIRED STANDARD: The Carrier shall average no more than 30 working days from the date it identifies an FEHB erroneous payment to the date it begins the collection action.
(4) *Claims Timeliness*
SPECIFICATION: the number of FEHB claims adjudicated (paid, denied, or a request for further information is sent out) within 30 working days from the date the Carrier received the claim, divided by the total number of FEHB claims received.
REQUIRED STANDARD: The Carrier shall adjudicate at least 95 percent of claims within 30 working days.
(5)*Processing ID cards on change of plan or option –*
SPECIFICATION: the number of calendar days from the date the Carrier receives the enrollment from the Enrollee's agency, Tribal Employer, or retirement system to the date it issues the ID card.
REQUIRED STANDARD: The Carrier shall issue all ID cards within 15 calendar days after receiving the enrollment from the Enrollee's agency, Tribal Employer, or retirement system except that the Carrier shall issue ID cards resulting from an open season election within 15 calendar days or by December 15, whichever is later.
(6) *Member Inquiries*
SPECIFICATION: the number of written inquiries responded to within 15 working days divided by the total number of written inquiries received.
REQUIRED STANDARD: The Carrier shall respond to at least 90 percent of inquiries within 15 working days.
(7) *Written Inquiries Accuracy*
SPECIFICATION: the number of FEHB written inquiries answered accurately divided by the total number of FEHB written inquiries received.
REQUIRED STANDARD: the Carrier shall accurately answer at least 97 percent of FEHB written inquiries.
(8) *Telephone Inquiries Accuracy*
SPECIFICATION: the number of FEHB telephone inquiries answered accurately divided by the total number of FEHB telephone inquiries received.

REQUIRED STANDARD: The Carrier shall accurately answer at least 97 percent of FEHB telephone inquiries.

(9) *Internet Inquiries Accuracy*
SPECIFICATION: the number of FEHB Internet inquiries answered accurately divided by the total number of FEHB Internet inquiries received.
REQUIRED STANDARD: The Carrier shall accurately answer at least 97 percent of FEHB Internet inquiries.
(10) *Telephone Access* - the Carrier shall report on the following statistics concerning telephone access to the member services department (or its equivalent) for the given time period. Except that, if the Carrier does not have a computerized phone system, report results of periodic surveys on telephone access.

(i) Call Answer Timeliness
SPECIFICATION: the percentage of calls answered by a live voice (during operating hours).
REQUIRED STANDARD: The Carrier shall answer 80% of telephone calls by a live voice (during operating hours) within 30 seconds.

(ii) Telephone Blockage Rate
SPECIFICATION: the number of calls receiving a busy signal when calling the Carrier, divided by the total number of calls received.
REQUIRED STANDARD: The Carrier shall ensure that no more than 5 percent of calls receive a busy signal.

(iii) Telephone Abandonment Rate
SPECIFICATION: the number of calls attempted but not connected to a live voice, divided by the total number of calls attempted.
REQUIRED STANDARD: The Carrier shall ensure that no more than 5 percent of calls are abandoned before connection to a live voice.

(*iv*) *Initial Call Resolution*
SPECIFICATION: the number of initial calls that result in a resolution of the issue, divided by the total number of initial calls for an issue.
REQUIRED STANDARD: The Carrier shall resolve the issue during the initial call at least 80 percent of the time.
(11) *Responsiveness to FEHB Member Requests for Reconsideration*
SPECIFICATION: the number of times the Carrier responds (affirms the denial in writing to the FEHB member, pays the claim, provides or authorizes coverage of the service, or requests additional information reasonably necessary to make a determination) within 30 days to a request for reconsideration of a disputed claim, divided by the total number of requests for reconsideration of disputed claims received.
REQUIRED STANDARD: The Carrier shall respond to 100 percent of written FEHB disputed claim requests within 30 days after receipt by the Carrier.

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3. <u>Section 1.26 Standards for Arrangements with Pharmacy Benefit Managers</u>

We amended this section to provide clarity on existing guidance, add terminology and definitions on "Pass-through transparent pricing," and to remove redundancies. We added performance standards on specialty pharmacy shipping. We added a requirement that PBMs

and certain PBM subcontractors must establish a system for detecting and eliminating Fraud Waste and Abuse.

SECTION 1.26 STANDARDS FOR ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS (JAN 2021)

The Carrier will ensure and report that the following standards are included in new, renewing or amended contracts with Pharmacy Benefit Managers (PBMs) providing services to Enrollees and family members effective on or after January 1, 2022. Notwithstanding the foregoing, the revisions to Section 1.26 shall not take effect before the expiration of the Carrier's current contract (including the exercise of an existing option to extend the term by not more than one year at a time) but not later than January 2024. The PBM includes all entities that have a majority ownership interest in or majority control over the PBM. The PBM also includes any other subsidiary of the entity that has majority ownership or control over the PBM.

All PBMs must adhere to the provisions of this Section 1.26.

If the Carrier's PBM arrangement is with an Underwriter rather than with the Carrier, then all references to the Carrier and Plan appearing in this Section 1.26 shall be deemed to be references to the Underwriter.

(a) Definitions. Under this section

(1) "Expedited request" means a request initiated by the Prescriber, member, or member's representative when the time limit for standard utilization management review for the prescribed medication could seriously jeopardize the patient's life, health, or ability to regain maximum function.

(2) "Licensed pharmacist" means an individual currently licensed by the appropriate jurisdiction to engage in the practice of pharmacy consistent with that jurisdiction's laws and regulations.

(3) "Manufacturer payment" means any and all compensation, financial benefits, or remuneration the PBM or any Third Party receives from a pharmaceutical manufacturer for any dispensing or distribution channel, including but not limited to, discounts, credits, rebates (regardless of how categorized), market share incentives, chargebacks, commissions, administrative or management fees, patient assistance and any fees received for sales of utilization data to a pharmaceutical manufacturer.

(4) "Network pharmacy," means any retail, mail order, specialty, or licensed pharmacy provider that contracts with the PBM.

(5) "Pass-Through Transparent Pricing" means drug pricing in which the Carrier receives the full value of all discounts, rebates, credits or other financial guarantees or adjustments including any true up or reconciliation.

(6) "Pharmacy Benefit Manager" or "PBM" means the combination of

(i) a business or other entity that, pursuant to a contract with the Carrier, either directly or through an intermediary, manages the prescription drug benefit provided by the Carrier including, but not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs; and

(ii) all entities that have a majority ownership interest in, or majority control over, the business or other entity that is in contract with the Carrier referenced in (i).

(7) "Prescriber" means any licensed, certified or otherwise legally authorized health care professional authorized by law to prescribe a prescription drug.

(8) "Third Party" means any consultant, partner, administrator, intermediary or other entity outside the scope of the relationships between or among the PBM and the FEHB enrollee, Carrier, and/or OPM. It does not include wholesalers, distributors, or pharmacies.

(9) "Total Product Revenue" means the total dollar sales of prescription drugs at the prescription price negotiated with clients and associated administrative fees, either through retail Networks or PBM-owned or controlled mail order pharmacies, with respect to the PBM's entire client base, for the reporting period.

(b) Transparency Standards

(1) The PBM shall not be majority-owned or majority-controlled by a pharmaceutical manufacturing company. The PBM must disclose to the Carrier and OPM the name of any entity that has a majority ownership interest in or majority control over the PBM.

(2) The PBM shall agree to provide Pass-Through Transparent Pricing as defined above for the following categories:

(i) Retail Pharmacies: The PBM shall charge the Carrier no more than the amount as determined by Pass-Through Transparent Pricing paid to the pharmacy for each drug plus a dispensing fee.

(ii) Mail Order or Specialty Pharmacies not owned or affiliated with the PBM: The PBM shall charge the Carrier no more than the amount as determined by Pass-Through Transparent Pricing paid to the pharmacy for each drug plus a dispensing fee.

(iii) Mail Order or Specialty Pharmacies owned or affiliated with the PBM: The PBM shall charge the Carrier the cost of the drugs based on the pharmacy's actual acquisition cost, plus a dispensing fee. Costs shall not be based on industry benchmarks or set pricing including, but not limited to, Average Acquisition Cost (AAC), Maximum Allowable Charge (MAC), Average Wholesale Price (AWP), and Wholesale Acquisition Cost (WAC).

(iv) The PBM must commit to minimum annual aggregate pharmacy claim discount guarantees, based on Average Wholesale Price (AWP) or other recognized industry benchmark, and maximum annual aggregate dispensing fee guarantees. PBM must reconcile Carrier claim costs to these guarantees no less frequently than annually. PBM must pay to the Carrier any shortfall in meeting these pricing guarantees, with the Carrier receiving any payment for under-performance of the pricing guarantees to credit its' FEHB Program reserves.

(3) The PBM or any other Third Party that negotiates or collects Manufacturer Payments allocable to the Carrier agrees to credit to the Carrier either as a price reduction or by cash refund the value of all Manufacturer Payments properly allocable to the Carrier.

(4) The PBM must identify sources of profit to the Carrier and OPM as it relates to the FEHB contract.

(5) All of the PBM's fees, including, but not limited to, administrative or dispensing fees, must be clearly identified to retail claims, mail claims, specialty claims, and clinical or other programs, if applicable. The PBM must agree to disclose each fee to the Carrier and OPM.

(6) The PBM, or any Third Party that negotiates or collects Manufacturer Payments allocable to the Plan, will provide the Carrier with quarterly and annual Manufacturer

Payment Reports identifying the following information. This information shall be presented for both the total of all prescription drugs dispensed through the PBM, acting as a specialty and/or a mail order pharmacy, and its retail Network and in the aggregate for the 25 brand name drugs that represent the greatest cost to the Carrier or such number of brand name drugs that together represent 75 percent of the total cost to the Carrier, whichever is the greater number:

(i) the dollar amount of Total Product Revenue;
(ii) the dollar amount of total drug expenditures for the Plan;
(iii)the dollar amount of all Manufacturer Payments earned by the PBM for the reporting period;
(iv)the Manufacturer Payments that have been (1) earned but not billed (2) billed and (3) paid to the PBM based on the drugs dispensed to the Plan members during the past year.
(v) the percentage of all Manufacturer Payments earned by the PBM for the reporting
period that were Manufacturer Formulary Payments, which are payments the PBM receives from a manufacturer in return for formulary placement and/or access, or payments that are characterized as "formulary" or "base" rebates or payments pursuant to the PBM's agreements with pharmaceutical manufacturers;
(vi) the percentage of all Manufacturer Payments received by the PBM during the reporting period that were Manufacturer Additional Payments, which are all Manufacturer Payments other than Manufacturer Formulary Payments.

(7) The PBM agrees to provide the Carrier, at least annually, with all financial and utilization information requested by the Carrier relating to the provision of benefits to eligible enrollees through the PBM and all financial and utilization information relating to services provided to the Carrier, including but not limited to, a reasonable sample of retail pharmacy remittance advices, as selected by the Carrier.

(8) The Carrier shall provide any information it receives from the PBM, including a copy of its contract with the PBM to OPM. At OPM's request, the Carrier must obtain from the PBM any reasonable information or reports and provide it to OPM. A PBM providing information to a Carrier under this subsection may mark that information as confidential commercial information. The Carrier, in its contract with the PBM shall effectuate the PBM's consent to the disclosure of this information to OPM. OPM shall handle the information in accordance with 5 CFR Part 294.

(9) The Carrier will require that its PBM:

(i) Provide information to physicians, pharmacists, other health care professionals, consumers, and payers about the factors that affect formulary system decisions, including: cost containment measures; the procedures for obtaining non-formulary drugs; and the importance of formulary compliance to improving quality of care and restraining health care costs;
(ii) Provide consumer education that explains how formulary decisions are made and the roles and responsibilities of the consumer; and
(iii)Disclose the existence of formularies and have copies of the current formulary readily available and publicly accessible.

(10) In accordance with FEHBAR 1652.204-74, FAR 52.215-2 and FEHBAR 1652.246-70, all contracts and other documentation that support amounts charged and credited to the Carrier contract are fully disclosed to and auditable by the OPM Office of Inspector General

(OPM OIG). The PBM must provide the OPM OIG upon request complete copies of all PBM records including, but not limited to:

(i) All PBM contracts with Participating Pharmacies, including invoices, receipts and credits;
(ii) All PBM contracts with Pharmaceutical Manufacturers, including invoices, receipts, and credits;
(iii) All PBM contracts with Third Parties purchasing or using claims data;
(iv) All PBM transmittals in connection with sales of claims data to Third Parties or other entities;
(iv) All PBM Maximum Allowable Cost (MAC) price lists;
(v) All PBM records relating to patient assistance maximizer programs, optimizer programs, or similar arrangements with Third Parties; and
(vi) All PBM records pertaining to arrangements with Third Parties, including Group Purchasing Organizations (GPOs).

(c) Integrity Standards

(1) The Carrier will require that its PBM agree to adopt and adhere to a code of ethics promulgated by a national professional association, such as the Code of Ethics of the American Pharmacists Association, for their employed pharmacists.
(2) The Carrier will require that its' PBM be licensed as required by the appropriate jurisdiction's laws and regulations.
(3) The Carrier will require that its PBM only employ or contract with licensed pharmacists for roles that require such a license under the appropriate jurisdiction's laws and regulations.
(4) The PBM shall perform its duties with care, skill, prudence, diligence, and professionalism.
(5) A PBM shall notify the Carrier in writing of any activity, policy, or practice of the PBM that directly or indirectly presents any conflict of interest with the duties imposed in this subsection.
(6) A PBM, or Carrier, shall not enter into a contract with a pharmacy or pharmacist that prohibits or penalizes a pharmacy or pharmacist for disclosure of information to a member regarding:

(i) The cost of a prescription medication to the member; or
(ii) The availability of any therapeutically-equivalent alternative medications or alternative methods of purchasing the prescription medication, including but not limited to, paying a cash price that is less expensive to the member than the cost of the prescription under the Plan.

(d) Performance Standards

The Carrier will require that its' PBM contractors develop and apply a quality assurance program specifying procedures for ensuring contract quality on the following standards at a minimum and submit reports to the Carrier on their performance. PBMs must meet, at minimum, the member inquiry, customer service, claims processing, and other applicable standards set for Carriers at Section 1.9(f). All other standards discussed below will have specific target goals the PBM is expected to achieve. Carriers may permit PBMs to measure compliance using statistically valid samples for the PBMs book of business. Agreed to standards shall be provided to OPM for its review and comment. If OPM has concerns about a particular standard, the Carrier agrees to present OPM's concerns to the PBM and either revise the standard as requested by OPM or revise the standard to the extent feasible and present to

OPM information demonstrating the problems associated with making the requested revisions in full.

(1) Point of Service (POS) system response time. The PBM's network electronic transaction system provides rapid response to Network pharmacies.

(2) POS system availability. The PBM's network electronic transaction system generally is available to, and accessible by, Network pharmacies.

(3) Licensing. The PBM verifies the appropriate licensing of its Network pharmacies. This includes DEA registration for U.S. pharmacies, and the equivalent, if one exists, for pharmacies outside of the U.S.

(4) Dispensing accuracy – The PBM dispenses its prescriptions to the correct patient and for the correct drug, drug strength and dosage in accordance with the prescription not less than 99.9 percent of the time.

(5) Mail service pharmacy turnaround time – The PBM promptly dispenses and ships at least 98 percent on average of all prescriptions not requiring intervention or clarification within 3 business days or meets an equivalent measure approved by OPM.

(6) Specialty pharmacy shipment stability. The Carrier or PBM's specialty pharmacy must have policies and procedures in place to promote effective shipping practices and monitor cold chain packaging. Specific areas to be addressed include achievement of internal and external metrics and the identification and appropriate use of best practices.

(7) Quality of Drug Therapy. The quality assurance program implemented by a Carrier's PBM contractor must include a process to measure the quality of its drug therapy provided to enrollees. Specific areas to be addressed include achievement of quality targets measured by both internal and external metrics; identification and appropriate use of best practices; and application of evidence-based medicine, as appropriate.

(e) Alternative Drug Options

The Carrier will require that its PBM contractors, at a minimum, utilize the following protocols for PBM initiated drug interchanges (any change from the original prescription) other than generic substitutions:

(1) The PBM must treat the Prescriber, and not itself, as the ultimate decision-maker. Furthermore, to the extent appropriate under the circumstances, the PBM must allow the patient input into that decision-making process. At a minimum, the PBM must provide the patient with a written notice in the package sent to the patient that the drug interchange has occurred with the approval of the Prescriber.

(2) The PBM will obtain authorization for a drug interchange only with the express, verifiable authorization from the Prescriber as communicated directly by the Prescriber, in writing or verbally, or by a licensed medical professional or other office staff member as authorized by the Prescriber.

(3) The PBM must memorialize in appropriate detail all conversations with patients and Prescribers in connection with drug interchanging requests, including the identity of the contact person at the Prescriber's office and the basis for his or her authority.

(4) The PBM will only interchange a patient's drug from a lower priced drug to a drug with a higher cost to the patient or Plan when authorized by the Carrier or the Plan.

(5) The PBM will permit pharmacists to express their professional judgment to both the PBM and Prescribers on the impact of drug interchanges and to answer Prescribers' questions. PBMs will not require pharmacists to, and will not penalize pharmacists for refusing to, initiate calls to Prescribers for drug interchanges that in their professional judgment should not be made.

(6) The PBM will offer to disclose, and if requested, will disclose to Prescribers, the Carrier, and patients (i) the reason(s) why it is suggesting a drug interchange and (ii) how the interchange will affect the PBM, the Plan, and the patients financially.

(f) Utilization Management Timeframe – The PBM must promptly review and respond to requests for prior approval for specific drugs and any other utilization management edits following receipt of all required information.

(1) For Expedited requests, the PBM must review and respond within 24 hours.

(2) For other, non-expedited requests, the PBM must review and respond within 72 hours.

(g) Patient Safety Standard - The Carrier will require that its PBM establish drug utilization management, formulary process and procedures that have distinct systems for identifying and rectifying consumer safety issues including:

(i) A system for identifying and communicating drug and consumer safety issues at point-of-service;

(ii) A system of drug utilization management tools, such as prospective and concurrent drug utilization management that identifies situations which may compromise the safety of the consumer.

(iii) A system/process for error reporting; and

(iv) A system/process for identifying/managing risk

(h) Safety and Accessibility for Consumers - The Carrier will require that its PBM meets the following standards related to pharmacy Network management and consumer access to medications.

(1) The Carrier will require that its PBM define the scope of its services with respect to:

(i) The distribution channels offered (e.g. pharmacy Network, mail order pharmacies, or specialty pharmacies);

(ii) The types of pharmacy services offered within each distribution channel; and

(iii) The geographic area served by each distribution channel.

(2) The Carrier will require that for each distribution channel provided by its PBM, the PBM:

(i) Establishes criteria and measures actual performance in comparison to those criteria: and

(ii) Makes improvements where necessary to maintain the Network and meet contractual requirements.

(3) The Carrier will require that its PBM establish a quality and safety mechanism for each distribution channel in order to identify and address concerns related to:

(i) Quality and safety of drug distribution; and

(ii) Quality of service

(i) Fraud, Waste, and Abuse

(1) The PBM must establish fraud, waste and abuse detection processes and procedures, with distinct systems for identifying and rectifying FWA issues including:

(i) A system designed to detect and eliminate FWA

(ii) A system that assesses its vulnerability to FWA to include, but not limited to, performing post-payment reviews and audits of providers identified either proactively or reactively;

(iii)A system/process for FWA reporting; and

(iv) A system/process for identifying/managing risk

(2) Any Third Party or entity providing services or supplies related to the administration of payments or benefits must certify to the PBM that it has established fraud, waste and

abuse detection processes and procedures, with distinct systems for identifying and rectifying FWA issues including:

(i) A system designed to detect and eliminate FWA;
(ii) A system that assesses its vulnerability to FWA to include, but not limited to, performing post-payment reviews and audits of providers identified either proactively or reactively;
(iii) A system/process for FWA reporting; and
(iv) A system/process for identifying/managing risk.

(j) Contract Terms - The contract between the PBM and the Carrier must not exceed 3 years without re-competition unless the Contracting Officer approves an exception. The Carrier's PBM contract must allow for termination based on a material breach of any terms and conditions stated in the Carrier's PBM contract. The Carrier must provide sufficient written notice of the material breach to the PBM and the PBM must be given adequate time to respond and cure the material breach.

4. Section 1.32 Carrier Personnel Access Determination Requirements

This section was amended to update the website address for Memorandum M-05-24.

SECTION 1.32 CARRIER PERSONNEL ACCESS DETERMINATION REQUIREMENTS (JAN 2021)

(a) Carrier personnel who receive a user identification and password to access OPM's LOC System shall comply with the U.S. Office of Management and Budget (OMB) Memorandum M-05-24, referenced in paragraph (a) of FAR 52.204-9, Personal Identity Verification of Contractor Personnel, which is available on-line at https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/memoranda/2005/m05-24.pdf

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5. New: Section 1.37 Procedures for Information Security Incident and Data Breach Reporting

We added a new section to provide the Carrier contractual guidance for reporting an Information Security Incident and a Data Breach.

SECTION 1.37 PROCEDURES FOR INFORMATION SECURITY INCIDENT AND DATA BREACH REPORTING (JAN 2021)

(a) The specific terms listed below are defined as stated for purposes of this Section.
(1) Incident is defined by 44 U.S.C. § 3552(b)(2) and applicable OMB guidance.
(2) Breach is defined in HHS regulations 45 CFR Part 164 Subpart D.
(3) Compromise is defined in the current revisions of the glossary of NIST SP 800-32.

(b) A Carrier must report to OPM incidents and breaches where the confidentiality, integrity, or availability of FEHB member protected health information (PHI) is compromised or if a Carrier notifies law enforcement of an incident or breach that: (1) compromises its systems that contain or process FEHB Program data or (2) compromises its systems operating in the

same general information technology control environment as the information systems that process FEHB Program data.

(c) The Carrier must report to OPM before any other external notifications are made (excluding notification to necessary parties for incident response), and in no case later than 24 hours after its incident response team determines the confidentiality, integrity, or availability of FEHB member PHI is compromised, or it has notified law enforcement of an incident or breach that meets the requirements stated in paragraph (b) of this Section.

(d) The Carrier must submit reports to OPM via email to Cybersolutions@opm.gov or via phone to (844) 377-6109.

(1) Any data shared with OPM that relates to an incident or breach must be transmitted in a secure manner.

(2) The report should include the following:

i. A brief description of the nature of the incident or breach.

ii. An estimate of the number of affected FEHB members, if feasible.

iii. A brief description of the remedial steps that the Carrier has already taken and those they plan to take.

(3) The Carrier is responsible for providing additional detailed information as soon as it becomes available.

(e) For a breach of PHI, the notice to FEHB enrollees will comport with 45 CFR § 164.404 for breaches as defined in this Section or OPM guidance and must be coordinated with OPM before any communication with FEHB enrollees. All other notices must also be coordinated with OPM and the Carrier must follow OPM guidance to the extent practicable.

(f) In case of a subcontractor breach or incident the following applies.

(1) A subcontractor breach or incident must be reported to OPM by the Carrier no later than the calendar day following notice to the Carrier.

(2) Either the Carrier or its subcontractor may provide a notice of the breach to FEHB enrollees.

(3) If the subcontractor provides the notice, it must be in a form that allows the enrollee to easily identify the Carrier and FEHB plan. If specific identification is not practical under the circumstances, Carrier and FEHB plan identification shall be otherwise accomplished in a manner agreed upon with OPM.

(4) The Contracting Officer may direct the Carrier to issue a separate notice in order to avoid enrollee confusion.

6. <u>Section 2.3 Payment of Benefits and Provision of Services and Supplies</u>

We added this language to provide guidance to Carriers for erroneous payment recoveries in cases of Fraud and Abuse.

SECTION 2.3 PAYMENT OF BENEFITS AND PROVISION OF SERVICES AND SUPPLIES (JAN 2021)

* * * * *

(g) Erroneous Payments It is the Carrier's responsibility to proactively identify overpayments through comprehensive, statistically valid reviews and a robust internal control program. If the Carrier determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider. In the case of fraud or abuse, the Carrier must coordinate with OPM OIG as required by Section 1.9 and OPM's Fraud, Waste and Abuse guidance. The recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment under 48 C.F.R. §1631.201-70(h) regardless of any time period limitations in the written agreement with the provider. The Carrier shall follow general business practices and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall--

(1) Send a written notice of erroneous payment to the member or provider that provides: (A) an explanation of when and how the erroneous payment occurred, (B) when applicable, cite the appropriate contractual benefit provision, (C) the exact identifying information (i.e., dollar amount paid erroneously, date paid, check number, date of service and provider name), (D) a request for payment of the debt in full, and (E) an explanation of what may occur should the debt not be paid, including possible offset to future benefits. The notice may also offer an installment option. In addition, the Carrier shall provide the debtor with an opportunity to dispute the existence and amount of the debt before proceeding with collection activities;

(2) After confirming that the debt does exist and in the appropriate amount, send follow-up notices to the member or the provider at 30, 60 and 90 day intervals, if the debt remains unpaid and undisputed;

(3) (i) The Carrier may off-set future Benefits payable to the Member or to a provider on behalf of the Member to satisfy a debt due under the FEHBP if the debt remains unpaid and undisputed for 120 days after the first notice.
(ii) Notwithstanding section 2.3(g)(3)(i), a Carrier may set up benefit off-sets to a provider less than 120 days after the first notice as long as the Carrier electing this option continues to comply with any remaining applicable steps enumerated in this subsection 2.3(g) as part of the Carrier's effort to recover erroneous benefit payments.

(4) After applying the first three steps, refer cases when it is cost effective to do so to a collection attorney or a collection agency if the debt is not recovered; provided, however, that the Carrier may not commence an overpayment recovery lawsuit later than December 31 of the third year after the year in which the overpayment was discovered by the Carrier (except in cases where the False Claims Act, 31 U.S.C § 3729, or another federal limitations period applies);

(5) Make prompt and diligent effort to recover erroneous payments until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost effective to pursue further collection efforts or it would be against equity and good conscience to continue collection efforts;

(6) Additional prompt and diligent effort is required for significant claim overpayments that exceed $10,000 per each claim. Examples of such efforts include copies of dated notices, offset attempt(s) made, certified letter communication(s), and Third Party collection efforts to the extent required under (g)(4) above. The Carrier should maintain and provide to OPM upon request, documentation of those efforts.

(7) Suspend recovery efforts for a debt which is based upon a retroactive disenrollment that

has been appealed under 5 C.F.R. § 890.104 or a claim that has been appealed as a disputed claim under Section 2.8, until the appeal has been resolved;

(8) (i) The Carrier may charge the contract for benefit payments made erroneously but in good faith provided that it can document that it made a prompt and diligent effort to recover erroneous payments as described above.

(ii) Notwithstanding (g)(8)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that caused erroneous benefit payments) when the errors are egregious or repeated. These costs are deemed to be unreasonable and unallowable under section 3.2(b)(2)(ii);

(9) Maintain records that document individual unrecovered erroneous payment collection activities for audit or future reference.

(10) If OPM determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the Member, from the Member or, if to the provider, from the provider as specified in (g)(1) through (9).

(11) At the request of OPM, the Carrier shall provide evidence that it has taken the steps enumerated above in this subsection to promptly recover erroneous payments, including but not limited to overpayments related to Medicare coordination of benefits. OPM will review the Carrier's claims payments and procedures to validate the Carrier's prompt and diligent effort. The Contracting Officer may require the Carrier to establish and submit to the Contracting Officer a written corrective action plan.

(12) In compliance with the provisions of the Contract Disputes Act, the Carrier shall return to the Program an amount equal to the uncollected erroneous payment where the Contracting Officer determines that (a) the Carrier's failure to appropriately apply its operating procedure caused the erroneous payment and (b) that the Carrier failed to make a prompt and diligent effort to recover an erroneous payment.

(h) Erroneous payment recoveries may be reduced by any legal or collection agency fees expended to obtain the recoveries and which are not otherwise payable under this experience-rated contract. The amount credited to the contract shall be the net amount remaining after deducting the related legal or collection agency fees.

(i) All health benefit refunds and recoveries, including erroneous payment recoveries, must be deposited into the working capital or investment account within 30 days and returned to or accounted for in the FEHBP letter of credit account within 60 days after receipt by the Carrier.

(j) Notwithstanding subsection (f), the Carrier reserves the right to pay the Member directly for all covered services described in the agreed upon brochure text attached as Appendix A.

7. FAR Changes

We have updated the following sections so that they are consistent with the Federal Acquisition Regulation (FAR).

SECTION 5.1

DEFINITIONS (JUN 2020) (FAR 52.202-1)

When a solicitation provision or contract clause uses a word or term that is defined in the Federal Acquisition Regulation (FAR), the word or term has the same meaning as the definition in FAR 2.101 in effect at the time the solicitation was issued, unless—

(a) The solicitation, or amended solicitation, provides a different definition;

(b) The contracting parties agree to a different definition;
(c) The part, subpart, or section of the FAR where the provision or clause is prescribed provides a different meaning;
(d) The word or term is defined in FAR Part 31, for use in the cost principles and procedures; or
(e) The word or term defines an acquisition-related threshold, and if the threshold is adjusted for inflation as set forth in FAR 1.109(a), then the changed threshold applies throughout the remaining term of the contract, unless there is a subsequent threshold adjustment; see FAR 1.109(d).

SECTION 5.5
ANTI-KICKBACK PROCEDURES (JUN 2020) (FAR 52.203-7)

(a) Definitions.

"Kickback," as used in this clause, means any money, fee, commission, credit, gift, gratuity, thing of value, or compensation of any kind which is provided to any prime Contractor, prime Contractor employee, subcontractor, or subcontractor employee for the purpose of improperly obtaining or rewarding favorable treatment in connection with a prime contract or in connection with a subcontract relating to a prime contract.

"Person," as used in this clause, means a corporation, partnership, business association of any kind, trust, joint-stock company, or individual.

"Prime contract," as used in this clause, means a contract or contractual action entered into by the United States for the purpose of obtaining supplies, materials, equipment, or services of any kind.

"Prime Contractor," as used in this clause, means a person who has entered into a prime contract with the United States.

"Prime Contractor employee," as used in this clause, means any officer, partner, employee, or agent of a prime Contractor.

"Subcontract," as used in this clause, means a contract or contractual action entered into by a prime Contractor or subcontractor for the purpose of obtaining supplies, materials, equipment, or services of any kind under a prime contract.

"Subcontractor," as used in this clause, (1) means any person, other than the prime Contractor, who offers to furnish or furnishes any supplies, materials, equipment, or services of any kind under a prime contract or a subcontract entered into in connection with such prime contract, and (2) includes any person who offers to furnish or furnishes general supplies to the prime Contractor or a higher tier subcontractor.

"Subcontractor employee," as used in this clause, means any officer, partner, employee, or agent of a subcontractor.

(b) 41 U.S.C. chapter 87, Kickbacks, prohibits any person from --

(1) Providing or attempting to provide or offering to provide any kickback;

(2) Soliciting, accepting, or attempting to accept any kickback; or

(3) Including, directly or indirectly, the amount of any kickback in the contract price charged by a prime Contractor to the United States or in the contract price charged by a subcontractor to a prime Contractor or higher tier subcontractor.

(c)(1) The Contractor shall have in place and follow reasonable procedures designed to prevent and detect possible violations described in paragraph (b) of this clause in its own operations and direct business relationships.

(2) When the Contractor has reasonable grounds to believe that a violation described in paragraph (b) of this clause may have occurred, the Contractor shall promptly report in writing the possible violation. Such reports shall be made to the inspector general of the contracting agency, the head of the contracting agency if the agency does not have an inspector general, or the Attorney General.

(3) The Contractor shall cooperate fully with any Federal agency investigating a possible violation described in paragraph (b) of this clause.

(4) The Contracting Officer may (i) offset the amount of the kickback against any monies owed by the United States under the prime contract and/or (ii) direct that the Prime Contractor withhold, from sums owed a subcontractor under the prime contract, the amount of the kickback. The Contracting Officer may order that monies withheld under subdivision (c)(4)(ii) of this clause be paid over to the Government unless the Government has already offset those monies under subdivision (c)(4)(i) of this clause. In either case, the Prime Contractor shall notify the Contracting Officer when the monies are withheld.

(5) The Contractor agrees to incorporate the substance of this clause, including this paragraph (c)(5) but excepting paragraph (c)(1) of this clause, in all subcontracts under this contract that exceed the threshold specified in Federal Acquisition Regulation 3.502–2(i) on the date of subcontract award.

SECTION 5.7

AUDIT AND RECORDS-NEGOTIATION (JUN 2020) (FAR 52.215-2)

(a) As used in this clause, "records" includes books, documents, accounting procedures and practices, and other data, regardless of type and regardless of whether such items are in written form, in the form of computer data, or in any other form.

(b) *Examination of costs*. If this is a cost- reimbursement, incentive, time-and-materials, labor-hour, or price redeterminable contract, or any combination of these, the Contractor shall maintain and the Contracting Officer, or an authorized representative of the Contracting Officer, shall have the right to examine and audit all records and other evidence sufficient to reflect properly all costs claimed to have been incurred or anticipated to be incurred directly or indirectly in performance of this contract. This right of examination shall include inspection at all reasonable times of the Contractor's plants, or parts of them, engaged in performing the contract.

(c) *Certified cost or pricing data*. If the Contractor has been required to submit certified cost or pricing data in connection with any pricing action relating to this contract, the Contracting Officer, or an authorized representative of the Contracting Officer, in order to evaluate the accuracy, completeness, and currency of the certified cost or pricing data, shall have the right to examine and audit all of the Contractor's records, including computations and projections, related to--

(1) The proposal for the contract, subcontract, or modification;

(2) The discussions conducted on the proposal(s), including those related to negotiating;

(3) Pricing of the contract, subcontract, or modification; or

(4) Performance of the contract, subcontract or modification.

(d) *Comptroller General* -- (1) The Comptroller General of the United States, or an authorized representative, shall have access to and the right to examine any of the Contractor's directly pertinent records involving transactions related to this contract or a subcontract hereunder and to interview any current employee regarding such transactions.

(1) This paragraph may not be construed to require the Contractor or subcontractor to create or maintain any record that the Contractor or subcontractor does not maintain in the ordinary course of business or pursuant to a provision of law.

(e) *Reports*. If the Contractor is required to furnish cost, funding, or performance reports, the Contracting Officer or an authorized representative of the Contracting Officer shall have the right to examine and audit the supporting records and materials, for the purpose of evaluating--

(1) The effectiveness of the Contractor's policies and procedures to produce data compatible with the objectives of these reports and (2) The data reported.

(f) *Availability*. The Contractor shall make available at its office at all reasonable times the records, materials, and other evidence described in paragraphs (a), (b), (c), (d), and (e) of this clause, for examination, audit, or reproduction, until 3 years after final payment under this contract or for any shorter period specified in Subpart 4.7, Contractor Records Retention, of the Federal Acquisition Regulation (FAR), or for any longer period required by statute or by other clauses of this contract. In addition--(1) If this contract is completely or partially terminated, the Contractor shall make available the records relating to the work terminated until 3 years after any resulting final termination settlement; and (2) The Contractor shall make available records relating to appeals under the Disputes clause or to litigation or the settlement of claims arising under or relating to this contract until such appeals, litigation, or claims are finally resolved.

(g) The Contractor shall insert a clause containing all the terms of this clause, including this paragraph (g), in all subcontracts under this contract that exceed the simplified acquisition threshold, as defined in FAR 2.101 on the date of subcontract award, and--

(1) That are cost-reimbursement, incentive, time-and-materials, labor-hour, or price-redeterminable type or any combination of these;

(2) For which certified cost or pricing data are required; or

(3) That require the subcontractor to furnish reports as discussed in paragraph (e) of this clause.

The clause may be altered only as necessary to identify properly the contracting parties and the Contracting Officer under the Government prime contract.

SECTION 5.10

SUBCONTRACTOR CERTIFIED COST OR PRICING DATA (JUN 2020) (FAR 52.215-12**)**

(a) Before awarding any subcontract expected to exceed the threshold for submission of certified cost or pricing data in Federal Acquisition Regulation (FAR) 15.403-4(a)(1), on the date of agreement on price or the date of award, whichever is later; or before pricing any subcontract modification involving a pricing adjustment expected to exceed the threshold for submission of certified cost or pricing data in FAR 15.403-4(a)(1), the Contractor shall require the subcontractor to submit certified cost or pricing data (actually or by specific identification in writing), in accordance with FAR 15.408, Table 15-2 (to include any information reasonably required to explain the subcontractor's estimating process such as the judgmental factors applied and the mathematical or other methods used in the estimate, including those used in projecting from known data, and the nature and amount of any contingencies included in the price), unless an exception under 15.403-1(b) applies. If the threshold for submission of certified cost or pricing data specified in FAR 15.403-4(a)(1) is adjusted for inflation as set forth in FAR 1.109(a),

then pursuant to FAR 1.109(d) the changed threshold applies throughout the remaining term of the contract, unless there is a subsequent threshold adjustment.

(b) The Contractor shall require the subcontractor to certify in substantially the form prescribed in FAR 15.406-2 that, to the best of its knowledge and belief, the data submitted under paragraph (a) of this clause were accurate, complete, and current as of the date of agreement on the negotiated price of the subcontract or subcontract modification.

(c) In each subcontract that, when entered into, exceeds the threshold for submission of certified cost or pricing data in FAR 15.403-4(a)(1), the Contractor shall insert either --

(1) The substance of this clause, including this paragraph (c), if paragraph (a) of this clause requires submission of certified cost or pricing data for the subcontract; or

(2) The substance of the clause at FAR 52.215-13, Subcontractor Certified Cost or Pricing Data - Modifications.

SECTION 5.22

EQUAL OPPORTUNITY FOR VETERANS (JUN 2020) (FAR 52.222-35)

(a) *Definitions.* As used in this clause—

"Active duty wartime or campaign badge veteran," "Armed Forces service medal veteran," "disabled veteran," "protected veteran," "qualified disabled veteran," and "recently separated veteran" have the meanings given at Federal Acquisition Regulation (FAR) 22.1301.

(b) *Equal opportunity clause*. The Contractor shall abide by the requirements of the equal opportunity clause at 41 CFR 60-300.5(a), as of March 24, 2014. This clause prohibits discrimination against qualified protected veterans, and requires affirmative action by the Contractor to employ and advance in employment qualified protected veterans.

(c) *Subcontracts.* The Contractor shall insert the terms of this clause in subcontracts valued at or above the threshold specified in FAR 22.1303(a) on the date of subcontract award, unless exempted by rules, regulations, or orders of the Secretary of Labor. The Contractor shall act as specified by the Director, Office of Federal Contract Compliance Programs, to enforce the terms, including action for noncompliance. Such necessary changes in language may be made as shall be appropriate to identify properly the parties and their undertakings.

SECTION 5.23

EQUAL OPPORTUNITY FOR WORKERS WITH DISABILITIES (JUN 2020) (FAR 52.222-36)

(a) *Equal opportunity clause*. The Contractor shall abide by the requirements of the equal opportunity clause at 41 CFR 60-741.5(a), as of March 24, 2014. This clause prohibits discrimination against qualified individuals on the basis of disability, and requires affirmative action by the Contractor to employ and advance in employment qualified individuals with disabilities.

(b) Subcontracts. The Contractor shall include the terms of this clause in every subcontract or purchase order in excess of the threshold specified in Federal Acquisition Regulation (FAR) 22.1408(a) on the date of subcontract award, unless exempted by rules, regulations, or orders of the Secretary, so that such provisions will be binding upon each

subcontractor or vendor. The Contractor shall act as specified by the Director, Office of Federal Contract Compliance Programs of the U.S. Department of Labor, to enforce the terms, including action for noncompliance. Such necessary changes in language may be made as shall be appropriate to identify properly the parties and their undertakings.

SECTION 5.45

LIMITATION ON PAYMENTS TO INFLUENCE CERTAIN FEDERAL TRANSACTIONS (JUN 2020) (FAR 52.203-12)

(a) *Definitions*. As used in this clause—

"Agency" means "executive agency" as defined in Federal Acquisition Regulation (FAR) 2.101.

"Covered Federal action" means any of the following actions:

(1) Awarding any Federal contract.

(2) Making any Federal grant.

(3) Making any Federal loan.

(4) Entering into any cooperative agreement.

(5) Extending, continuing, renewing, amending, or modifying any Federal contract, grant, loan, or cooperative agreement.

"Indian tribe" and "tribal organization" have the meaning provided in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b) and include Alaskan Natives.

"Influencing or attempting to influence" means making, with the intent to influence, any communication to or appearance before an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any covered Federal action.

"Local government" means a unit of government in a State and, if chartered, established, or otherwise recognized by a State for the performance of a governmental duty, including a local public authority, a special district, an intrastate district, a council of governments, a sponsor group representative organization, and any other instrumentality of a local government.

"Officer or employee of an agency" includes the following individuals who are employed by an agency:

(1) An individual who is appointed to a position in the Government under Title 5, United States Code, including a position under a temporary appointment.

(2) A member of the uniformed services, as defined in subsection 101(3), Title 37, United States Code.

(3) A special Government employee, as defined in section 202, Title 18, United States Code.

(4) An individual who is a member of a Federal advisory committee, as defined by the Federal Advisory Committee Act, Title 5, United States Code, appendix 2.

"Person" means an individual, corporation, company, association, authority, firm, partnership, society, State, and local government, regardless of whether such entity is operated for profit, or not for profit. This term excludes an Indian tribe, tribal organization, or any other Indian organization eligible to receive Federal contracts, grants, cooperative agreements, or loans from an agency, but only with respect to expenditures by such tribe or organization that are made for purposes specified in paragraph (b) of this clause and are permitted by other Federal law.

"Reasonable compensation" means, with respect to a regularly employed officer or

employee of any person, compensation that is consistent with the normal compensation for such officer or employee for work that is not furnished to, not funded by, or not furnished in cooperation with the Federal Government.

"Reasonable payment" means, with respect to professional and other technical services, a payment in an amount that is consistent with the amount normally paid for such services in the private sector.

"Recipient" includes the Contractor and all subcontractors. This term excludes an Indian tribe, tribal organization, or any other Indian organization eligible to receive Federal contracts, grants, cooperative agreements, or loans from an agency, but only with respect to expenditures by such tribe or organization that are made for purposes specified in paragraph (b) of this clause and *are* permitted by other Federal law.

"Regularly employed" means, with respect to an officer or employee of a person requesting or receiving a Federal contract, an officer or employee who is employed by such person for at least 130 working days within 1 year immediately preceding the date of the submission that initiates agency consideration of such person for receipt of such contract. An officer or employee who is employed by such person for less than 130 working days within 1 year immediately preceding the date of the submission that initiates agency consideration of such person shall be considered to be regularly employed as soon as he or she is employed by such person for 130 working days.

"State" means a State of the United States, the District of Columbia, or an outlying area of the United States, an agency or instrumentality of a State, and multi-State, regional, or interstate entity having governmental duties and powers.

(b) *Prohibition*. 31 U.S.C. 1352 prohibits a recipient of a Federal contract, grant, loan, or cooperative agreement from using appropriated funds to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any covered Federal actions. In accordance with 31 U.S.C. 1352 the Contractor shall not use appropriated funds to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of this contractor the extension, continuation, renewal, amendment, or modification of this contract.

(1) The term *appropriated funds* does not include profit or fee from a covered Federal action.

(2) To the extent the Contractor can demonstrate that the Contractor has sufficient monies, other than Federal appropriated funds, the Government will assume that these other monies were spent for any influencing activities that would be unallowable if paid for with Federal appropriated funds.

(c) *Exceptions*. The prohibition in paragraph (b) of this clause does not apply under the following conditions:

(1) *Agency and legislative liaison by Contractor employees*.

(i) Payment of reasonable compensation made to an officer or employee of the Contractor if the payment is for agency and legislative liaison activities not directly related to this contract. For purposes of this paragraph, providing any information specifically requested by an agency or Congress is permitted at any time.

(ii) Participating with an agency in discussions that are not related to a specific solicitation for any covered Federal action, but that concern—

(A) The qualities and characteristics (including individual demonstrations) of the person's products or services, conditions or terms of sale, and service capabilities; or

(B) The application or adaptation of the person's products or services for an agency's use.

(iii) Providing prior to formal solicitation of any covered Federal action any information not specifically requested but necessary for an agency to make an informed decision about initiation of a covered Federal action;

(iv) Participating in technical discussions regarding the preparation of an unsolicited proposal prior to its official submission; and

(v) Making capability presentations prior to formal solicitation of any covered Federal action by persons seeking awards from an agency pursuant to the provisions of the Small Business Act, as amended by Pub. L. 95-507, and subsequent amendments.

(2) *Professional and technical services*.

(i) A payment of reasonable compensation made to an officer or employee of a person requesting or receiving a covered Federal action or an extension, continuation, renewal, amendment, or modification of a covered Federal action, if payment is for professional or technical services rendered directly in the preparation, submission, or negotiation of any bid, proposal, or application for that Federal action or for meeting requirements imposed by or pursuant to law as a condition for receiving that Federal action.

(ii) Any reasonable payment to a person, other than an officer or employee of a person requesting or receiving a covered Federal action or an extension, continuation, renewal, amendment, or modification of a covered Federal action if the payment is for professional or technical services rendered directly in the preparation, submission, or negotiation of any bid, proposal, or application for that Federal action or for meeting requirements imposed by or pursuant to law as a condition for receiving that Federal action. Persons other than officers or employees of a person requesting or receiving a covered Federal action include consultants and trade associations.

(iii)As used in paragraph (c)(2) of this clause, "professional and technical services" are limited to advice and analysis directly applying any professional or technical discipline (for examples, see FAR 3.803(a)(2)(iii)).

(iv)Requirements imposed by or pursuant to law as a condition for receiving a covered Federal award include those required by law or regulation and any other requirements in the actual award documents.

(3) Only those communications and services expressly authorized by paragraphs (c)(1) and (2) of this clause are permitted.

(d) *Disclosure*.

(1) If the Contractor did not submit OMB Standard Form LLL, Disclosure of Lobbying Activities, with its offer, but registrants under the Lobbying Disclosure Act of 1995 have subsequently made a lobbying contact on behalf of the Contractor with respect to this contract, the Contractor shall complete and submit OMB Standard Form LLL to provide the name of the lobbying registrants, including the individuals performing the services.

(2) If the Contractor did submit OMB Standard Form LLL disclosure pursuant to paragraph (d) of the provision at FAR 52.203-11, Certification and Disclosure

Regarding Payments to Influence Certain Federal Transactions, and a change occurs that affects Block 10 of the OMB Standard Form LLL (name and address of lobbying registrant or individuals performing services), the Contractor shall, at the end of the calendar quarter in which the change occurs, submit to the Contracting Officer within 30 days an updated disclosure using OMB Standard Form LLL.

(e) *Penalties*.

(1) Any person who makes an expenditure prohibited under paragraph (b) of this clause or who fails to file or amend the disclosure to be filed or amended by paragraph (d) of this clause shall be subject to civil penalties as provided for by 31 U.S.C. 1352. An imposition of a civil penalty does not prevent the Government from seeking any other remedy that may be applicable.

(2) Contractors may rely without liability on the representation made by their subcontractors in the certification and disclosure form.

(f) *Cost allowability*. Nothing in this clause makes allowable or reasonable any costs which would otherwise be unallowable or *unreasonable*. Conversely, costs made specifically unallowable by the requirements in this clause will not be made allowable under any other provision.

(g) *Subcontracts.*

(1) The Contractor shall obtain a declaration, including the certification and disclosure in paragraphs (c) and (d) of the provision at FAR 52.203–11, Certification and Disclosure Regarding Payments to Influence Certain Federal Transactions, from each person requesting or receiving a subcontract under this contract that exceeds the threshold specified in FAR 3.808 on the date of subcontract award. The Contractor or subcontractor that awards the subcontract shall retain the declaration.

(2) A copy of each subcontractor disclosure form (but not certifications) shall be forwarded from tier to tier until received by the prime Contractor. The prime Contractor shall, at the end of the calendar quarter in which the disclosure form is submitted by the subcontractor, submit to the Contracting Officer within 30 days a copy of all disclosures. Each subcontractor certification shall be retained in the subcontract file of the awarding Contractor.

(3) The Contractor shall include the substance of this clause, including this paragraph (g), in any subcontract that exceeds the threshold specified in FAR 3.808 on the date of subcontract award.

SECTION 5.47

PROTECTING THE GOVERNMENT'S INTEREST WHEN SUBCONTRACTING WITH CONTRACTORS DEBARRED, SUSPENDED OR PROPOSED FOR DEBARMENT (JUN 2020) (FAR 52.209-6)

(a) Definition. “Commercially available off-the-shelf (COTS)” item, as used in this clause—

(1) Means any item of supply (including construction material) that is—

(i) A commercial item (as defined in paragraph (1) of the definition in Federal Acquisition Regulation (FAR) 2.101);

(ii) Sold in substantial quantities in the commercial marketplace; and

(iii) Offered to the Government, under a contract or subcontract at any tier, without modification, in the same form in which it is sold in the commercial marketplace; and

(2) Does not include bulk cargo, as defined in 46 U.S.C. 40102(4), such as

agricultural products and petroleum products.

(b) The Government suspends or debars Contractors to protect the Government's interests. Other than a subcontract for a commercially available off-the-shelf item, the Contractor shall not enter into any subcontract, in excess of the threshold specified in FAR 9.405-2(b) on date of subcontract award with a Contractor that is debarred, suspended, or proposed for debarment by any executive agency unless there is a compelling reason to do so.

(c) The Contractor shall require each proposed subcontractor whose subcontract will exceed the threshold specified in FAR 9.405-2(b) on the date of the subcontract award, other than a subcontractor providing a commercially available off-the-shelf item, to disclose to the Contractor, in writing, whether as of the time of award of the subcontract, the subcontractor, or its principals, is or is not debarred, suspended, or proposed for debarment by the Federal Government.

(d) A corporate officer or a designee of the Contractor shall notify the Contracting Officer, in writing, before entering into a subcontract with a party (other than a subcontractor providing a commercially available off-the-shelf item) that is debarred, suspended, or proposed for debarment (see FAR 9.404 for information on the System for Award Management (SAM) Exclusions). The notice must include the following:

(1) The name of the subcontractor.

(2) The Contractor's knowledge of the reasons for the subcontractor being listed with an exclusion in SAM.

(3) The compelling reason(s) for doing business with the subcontractor notwithstanding its being listed with an exclusion in SAM.

(4) The systems and procedures the Contractor has established to ensure that it is fully protecting the Government's interests when dealing with such subcontractor in view of the specific basis for the party's debarment, suspension, or proposed debarment.

(e) Subcontracts. Unless this is a contract for the acquisition of commercial items, the Contractor shall include the requirements of this clause, including this paragraph (e) (appropriately modified for the identification of the parties), in each subcontract that—

(1) Exceeds the threshold specified in FAR 9.405-2(b) on the date of subcontract award; and

(2) Is not a subcontract for commercially available off-the-shelf items.

SECTION 5.55

EMPLOYMENT REPORTS ON VETERANS (JUN 2020) (FAR 52.222-37)

(a) Definitions. As used in this clause, "active duty wartime or campaign badge veteran," "Armed Forces service medal veteran," "disabled veteran" "protected veteran," and "recently separated veteran," have the meanings given in FAR 22.1301.

(b) Unless the Contractor is a State or local government agency, the Contractor shall report at least annually, as required by the Secretary of Labor, on—

(1) The total number of employees in the contractor's workforce, by job category and hiring location, who are protected veterans (i.e., active duty wartime or campaign badge veterans, Armed Forces service medal veterans, disabled veterans and recently separated veterans);

(2) The total number of new employees hired during the period covered by the report, and of the total, the number of protected veterans (i.e., active duty

wartime or campaign badge veterans, Armed Forces service medal veterans, disabled veterans, and recently separated veterans); and

(3) The maximum number and minimum number of employees of the Contractor or subcontractor at each hiring location during the period covered by the report.

(c) The Contractor shall report the above items by filing the Form VETS-4212, entitled "Federal Contractor Veterans' Employment Report" (see VETS-4212 Federal Contractor Reporting" and Filing Your VETS-4212 Report" at http://www.dol.gov/vets/vets4212.htm)"

(d) The Contractor shall submit VETS-4212Reports no later than September 30 of each year.

(e) The employment activity report required by paragraphs (b)(2) and (b)(3) of this clause shall reflect total new hires, and maximum and minimum number of employees, during the most recent 12-month period preceding the ending date selected for the report. Contractors may select an ending date—

(1) As of the end of any pay period between July 1 and August 31 of the year the report is due; or

(2) As of December 31, if the Contractor has prior written approval from the Equal Employment Opportunity Commission to do so for purposes of submitting the Employer Information Report EEO-1 (Standard Form 100).

(f) The number of veterans reported must be based on data known to the contractor when completing the VETS–4212The contractor's knowledge of veterans status may be obtained in a variety of ways, including an invitation to applicants to self-identify (in accordance with 41 CFR 60–300.42), voluntary self-disclosure by employees, or actual knowledge of veteran status by the contractor. This paragraph does not relieve an employer of liability for discrimination under 38 U.S.C. 4212.

(g) The Contractor shall insert the terms of this clause in subcontracts valued at or above the threshold specified in FAR 22.1303(a) on the date of subcontract award, unless exempted by rules, regulations, or orders of the Secretary of Labor.

SECTION 5.56

AUTHORIZATION AND CONSENT (JUN 2020) (FAR 52.227-1)

(a) The Government authorizes and consents to all use and manufacture, in performing this contract or any subcontract at any tier, of any invention described in and covered by a United States patent—

(1) Embodied in the structure or composition of any article the delivery of which is accepted by the Government under this contract; or

(2) Used in machinery, tools, or methods whose use necessarily results from compliance by the Contractor or a subcontractor with (i) specifications or written provisions forming a part of this contract or (ii) specific written instructions given by the Contracting Officer directing the manner of performance. the entire liability to the Government for infringement of a United States patent shall be determined solely by the provisions of the indemnity clause, if any, included in this contract or any subcontract hereunder (including any lower-tier subcontract), and the Government assumes liability for all other infringement to the extent of the authorization and consent hereinabove granted.

(b) The Contractor shall include the substance of this clause, including this paragraph (b), in all subcontracts that are expected to exceed the simplified acquisition threshold, as

defined in Federal Acquisition Regulation (FAR) 2.101 on the date of subcontract award. However, omission of this clause from any subcontract, including those at or below the simplified acquisition threshold, as defined in Federal Acquisition Regulation (FAR) 2.101 on the date of subcontract award, does not affect this authorization and consent.

SECTION 5.57

NOTICE AND ASSISTANCE REGARDING PATENT AND COPYRIGHT INFRINGEMENT (JUN 2020) (FAR 52.227-2)

(a) The Contractor shall report to the Contracting Officer, promptly and in reasonable written detail, each notice or claim of patent or copyright infringement based on the performance of this contract of which the Contractor has knowledge.

(b) In the event of any claim or suit against the Government on account of any alleged patent or copyright infringement arising out of the performance of this contract or out of the use of any supplies furnished or work or services performed under this contract, the Contractor shall furnish to the Government, when requested by the Contracting Officer, all evidence and information in the Contractor's possession pertaining to such claim or suit. Such evidence and information shall be furnished at the expense of the Government except where the Contractor has agreed to indemnify the Government.

(c) The Contractor shall include the substance of this clause, including this paragraph (c), in all subcontracts that are expected to exceed the simplified acquisition threshold, as defined in Federal Acquisition Regulation (FAR) 2.101 on the date of subcontract award.

SECTION 5.60

SUBCONTRACTS FOR COMMERCIAL ITEMS (OCT 2020) (FAR 52.244-6)

(a) Definitions. As used in this clause —

"Commercial item" and "commercially available off-the-shelf item" have the meanings contained in Federal Acquisition Regulation 2.101.

"Subcontract" includes a transfer of commercial items between divisions, subsidiaries, or affiliates of the Contractor or subcontractor at any tier.

(b) To the maximum extent practicable, the Contractor shall incorporate, and require its subcontractors at all tiers to incorporate, commercial items or non-developmental items as components of items to be supplied under this contract.

(c)(1) The Contractor shall insert the following clauses in subcontracts for commercial items:

(i) 52.203-13, Contractor Code of Business Ethics and Conduct (Jun 2020) (41 U.S.C. 3509), if the subcontract exceeds the threshold specified in FAR 3.1004(a) on the date of subcontract award, and has a performance period of more than 120 days. In altering this clause to identify the appropriate parties, all disclosures of violation of the civil False Claims Act or of Federal criminal law shall be directed to the agency Office of the Inspector General, with a copy to the Contracting Officer.

(ii) 52.203-15, Whistleblower Protections Under the American Recovery and Reinvestment Act of 2009 (Jun 2010) (Section 1553 of Pub. L. 111-5), if the subcontract is funded under the Recovery Act.

(iii) 52.203-19, Prohibition on Requiring Certain Internal Confidentiality Agreements or Statements (JAN 2017).

(iv) 52.204–21, Basic Safeguarding of Covered Contractor Information Systems

(June, 2016), other than subcontracts for commercially available off-the-shelf items, if flow down is required in accordance with paragraph (c) of FAR clause 52.204–21.

(v) 52.204-23, Prohibition on Contracting for Hardware, Software, and Services Developed or Provided by Kaspersky Lab and Other Covered Entities (Jul 2018) (Section 1634 of Pub. L. 115-91).

(vi) 52.204-25, Prohibition on Contracting for Certain Telecommunications and Video Surveillance Services or Equipment. (Aug 2020) (Section 889(a)(1)(A) of Pub. L. 115-232).

(vii) 52.219-8, Utilization of Small Business Concerns (OCT 2018) (15 U.S.C. 637(d)(2) and (3)), if the subcontract offers further subcontracting opportunities. If the subcontract (except subcontracts to small business concerns) exceeds $700,000 ($1.5 million for construction of any public facility), the subcontractor must include 52.219-8 in lower tier subcontracts that offer subcontracting opportunities.

(viii) 52.222-21 Prohibition of Segregated Facilities (Apr 2015)

(ix) 52.222-26, Equal Opportunity (Apr 2015) (E.O. 11246).

(x) 52.222-35, Equal Opportunity for Veterans (Jun 2020) (38 U.S.C. 4212(a).

(xi) 52.222-36, Equal Opportunity for Workers with Disabilities (Jun 2020) (29 U.S.C. 793).

(xii) 52.222-37, Employment Reports on Veterans (Jun 2020) (38 U.S.C. 4212).

(xiii) 52.222-40, Notification of Employee Rights Under the National Labor Relations Act (Dec 2010) (E.O. 13496), if flow down is required in accordance with paragraph (f) of FAR clause 52.222-40.

(xiv)(A) 52.222-50, Combating Trafficking in Persons (Oct 2020) (22 U.S.C. chapter 78 and E.O. 13627).

(B) Alternate I (MAR 2015) of 52.222-50 (22 U.S.C. chapter 78 and E.O. 13627).

(xv) 52.222-55 , Minimum Wages under Executive Order 13658 (Dec 2015), if flow down is required in accordance with paragraph (k) of FAR clause 52.222-55.

(xvi) 52.222-62, Paid Sick Leave Under Executive Order 13706 (Jan 2017) (E.O. 13706), if flow down is required in accordance with paragraph (m) of FAR clause 52.222-62.

(xvii)(A) 52.224-3, Privacy Training (Jan 2017) (5 U.S.C. 552a) if flow down is required in accordance with 52.224-3(f).

(B) Alternate I (Jan 2017) of 52.224-3, if flow down is required in accordance with 52.224-3(f) and the agency specifies that only its agency-provided training is acceptable).

(xviii) 52.225-26, Contractors Performing Private Security Functions Outside the United States (Oct 2016) (Section 862, as amended, of the National Defense Authorization Act for Fiscal Year 2008; 10 U.S.C. 2302 Note).

(xvix) 52.232-40, Providing Accelerated Payments to Small Business Subcontractors (Dec 2013), if flow down is required in accordance with paragraph (c) of FAR clause 52.232-40.

(xx) 52.247-64, Preference for Privately Owned U.S.-Flag Commercial Vessels (Feb 2006) (46 U.S.C. App. 1241 and 10 U.S.C. 2631), if flow down is required in accordance with paragraph (d) of FAR clause 52.247-64).

(2) While not required, the Contractor may flow down to subcontracts for commercial items a minimal number of additional clauses necessary to satisfy its contractual obligations.

(d) The Contractor shall include the terms of this clause, including this paragraph (d), in subcontracts awarded under this contract.

SECTION 5.64
CONTRACTOR CODE OF BUSINESS ETHICS AND CONDUCT (JUN 2020) (FAR 52.203–13).

(a) Definitions. As used in this clause--

Agent means any individual, including a director, an officer, an employee, or an independent Contractor, authorized to act on behalf of the organization.

Full cooperation--(1) Means disclosure to the Government of the information sufficient for law enforcement to identify the nature and extent of the offense and the individuals responsible for the conduct. It includes providing timely and complete response to Government auditors' and investigators' request for documents and access to employees with information;

(2) Does not foreclose any Contractor rights arising in law, the FAR, or the terms of the contract. It does not require--

(i) A Contractor to waive its attorney-client privilege or the protections afforded by the attorney work product doctrine; or

(ii) Any officer, director, owner, or employee of the Contractor, including a sole proprietor, to waive his or her attorney client privilege or Fifth Amendment rights; and

(3) Does not restrict a Contractor from--

(i) Conducting an internal investigation; or

(ii) Defending a proceeding or dispute arising under the contract or related to a potential or disclosed violation.

"*Principal"* means an officer, director, owner, partner, or a person having primary management or supervisory responsibilities within a business entity (e.g., general manager; plant manager; head of a division, or business segment; and similar positions).

"*Subcontract"* means any contract entered into by a subcontractor to furnish supplies or services for performance of a prime contract or a subcontract.

"*Subcontractor"* means any supplier, distributor, vendor, or firm that furnished supplies or services to or for a prime contractor or another subcontractor.

"*United States"* means the 50 States, the District of Columbia, and outlying areas.

(b) *Code of business ethics and conduct*.

(1) Within 30 days after contract award, unless the Contracting Officer establishes a longer time period, the Contractor shall—

(i) Have a written code of business ethics and conduct; and

(ii) Make a copy of the code available to each employee engaged in performance of the contract.

(2) The Contractor shall--

(i) Exercise due diligence to prevent and detect criminal conduct; and

(ii) Otherwise promote an organizational culture that encourages ethical conduct and a commitment to compliance with the law.

(3)(i) The Contractor shall timely disclose, in writing, to the agency Office of the Inspector General (OIG), with a copy to the Contracting Officer, whenever, in connection with the award, performance, or closeout of this contract or any subcontract thereunder, the Contractor has credible evidence that a principal, employee, agent, or subcontractor of the Contractor has committed--

(A) A violation of Federal criminal law involving fraud, conflict of interest, bribery, or gratuity violations found in Title 18 of the United States Code; or

(B) A violation of the civil False Claims Act (31 U.S.C. 3729- 3733).

(ii) The Government, to the extent permitted by law and regulation, will safeguard and treat information obtained pursuant to the Contractor's disclosure as confidential where the information has been marked ``confidential'' or ``proprietary'' by the company. To the extent permitted by law and regulation, such information will not be released by the Government to the public pursuant to a Freedom of Information Act request, 5 U.S.C. Section 552, without prior notification to the Contractor. The Government may transfer documents provided by the Contractor to any department or agency within the Executive Branch if the information relates to matters within the organization's jurisdiction.

(iii) If the violation relates to an order against a Government wide acquisition contract, a multi-agency contract, a multiple-award schedule contract such as the Federal Supply Schedule, or any other procurement instrument intended for use by multiple agencies, the Contractor shall notify the OIG of the ordering agency and the IG of the agency responsible for the basic contract.

(c) Business ethics awareness and compliance program and internal control system. This paragraph (c) does not apply if the Contractor has represented itself as a small business concern pursuant to the award of this contract or if this contract is for the acquisition of a commercial item as defined at FAR 2.101. The Contractor shall establish the following within 90 days after contract award, unless the Contracting Officer establishes a longer time period:

(1) An ongoing business ethics awareness and compliance program.

(i) This program shall include reasonable steps to communicate periodically and in a practical manner the Contractor's standards and procedures and other aspects of the Contractor's business ethics awareness and compliance program and internal control system, by conducting effective training programs and otherwise disseminating information appropriate to an individual's respective roles and responsibilities.

(ii) The training conducted under this program shall be provided to the Contractor's principals and employees, and as appropriate, the Contractor's agents and subcontractors.

(2) An internal control system.

(i) The Contractor's internal control system shall--

(A) Establish standards and procedures to facilitate timely discovery of improper conduct in connection with Government contracts; and

(B) Ensure corrective measures are promptly instituted and carried out.

(ii) At a minimum, the Contractor's internal control system shall provide for the following:

(A) Assignment of responsibility at a sufficiently high level and adequate resources to ensure effectiveness of the business ethics awareness and compliance program and internal control system.

(B) Reasonable efforts not to include an individual as a principal, whom due diligence would have exposed as having engaged in conduct that is in conflict with the Contractor's code of business ethics and conduct.

(C) Periodic reviews of company business practices, procedures, policies, and internal controls for compliance with the Contractor's code of business ethics and conduct and the special requirements of Government contracting, including--

(1) Monitoring and auditing to detect criminal conduct;

(2) Periodic evaluation of the effectiveness of the business ethics awareness and

compliance program and internal control system, especially if criminal conduct has been detected; and

(3) Periodic assessment of the risk of criminal conduct, with appropriate steps to design, implement, or modify the business ethics awareness and compliance program and the internal control system as necessary to reduce the risk of criminal conduct identified through this process.

(D) An internal reporting mechanism, such as a hotline, which allows for anonymity or confidentiality, by which employees may report suspected instances of improper conduct, and instructions that encourage employees to make such reports.

(E) Disciplinary action for improper conduct or for failing to take reasonable steps to prevent or detect improper conduct.

(F) Timely disclosure, in writing, to the agency OIG, with a copy to the Contracting Officer, whenever, in connection with the award, performance, or closeout of any Government contract performed by the Contractor or a subcontract thereunder, the Contractor has credible evidence that a principal, employee, agent, or subcontractor of the Contractor has committed a violation of Federal criminal law involving fraud, conflict of interest, bribery, or gratuity violations found in Title 18 U.S.C. or a violation of the civil False Claims Act (31 U.S.C. 3729-3733).

(1) If a violation relates to more than one Government contract, the Contractor may make the disclosure to the agency OIG and Contracting Officer responsible for the largest dollar value contract impacted by the violation.

(2) If the violation relates to an order against a Government wide acquisition contract, a multi-agency contract, a multiple-award schedule contract such as the Federal Supply Schedule, or any other procurement instrument intended for use by multiple agencies, the contractor shall notify the OIG of the ordering agency and the IG of the agency responsible for the basic contract, and the respective agencies' contracting officers.

(3) The disclosure requirement for an individual contract continues until at least 3 years after final payment on the contract.

(4) The Government will safeguard such disclosures in accordance with paragraph (b)(3)(ii) of this clause.

(G) Full cooperation with any Government agencies responsible for audits, investigations, or corrective actions.

(d) Subcontracts. (1) The Contractor shall include the substance of this clause, including this paragraph (d), in subcontracts that exceed the threshold specified in FAR 3.1004(a) on the date of subcontract award and a performance period of more than 120 days.

(2) In altering this clause to identify the appropriate parties, all disclosures of violation of the civil False Claims Act or of Federal criminal law shall be directed to the agency Office of the Inspector General, with a copy to the Contracting Officer.

SECTION 5.69

ENCOURAGING CONTRACTOR POLICIES TO BAN TEXT MESSAGING WHILE DRIVING (JUN 2020) (FAR 52.223-18)

(a) Definitions. As used in this clause—

"Driving"–

(1) Means operating a motor vehicle on an active roadway with the motor running, including while temporarily stationary because of traffic, a traffic light, stop sign, or

otherwise.

(2) Does not include operating a motor vehicle with or without the motor running when one has pulled over to the side of, or off, an active roadway and has halted in a location where one can safely remain stationary.

"Text messaging" means reading from or entering data into any handheld or other electronic device, including for the purpose of short message service texting, e-mailing, instant messaging, obtaining navigational information, or engaging in any other form of electronic data retrieval or electronic data communication. The term does not include glancing at or listening to a navigational device that is secured in a commercially designed holder affixed to the vehicle, provided that the destination and route are programmed into the device either before driving or while stopped in a location off the roadway where it is safe and legal to park.

(b) This clause implements Executive Order 13513, Federal Leadership on Reducing Text Messaging While Driving, dated October 1, 2009.

(c) The Contractor is encouraged to—

(1) Adopt and enforce policies that ban text messaging while driving—

(i) Company-owned or -rented vehicles or Government-owned vehicles; or

(ii) Privately-owned vehicles when on official Government business or when performing any work for or on behalf of the Government.

(2) Conduct initiatives in a manner commensurate with the size of the business, such as—

(i) Establishment of new rules and programs or re-evaluation of existing programs to prohibit text messaging while driving; and

(ii) Education, awareness, and other outreach to employees about the safety risks associated with texting while driving.

(d) Subcontracts. The Contractor shall insert the substance of this clause, including this paragraph (d), in all subcontracts that exceed the micro-purchase threshold, as defined in Federal Acquisition Regulation 2.101 on the date of subcontract award.

SECTION 5.70

CONTRACTOR EMPLOYEE WHISTLEBLOWER RIGHTS AND REQUIREMENT TO INFORM EMPLOYEES OF WHISTLEBLOWER RIGHTS (JUN 2020) (FAR 52.203-17).

(a) This contract and employees working on this contract will be subject to the whistleblower rights and remedies in the pilot program on Contractor employee whistleblower protections established at 41 U.S.C. 4712 by section 828 of the National Defense Authorization Act for Fiscal Year 2013 (Pub. L. 112-239) and Federal Acquisition Regulation (FAR) 3.908

(b) The Contractor shall inform its employees in writing, in the predominant language of the workforce, of employee whistleblower rights and protections under 41 U.S.C. 4712, as described in section FAR 3.908.

(c) The Contractor shall insert the substance of this clause, including this paragraph (c), in all subcontracts over the simplified acquisition threshold, as defined in FAR 2.101 on the date of subcontract award.

SECTION 5.71

COMBATING TRAFFICKING IN PERSONS (OCT 2020) (FAR 52.222-50)
(a) Definitions. As used in this clause—
"Agent" means any individual, including a director, an officer, an employee, or an independent contractor, authorized to act on behalf of the organization.
"Coercion" means—
(1) Threats of serious harm to or physical restraint against any person;
(2) Any scheme, plan, or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to or physical restraint against any person; or
(3) The abuse or threatened abuse of the legal process.
"Commercially available off-the-shelf (COTS) item" means-
(1) Any item of supply (including construction material) that is-
(i) A commercial item (as defined in paragraph (1) of the definition at FAR 2.101);
(ii) Sold in substantial quantities in the commercial marketplace; and
(iii) Offered to the Government, under a contract or subcontract at any tier, without modification, in the same form in which it is sold in the commercial marketplace; and
(2) Does not include bulk cargo, as defined in 46 U.S.C. 40102(4), such as agricultural products and petroleum products.
"Commercial sex act" means any sex act on account of which anything of value is given to or received by any person.
"Debt bondage" means the status or condition of a debtor arising from a pledge by the debtor of his or her personal services or of those of a person under his or her control as a security for debt, if the value of those services as reasonably assessed is not applied toward the liquidation of the debt or the length and nature of those services are not respectively limited and defined.

"Employee" means an employee of the Contractor directly engaged in the performance of work under the contract who has other than a minimal impact or involvement in contract performance.
"Forced labor" means knowingly providing or obtaining the labor or services of a person—
(1) By threats of serious harm to, or physical restraint against, that person or another person;
(2) By means of any scheme, plan, or pattern intended to cause the person to believe that, if the person did not perform such labor or services, that person or another person would suffer serious harm or physical restraint; or
(3) By means of the abuse or threatened abuse of law or the legal process.
"Involuntary servitude" includes a condition of servitude induced by means of—
(1) Any scheme, plan, or pattern intended to cause a person to believe that, if the person did not enter into or continue in such conditions, that person or another person would suffer serious harm or physical restraint; or
(2) The abuse or threatened abuse of the legal process.
"Recruitment fees" means fees of any type, including charges, costs, assessments, or other financial obligations, that are associated with the recruiting process, regardless of the time, manner, or location of imposition or collection of the fee.
(1) Recruitment fees include, but are not limited to, the following fees (when they are associated with the recruiting process) for—

(i) Soliciting, identifying, considering, interviewing, referring, retaining, transferring, selecting, training, providing orientation to, skills testing, recommending, or placing employees or potential employees;
(ii) Advertising;
(iii) Obtaining permanent or temporary labor certification, including any associated fees;
(iv) Processing applications and petitions;
(v) Acquiring visas, including any associated fees;
(vi) Acquiring photographs and identity or immigration documents, such as passports, including any associated fees;
(vii) Accessing the job opportunity, including required medical examinations and immunizations; background, reference, and security clearance checks and examinations; and additional certifications;
(viii) An employer's recruiters, agents or attorneys, or other notary or legal fees;
(ix) Language interpretation or translation, arranging for or accompanying on travel, or providing other advice to employees or potential employees;
(x) Government-mandated fees, such as border crossing fees, levies, or worker welfare funds;
(xi) Transportation and subsistence costs—
(A) While in transit, including, but not limited to, airfare or costs of other modes of transportation, terminal fees, and travel taxes associated with travel from the country of origin to the country of performance and the return journey upon the end of employment; and
(B) From the airport or disembarkation point to the worksite;
(xii) Security deposits, bonds, and insurance; and
(xiii) Equipment charges.
(2) A recruitment fee, as described in the introductory text of this definition, is a recruitment fee, regardless of whether the payment is—
(i) Paid in property or money;
(ii) Deducted from wages;
(iii) Paid back in wage or benefit concessions;
(iv) Paid back as a kickback, bribe, in-kind payment, free labor, tip, or tribute; or V-54 (FFS-2020)
(v) Collected by an employer or a third party, whether licensed or unlicensed, including, but not limited to—
(A) Agents;
(B) Labor brokers;
(C) Recruiters;
(D) Staffing firms (including private employment and placement firms);
(E) Subsidiaries/affiliates of the employer;
(F) Any agent or employee of such entities; and
(G) Subcontractors at all tiers.
“Severe forms of trafficking in persons” means—
(1) Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or
(2) The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.
“Sex trafficking” means the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act.

(b) Policy. The United States Government has adopted a policy prohibiting trafficking in persons including the trafficking-related activities of this clause. Contractors, contractor employees, and their agents shall not—
(1) Engage in severe forms of trafficking in persons during the period of performance of the contract;
(2) Procure commercial sex acts during the period of performance of the contract; or
(3) Use forced labor in the performance of the contract.
(4) Destroy, conceal, confiscate, or otherwise deny access by an employee to the employee's identity or immigration documents, such as passports or drivers' licenses, regardless of issuing authority;
(5)(i) Use misleading or fraudulent practices during the recruitment of employees or offering of employment, such as failing to disclose, in a format and language understood by the employee or potential employee, basic information or making material misrepresentations during the recruitment of employees regarding the key terms and conditions of employment, including wages and fringe benefits, the location of work, the living conditions, housing and associated costs (if employer or agent provided or arranged), any significant cost to be charged to the employee, and, if applicable, the hazardous nature of the work;
(ii) Use recruiters that do not comply with local labor laws of the country in which the recruiting takes place;
(6) Charge employees or potential employees recruitment fees;
(7)(i) Fail to provide return transportation or pay for the cost of return transportation upon the end of employment-
(A) For an employee who is not a national of the country in which the work is taking place and who was brought into that country for the purpose of working on a U.S. Government contract or subcontract (for portions of contracts performed outside the United States); or
(B) For an employee who is not a United States national and who was brought into the United States for the purpose of working on a U.S. Government contract or subcontract, if the payment of such costs is required under existing temporary worker programs or pursuant to a written agreement with the employee (for portions of contracts performed inside the United States); except that
(ii) The requirements of paragraphs (b)(7)(i) of this clause shall not apply to an employee who is-
(A) Legally permitted to remain in the country of employment and who chooses to do so; or
(B) Exempted by an authorized official of the contracting agency from the requirement to provide return transportation or pay for the cost of return transportation;
(iii) The requirements of paragraph (b)(7)(i) of this clause are modified for a victim of trafficking in persons who is seeking victim services or legal redress in the country of employment, or for a witness in an enforcement action related to trafficking in persons. The contractor shall provide the return transportation or pay the cost of return transportation in a way that does not obstruct the victim services, legal redress, or witness activity. For example, the contractor shall not only offer return transportation to a witness at a time when the witness is still needed to testify. This paragraph does not apply when the exemptions at paragraph (b)(7)(ii) of this clause apply.
(8) Provide or arrange housing that fails to meet the host country housing and safety standards; or
(9) If required by law or contract, fail to provide an employment contract, recruitment

agreement, or other required work document in writing. Such written work document shall be in a language the employee understands. If the employee must relocate to perform the work, the work document shall be provided to the employee at least five days prior to the employee relocating. The employee's work document shall include, but is not limited to, details about work description, wages, prohibition on charging recruitment fees, work location(s), living accommodations and associated costs, time off, roundtrip transportation arrangements, grievance process, and the content of applicable laws and regulations that prohibit trafficking in persons.

(c) Contractor requirements. The Contractor shall—

(1) Notify its employees and agents of—

(i) The United States Government's policy prohibiting trafficking in persons, described in paragraph (b) of this clause; and

(ii) The actions that will be taken against employees or agents for violations of this policy. Such actions for employees may include, but are not limited to, removal from the contract, reduction in benefits, or termination of employment; and

(2) Take appropriate action, up to and including termination, against employees, agents, or subcontractors that violate the policy in paragraph (b) of this clause.

(d) Notification.

(1) The Contractor shall inform the Contracting Officer and the agency Inspector General immediately of—

(i) Any credible information it receives from any source (including host country law enforcement) that alleges a Contractor employee, subcontractor, subcontractor employee, or their agent has engaged in conduct that violates the policy; in in paragraph (b) of this clause (see also 18 U.S.C. 1351, Fraud in Foreign Labor Contracting, and 52.203-13(b)(3)(i)(A), if that clause is included in the solicitation or contract, which requires disclosure to the agency Office of the Inspector General when the Contractor has credible evidence of fraud) ; and

(ii) Any actions taken against a Contractor employee, subcontractor, or subcontractor employee, or their agent pursuant to this clause.

(2) If the allegation may be associated with more than one contract, the Contractor shall inform the contracting officer for the contract with the highest dollar value.

(e) Remedies. In addition to other remedies available to the Government, the Contractor's failure to comply with the requirements of paragraphs (c), (d), (g), (h) or (i) of this clause may result in—

(1) Requiring the Contractor to remove a Contractor employee or employees from the performance of the contract;

(2) Requiring the Contractor to terminate a subcontract;

(3) Suspension of contract payments until the Contractor has taken appropriate remedial action;

(4) Loss of award fee, consistent with the award fee plan, for the performance period in which the Government determined Contractor non-compliance;

(5) Declining to exercise available options under the contract;

(6) Termination of the contract for default or cause, in accordance with the termination clause of this contract; or

(7) Suspension or debarment.

(f) Mitigating and aggravating factors. When determining remedies, the Contracting Officer may consider the following:

(1) Mitigating factors. The Contractor had a Trafficking in Persons compliance plan or an awareness program at the time of the violation, was in compliance with the plan, and has

taken appropriate remedial actions for the violation, that may include reparation to victims for such violations.
(2) Aggravating factors. The Contractor failed to abate an alleged violation or enforce the requirements of a compliance plan, when directed by the Contracting Officer to do so.
(g) Full cooperation.
(1) The Contractor shall, at a minimum-
(i) Disclose to the agency Inspector General information sufficient to identify the nature and extent of an offense and the individuals responsible for the conduct;
(ii) Provide timely and complete responses to Government auditors' and investigators' requests for documents;
(iii) Cooperate fully in providing reasonable access to its facilities and staff (both inside and outside the U.S.) to allow contracting agencies and other responsible Federal agencies to conduct audits, investigations, or other actions to ascertain compliance with the Trafficking Victims Protection Act of 2000 (22 U.S.C. chapter 78), E.O. 13627, or any other applicable law or regulation establishing restrictions on trafficking in persons, the procurement of commercial sex acts, or the use of forced labor; and
(iv) Protect all employees suspected of being victims of or witnesses to prohibited activities, prior to returning to the country from which the employee was recruited, and shall not prevent or hinder the ability of these employees from cooperating fully with Government authorities.
(2) The requirement for full cooperation does not foreclose any Contractor rights arising in law, the FAR, or the terms of the contract. It does not-
(i) Require the Contractor to waive its attorney-client privilege or the protections afforded by the attorney work product doctrine;
(ii) Require any officer, director, owner, employee, or agent of the Contractor, including a sole proprietor, to waive his or her attorney client privilege or Fifth Amendment rights; or
(iii) Restrict the Contractor from-
(A) Conducting an internal investigation; or
(B) Defending a proceeding or dispute arising under the contract or related to a potential or disclosed violation.
(h) Compliance plan.
(1) This paragraph (h) applies to any portion of the contract that-
(i) Is for supplies, other than commercially available off-the-shelf items, acquired outside the United States, or services to be performed outside the United States; and
(ii) Has an estimated value that exceeds $550,000.
(2) The Contractor shall maintain a compliance plan during the performance of the contract that is appropriate-
(i) To the size and complexity of the contract; and
(ii) To the nature and scope of the activities to be performed for the Government, including the number of non-United States citizens expected to be employed and the risk that the contract or subcontract will involve services or supplies susceptible to trafficking in persons.
(3) Minimum requirements. The compliance plan must include, at a minimum, the following:
(i) An awareness program to inform contractor employees about the Government's policy prohibiting trafficking-related activities described in paragraph (b) of this clause, the activities prohibited, and the actions that will be taken against the employee for violations. Additional information about Trafficking in Persons and examples of awareness programs can be found at the website for the Department of State's Office to Monitor and Combat

Trafficking in Persons at http://www.state.gov/j/tip/.
(ii) A process for employees to report, without fear of retaliation, activity inconsistent with the policy prohibiting trafficking in persons, including a means to make available to all employees the hotline phone number of the Global Human Trafficking Hotline at 1-844-888- FREE and its email address at help@befree.org.
(iii) A recruitment and wage plan that only permits the use of recruitment companies with trained employees, prohibits charging recruitment fees to the employee or potential employees, and ensures that wages meet applicable host-country legal requirements or explains any variance.
(iv) A housing plan, if the Contractor or subcontractor intends to provide or arrange housing, that ensures that the housing meets host-country housing and safety standards.
(v) Procedures to prevent agents and subcontractors at any tier and at any dollar value from engaging in trafficking in persons (including activities in paragraph (b) of this clause) and to monitor, detect, and terminate any agents, subcontracts, or subcontractor employees that have engaged in such activities.
(4) Posting.
(i) The Contractor shall post the relevant contents of the compliance plan, no later than the initiation of contract performance, at the workplace (unless the work is to be performed in the field or not in a fixed location) and on the Contractor's Web site (if one is maintained). If posting at the workplace or on the Web site is impracticable, the Contractor shall provide the relevant contents of the compliance plan to each worker in writing.
(ii) The Contractor shall provide the compliance plan to the Contracting Officer upon request.
(5) Certification. Annually after receiving an award, the Contractor shall submit a certification to the Contracting Officer that-
(i) It has implemented a compliance plan to prevent any prohibited activities identified at paragraph (b) of this clause and to monitor, detect, and terminate any agent, subcontract or subcontractor employee engaging in prohibited activities; and
(ii) After having conducted due diligence, either-
(A) To the best of the Contractor's knowledge and belief, neither it nor any of its agents, subcontractors, or their agents is engaged in any such activities; or
(B) If abuses relating to any of the prohibited activities identified in paragraph (b) of this clause have been found, the Contractor or subcontractor has taken the appropriate remedial and referral actions.
(i) Subcontracts.
(1) The Contractor shall include the substance of this clause, including this paragraph (f), in all subcontracts and in all contracts with agents. The requirements in paragraph (h) of this clause apply only to any portion of the subcontract that-
(i) Is for supplies, other than commercially available off-the-shelf items, acquired outside the United States, or services to be performed outside the United States; and
(ii) Has an estimated value that exceeds $550,000.
(2) If any subcontractor is required by this clause to submit a certification, the Contractor shall require submission prior to the award of the subcontract and annually thereafter. The certification shall cover the items in paragraph (h)(5) of this clause.

SECTION 5.75
PROHIBITION ON CONTRACTING FOR CERTAIN TELECOMMUNICATIONS AND VIDEO SURVEILLANCE SERVICES OR EQUIPMENT (AUG 2020) (FAR 52.204-25).

i. *Definitions.* As used in this clause—

"Backhaul" means intermediate links between the core network, or backbone network, and the small subnetworks at the edge of the network (e.g., connecting cell phones/towers to the core telephone network). Backhaul can be wireless (e.g., microwave) or wired (e.g., fiber optic, coaxial cable, Ethernet).

"Covered foreign country" means The People's Republic of China. "Covered telecommunications equipment or services" means–

(1) Telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities);

(2) For the purpose of public safety, security of Government facilities, physical security surveillance of critical infrastructure, and other national security purposes, video surveillance and telecommunications equipment produced by Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities);

(3) Telecommunications or video surveillance services provided by such entities or using such equipment; or

(4) Telecommunications or video surveillance equipment or services produced or provided by an entity that the Secretary of Defense, in consultation with the Director of National Intelligence or the Director of the Federal Bureau of Investigation, reasonably believes to be an entity owned or controlled by, or otherwise connected to, the government of a covered foreign country.

"Critical technology" means–

(1) Defense articles or defense services included on the United States Munitions List set forth in the International Traffic in Arms Regulations under subchapter M of chapter I of title 22, Code of Federal Regulations;

(2) Items included on the Commerce Control List set forth in Supplement No. 1 to part 774 of the Export Administration Regulations under subchapter C of chapter VII of title 15, Code of Federal Regulations, and controlled-

(i) Pursuant to multilateral regimes, including for reasons relating to national security, chemical and biological weapons proliferation, nuclear nonproliferation, or missile technology; or

(ii) For reasons relating to regional stability or surreptitious listening;

(3) Specially designed and prepared nuclear equipment, parts and components, materials, software, and technology covered by part 810 of title 10, Code of Federal Regulations (relating to assistance to foreign atomic energy activities);

(4) Nuclear facilities, equipment, and material covered by part 110 of title 10, Code of Federal Regulations (relating to export and import of nuclear equipment and material);

(5) Select agents and toxins covered by part 331 of title 7, Code of Federal Regulations, part 121 of title 9 of such Code, or part 73 of title 42 of such Code; or

(6) Emerging and foundational technologies controlled pursuant to section 1758 of the Export Control Reform Act of 2018 (50 U.S.C. 4817).

"Interconnection arrangements" means arrangements governing the physical connection of two or more networks to allow the use of another's network to hand off traffic where it is ultimately delivered (e.g., connection of a customer of telephone provider A to a customer of telephone company B) or sharing data and other information resources.

"Reasonable inquiry" means an inquiry designed to uncover any information in the

entity's possession about the identity of the producer or provider of covered telecommunications equipment or services used by the entity that excludes the need to include an internal or third-party audit.

"Roaming" means cellular communications services (e.g., voice, video, data) received from a visited network when unable to connect to the facilities of the home network either because signal coverage is too weak or because traffic is too high.

"Substantial or essential component" means any component necessary for the proper function or performance of a piece of equipment, system, or service.

(b) Prohibition. (1) Section 889(a)(1)(A) of the John S. McCain National Defense Authorization Act for Fiscal Year 2019 (Pub. L. 115–232) prohibits the head of an executive agency on or after August 13, 2019, from procuring or obtaining, or extending or renewing a contract to procure or obtain, any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system. The Contractor is prohibited from providing to the Government any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system, unless an exception at paragraph (c) of this clause applies or the covered telecommunication equipment or services are covered by a waiver described in FAR 4.2104.

(2) Section 889(a)(1)(B) of the John S. McCain National Defense Authorization Act for Fiscal Year 2019 (Pub. L. 115–232) prohibits the head of an executive agency on or after August 13, 2020, from entering into a contract, or extending or renewing a contract, with an entity that uses any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system, unless an exception at paragraph (c) of this clause applies or the covered telecommunication equipment or services are covered by a waiver described in FAR 4.2104. This prohibition applies to the use of covered telecommunications equipment or services, regardless of whether that use is in performance of work under a Federal contract.

(c) *Exceptions.* This clause does not prohibit contractors from providing—

(1) A service that connects to the facilities of a third-party, such as backhaul, roaming, or interconnection arrangements; or

(2) Telecommunications equipment that cannot route or redirect user data traffic or permit visibility into any user data or packets that such equipment transmits or otherwise handles.

(d) Reporting requirement. (1)In the event the Contractor identifies covered telecommunications equipment or services used as a substantial or essential component of any system, or as critical technology as part of any system, during contract performance, or the Contractor is notified of such by a subcontractor at any tier or by any other source, the Contractor shall report the information in paragraph (d)(2) of this clause to the Contracting Officer, unless elsewhere in this contract are established procedures for reporting the information; in the case of the Department of Defense, the Contractor shall report to the website at https://dibnet.dod.mil. For indefinite delivery contracts, the Contractor shall report to the Contracting Officer for the indefinite delivery contract and the Contracting Officer(s) for any affected order or, in the case of the Department of Defense, identify both the indefinite delivery contract and any affected orders in the report provided at

https://dibnet.dod.mil.

(2) The Contractor shall report the following information pursuant to paragraph (d)(1) of this clause

(i) Within one business day from the date of such identification or notification: the contract number; the order number(s), if applicable; supplier name; supplier unique entity identifier (if known); supplier Commercial and Government Entity (CAGE) code (if known); brand; model number (original equipment manufacturer number, manufacturer part number, or wholesaler number); item description; and any readily available information about mitigation actions undertaken or recommended.

(ii) Within 10 business days of submitting the information in paragraph (d)(2)(i) of this clause: any further available information about mitigation actions undertaken or recommended. In addition, the Contractor shall describe the efforts it undertook to prevent use or submission of covered telecommunications equipment or services, and any additional efforts that will be incorporated to prevent future use or submission of covered telecommunications equipment or services.

(e) *Subcontracts.* The Contractor shall insert the substance of this clause, including this paragraph (e) and excluding (b)(2), in all subcontracts and other contractual instruments, including subcontracts for the acquisition of commercial items.

Part IV-SPECIAL PROVISIONS is deleted and replaced with the following:

SECTION 4.1
ALTERATIONS IN CONTRACT (JAN 2019) (FAR 52.252-4)

Portions of this contract are altered as follows:

(a) Section 1.6 Confidentiality of Records. The following subsection is added:

(d) Local Blue Cross and/or Blue Shield Plans may combine the personal data and medical records of Federal subscribers, and information relating thereto, with the same information of other individuals who have health benefits coverage under the Local Blue Cross and/or Blue Shield Plan. This combined data may only be used and disclosed for the Plan's health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501). Such activities include, but are not limited to: care management; prevention, detection, and recovery of funds subject to fraud and abuse; and negotiation of provider contracts.

(e) As used in subsection (b)(1) of this section, "administration of this contract" means health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501).

(b) Section 1.9 Plan Performance - Experience-Rated FFS Contracts.

The Carrier may use the appropriate systems for measurement and/or collection of data on the quality of the health care services as described in subparagraph 1.9(b).

(c) Section 1.14, Misleading, Deceptive, or Unfair Advertising, is amended by removing the reference to the NAIC Advertisements of Accident and Sickness Insurance Model Regulation (Appendix D-b). Carrier should continue to use the FEHB Supplemental Literature Guidelines (now at the renumbered Appendix C) along with FEHBAR 1603.7002.

(d) Section 1.15 Renewal and Withdrawal of Approval (FEHBAR). The following subsections are added:

(d) If the agency suspends payment of the subscription charges for any reason, the Carrier may (1) suspend making benefit payments until payment of all subscription charges due is fully restored; or (2) terminate the contract without prior notice.

(e) Section 1.21 Patient Bill of Rights. For the purpose of compliance with this Section, the Carrier will conduct the following minimum activities: (1) the Carrier will provide subscribers with a Fact Sheet that includes information about the disenrollment rate in the Blue Cross and Blue Shield Service Benefit Plan, as well as Local Plan-specific information including compliance with Federal and State financial requirements, public corporate information, years in existence, and accreditation status; (2) Provider Directories will include language advising subscribers to contact their providers directly obtain information about the providers, including but not limited to board certifications, languages spoken, availability of

interpreters, facility accessibility, and whether the provider is accepting new patients.

(f) Section 1.30 Health Information Technology Privacy and Security. Subsections (b), (c) and the introductory paragraph of Subsection (d) of Section 1.30 are amended to read as follows:

(b) The Carrier will promote consumer transparency by ensuring that at the point where the Federal member enters the subcontractor's, large provider's, or vendor's website or web portal the link to the subcontractor's, large provider's, or vendor's notice of privacy practices and/or privacy policies is displayed on the bottom, or prominently displayed elsewhere, on the website or web portal.

(c) Notice of privacy practices and/or privacy policies disclosures must describe the uses of individually identifiable protected health information and any potential disclosure to other entities as described in the HIPAA Privacy Rule.

(d) The Carrier will participate with the Contracting Officer or an authorized representative of the Contracting Officer in credential vulnerability scans and configuration compliance audits conducted in accordance with rules of engagement agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The rules of engagement will include the software and hardware used for vulnerability scanning; the specific process used to conduct vulnerability scanning; precautions taken to prevent negative disruption on the systems being scanned; restrictions on the release of documents and artifacts; and how the results of the scanning will be reviewed and reported.

(g) Section 2.2 Benefits Provided. The following paragraph is added to subsection 2.2(a):

(4) The Carrier may pay the Preferred Provider Organization level of benefits under this contract to ease the hardship of members affected by natural disasters such as earthquakes, floods, etc., when because of the natural disaster members have difficulty gaining access to Preferred network providers. The Carrier may pay the Preferred level of benefits without regard to the provider's contractual relationship with the Carrier and will determine an appropriate time frame based on local conditions during which the provision of this paragraph will apply. Benefits provided under this paragraph will be made available to all members similarly affected by the natural disaster.

(h) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Notwithstanding subsection (f) of Section 2.3, benefits provided under the contract are not assignable by the Member to any person without express written approval of the carrier, and in the absence of such approval, any such assignment shall be void. Notwithstanding such approval, no assignment of benefits may be made in any case prior to the time that a valid claim for benefits arises.

(i) Section 2.3 Payment of Benefits and Provision of Services and Supplies. The introductory paragraph of Subsection 2.3(g) is amended to read as follows:

(g) *Erroneous Payments*.

(i) If the Carrier or OPM determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a

prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider; the recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment under 48 C.F.R. 1631.201-70(h) regardless of any time period limitations in the written agreement with the provider.

(ii) The Carrier shall be deemed to have satisfied the requirements of Subsection (g) (i) above by complying with Subsections (ii), (iii), and (iv). Local Blue Cross and Blue Shield Plans which have time period limitations in their provider contracts which prevent the Plan from recovering erroneous benefit payments made to providers will participate in an action plan. The action plan shall be developed by the Blue Cross and Blue Shield Association by December 31, 2008 and agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield Association and the Contracting Officer shall utilize standards of commercial reasonableness and neither shall unreasonably withhold agreement. The action plan shall be designed to reduce the occurrence of erroneous benefit payments, to identify and recover erroneous benefit payments within the time limits stipulated in their provider contracts, and to demonstrate due diligence in making an attempt to identify and recover within that provider contract timeframe such erroneous benefit payments.

(iii) The Blue Cross and Blue Shield Association shall be responsible for monitoring and determining whether each Blue Cross and Blue Shield Plan participating in the action plan is complying with its obligations under the action plan.

(iv) A Blue Cross and Blue Shield Plan which is in compliance with its obligations under the action plan shall be found to be in compliance with its obligation under this Section 2.3(g) to make a prompt and diligent effort to recover erroneous benefit payments. In the event that any Plan with such time period limitations is determined to be not in substantial compliance with the action plan, and that Plan is determined not to have pursued material benefit payments with promptness and diligence, then the Plan shall return the erroneous benefit payments to the Program.

(v) The Carrier shall follow general business practices and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall—

(j) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(7)(ii) of Section 2.3 is amended to read as follows:

Notwithstanding (g)(7)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that caused erroneous benefit payments) when the errors are egregious and repeated. These costs are deemed to be unreasonable and unallowable under Section 3.2(b). The term "repeated" in the previous sentence does not apply to situations in which a claims processing system error causes multiple erroneous payments or to situations that involve audit findings on errors that are endemic to the provision of insurance and claims processing.

(k) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(10) of Section 2.3 is amended to read as follows:

(10) In compliance with the Contracts Disputes Act, the Carrier shall return to the Program an amount equal to the uncollected erroneous benefit payment where the Contracting Officer determines that the Carrier failed to make a prompt and diligent effort, as that term is described above, to recover the erroneous benefit payment. This provision applies to benefit payments which have been paid in error for any reason (except in the case of fraud or abuse).

(l) Section 2.4 Termination of Coverage and Conversion Privileges. The conversion contract set forth in Section 2.4(c) may be a contract that is regularly offered by the local Blue Cross and/or Blue Shield Plan.

(m) Section 2.5 Subrogation. The following subsections are added:

(c) To the extent that a Member has received benefits for covered services under this contract for an injury or illness caused by a third party, the Carrier shall have the right to be subrogated and succeed to any rights of recovery against any person or organization from whom the Member is legally entitled to receive all or part of those same benefits, including insurers of individuals (non-group) policies of liability insurance that are issued to and in the name of the Member. The obligation of the Carrier to recover amounts through subrogation is limited to making a reasonable effort to seek recovery of amounts to which it is entitled to recover in cases which are brought to its attention. The Carrier shall not be required to recover any amounts from any person or organization who causes an injury or illness for which the Member makes claims for benefits.

(d) The Carrier may also recover directly from the Member all amounts received by the Member by suit, settlement, or otherwise from any third party or its insurer, or the Member's insurer under an individual policy or liability insurance, for benefits which have also been paid under this contract.

(e) The Member shall take such action, furnish such information and assistance, and execute such papers as the Carrier or its representative believes are necessary to facilitate enforcement of its rights, and shall take no action which would prejudice the interests of the Carrier to subrogation.

(f) Effective January 1, 1997, all Participating Plans shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under the contract.

(n) Section 2.6 Coordination of Benefits (FEHBAR). The following subsections are added:

(g) The benefits payable by this Plan shall be determined, on a claim by claim basis, only for those claims in excess of $100, except where Medicare is the primary payer of benefits, claims in excess of $50.

(h) Whenever payments which should have been made under this contract in accordance with this provision have been made under any other group health coverage, the Carrier shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amount it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this contract and, to the extent of such payments discharged from liability under the contract.

(o) Section 3.1 Payments (FEHBAR). The following sentence is added to the end of Section 3.1(a):

OPM will withhold from the subscription charges amounts for other obligations due under the contract only to the extent that OPM and the Carrier have agreed in writing to specific deductions for such other obligations.

(p) Section 3.1 Payments (FEHBAR). The following subsection is added:

(g) Except as required pursuant to Sections 1.25 and 2.12, in the event this contract is terminated or not renewed, the agency shall be liable for all sums due and unpaid, including subscription charges, for the period up to the last day of the Member's entitlement to benefits.

(q) Section 3.2 Accounting and Allowable Cost (FEHBAR). Section 3.2(b)(2)(ii) of this contract is amended to comply with 5 U.S.C. 8909(f) as follows:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(r) Section 3.2 Accounting and Allowable Cost (FEHBAR). The provision in Section 3.2 (b)(2)(iv)(A) is supplemented as follows:

Charges for mandatory statutory reserves (Section 3.2(b)(2)(iv)(A)) to satisfy mandatory statutory reserve requirements of Participating Plans are allowable to the extent that such requirements exceed that portion of the service charge at Appendix B, Subscription Rates, Charges, Allowances and Limitations applicable to such Plans.

(s) Section 3.2 Accounting and Allowable Cost (FEHBAR). This section is modified as follows:

The Carrier, as required by the Blue Cross and Blue Shield Service Benefit Plan Workplan,

shall furnish OPM an accounting of its operations under the contract not less than 120 days after the end of the calendar year contract period.

(t) Section 3.3 Special Reserve. The provision in Section 3.3(a) is supplemented as follows:

The Special reserve held by or on behalf of the Carrier is to be used only for payment of charges against this contract, including advance payments to Participating Plans and to hospitals.

(u) Section 3.10, Audit, Financial, and Other Information. Compliance by the Carrier and Participating Blue Cross and Blue Shield Plans with the Blue Cross Blue Shield Service Benefit Plan Workplan, as agreed upon between the Carrier and OPM, will constitute compliance with the Audit Guide referred to in Sections 3.2 and 3.10.

SECTION 4.2
HOSPITAL (FACILITY) BENEFIT PAYMENTS AND CONDITIONS (JAN 1991)

(a) Benefits described in the agreed upon brochure text shall be provided to the extent practicable in the form of services rendered by hospitals, freestanding ambulatory facilities, and home health care agencies, and payment, therefore, by or on behalf of the carrier shall constitute a complete discharge of their obligations under this contract to the extent of services rendered in accordance with the terms and conditions of the contract.

(b) Benefits for inpatient hospital care shall be available only to a Member admitted to the hospital on the recommendation, and while under the active medical supervision of a duly licensed physician or alternative provider as described in section 8902(k)(1) of title 5 U.S.C. who is a member of the staff of, or acceptable to, the hospital selected.

(c) Hospital service is subject to all the rules and regulations of the hospital selected including rules governing admissions.

(d) While a Member may elect to be hospitalized in any hospital, the Carrier does not undertake to guarantee the admission of such Member to the hospital, nor the availability of any accommodations or services therein requested by the Member or his physician.

SECTION 4.3
DEFINITION OF CARRIER (JAN 1991)

The Carrier is the Blue Cross and Blue Shield Association, an Illinois not-for-profit corporation, acting on behalf of participating Blue Cross and Blue Shield Plans and pursuant to authority specified in Exhibit A for and in behalf of the organizations specified in Exhibit A (hereinafter sometimes referred to as “Participating Plans”).

SECTION 4.4
AUDIT DISPUTES (JAN 2000)

(a) Any questioned costs or issues documented by or on behalf of OPM’s Office of the Inspector General (OIG) in draft or final audit reports examining the Carrier’s and Participating Plans’ performance under this contract, that are provided to the Carrier and that

were initially raised in the timeframe set forth in subsection (c) below, remain open until resolved. Audit issues related to monetary findings for which extensions of the waiver period for the issuance of final decisions and processing of prior period adjustments were obtained in previous contract terms also remain open until resolved.

(b) Resolution of a questioned cost or issue can be the result of a resolution letter or the issuance of a final decision by the Contracting Officer, or by the processing of a prior period adjustment, an adjustment to the Special reserve, or submission of a claim to OPM (as appropriate) by the Carrier or Participating Plan. A prior period adjustment intended to partially or fully resolve an audit finding will not be considered closed until properly reported on the calendar year Annual Accounting Statement.

(c) A claim seeking, as a matter of right, the payment of money, in a sum certain, pursuant to 48 CFR section 52.233-1, shall not be made more than five years following the last day prescribed by the contract for filing the calendar year Annual Accounting Statement for the year with respect to which the claim arises. A claim includes, in the case of the carrier, a charge against the contract.

SECTION 4.5
ASSOCIATION DUES (JAN 2004)

A Participating local Blue Cross and Blue Shield Plan may charge to this contract Association Dues, with the exception of dues related to those lobbying costs and Special Assessments determined to be unallowable. In calculating the unallowable portion of dues related to lobbying costs for a contract year, the Blue Cross and Blue Shield Plan will rely on the percentage of dues, less any special assessments, as determined by the BCBSA for IRS purposes, to be not tax deductible from the previous contract year.

SECTION 4.6
TRAVEL COSTS (JAN 1996)

The Carrier may charge and account for travel expenses related to administration of the contract on a per diem basis, subject to the maximums prescribed by the Federal Travel Regulations. For those travel costs for each contract term that are subject to the Federal per diem rates set forth at 48 CFR section 31.205-46, the Carrier shall charge to the contract an amount equal to the lesser of:

(i) the actual aggregate charges for those costs, or
(ii) the aggregate charges calculated using the per diem rates set forth in the Federal Travel Regulations.

SECTION 4.7
MARKET RESEARCH COSTS (JAN 1996)

(a) Costs of market research surveys or studies are generally allowable if the survey or study is:

1. directed to current Members and Members who left the Blue Cross and Blue Shield Service Benefit Plan in the most recent Open season, or

2. focused on long-range planning, industry state-of-the-art developments, or product development issues for which a direct benefit or potential benefit to the FEHB Program can be identified, or
3. pre-approved by the Contracting Officer.

(b) Costs of market research surveys or studies are generally not allowable if the primary purpose is to survey or study an otherwise unallowable cost item, such as: to determine the effectiveness of advertising or sales strategies; to evaluate image effectiveness or ways to achieve image enhancement; or to perform a competitive analysis with other carriers in the FEHB Program. Such costs are unallowable, regardless of who receives the research surveys or studies.

(c) This provision does not supersede other contract requirements, such as prior approval for subcontracts under Section 1.16 Subcontracts (FEHBAR 1652.244-70).

SECTION 4.8
PRESCRIPTION DRUG BENEFITS WAIVER PROVISIONS (JAN 2009)

(a) For the purposes of applying the special provisions in this section, the Standard Option Mail Service Prescription Drug Program service standards are:

(1) When a prescription order is placed that does not require additional information or clarification (i.e., a clean or non-diverted prescription), the prescription order shall be dispensed within three business days from the date of receipt so the enrollee may expect to receive the medication within 7 calendar days.

(2) When a prescription order is placed that does require additional information, clarification or resolution of payment issues (i.e., a diverted prescription), the prescription order shall be dispensed within seven business days from the date of receipt so the enrollee may expect to receive the medication within 14 calendar days. However the following situations will not be considered a diverted prescription for the purposes of this section:

(i) Prescriptions for refrigerated products that require prior arrangements between the mail order pharmacy and a Member before the Member can receive the Prescription;

(ii) Prescriptions requiring specific counseling obligations imposed by the pharmaceutical manufacturer, distributor or the FDA;

(iii) Prescriptions requiring "registration" with a pharmaceutical manufacturer.

(b) The special provisions described in paragraphs (c)(1), (2), and (3) shall become effective automatically when less than 98 percent of the prescriptions are filled within the service standards described in either paragraph (a)(1) or (a)(2) for 7 consecutive business days. The special provisions shall terminate when for 7 consecutive business days 98 percent or more of the prescriptions are filled within the service standards described in paragraphs (a)(1) and (a)(2) of this section.

(c) The special provisions are:

(1) The Carrier shall waive during the effective periods in paragraph (b) the coinsurance for a 21 day prescription filled at a Preferred retail pharmacy when the Mail Service Prescription Drug Program vendor is unable to fill the prescription within the service standards. This waiver of the coinsurance shall be in effect for 14 calendar days after notice to the enrollee as described in paragraph (c)(2) below.

(2) The Carrier shall deliver to the enrollee a written or telephone notice no later than 5 days from the date of receipt for clean or non-diverted prescriptions and no later than 12 days from the date of receipt for diverted prescriptions.
This notice shall:

(i) advise the enrollee that the Mail Service Prescription Drug Program may not be able to fill the prescription(s) within the service standard timeframes;

(ii) advise the enrollee that any applicable coinsurance will be waived for a 21 day supply of the medication(s) when filled at a Preferred retail pharmacy;

(iii) provide the enrollee with instructions on how to use the waiver, and

(iv) advise the enrollee when the waiver will expire.

(3) The Carrier may use next day delivery service at no additional cost to the enrollee in order to meet the service standards in (a)(1) and (a)(2).

SECTION 4.9
SMALL BUSINESS SUBCONTRACTING PLAN (JUN 2020) (FAR 52.219-9) (AS AMENDED)

An amended clause 52.219-9, Small Business Subcontracting Plan, is attached to Appendix E.

SECTION 4.10
LETTER OF CREDIT (JAN 1997)

As of January 1, 1997, OPM will administer Letter of Credit drawdowns directly with the local Plans.

SECTION 4.11
PILOTING OF COST CONTAINMENT PROGRAMS (JAN 2001)

Upon approval by the Contracting Officer, the Carrier may design and implement pilot programs in one or more local Plan areas that test the feasibility and examine the impact of various managed care initiatives. The Carrier shall brief the Contracting Officer on a pilot program prior to its implementation, advise the Contracting Officer of the progress of the pilot program and provide a written evaluation at the conclusion of the pilot program. The evaluation of the pilot program shall, at a minimum, assess the cost effectiveness, effect on quality of care and/or quality of life, and customer satisfaction, and recommend whether the pilot program should be continued or expanded.

SECTION 4.12
TRANSITION COSTS FOR PLAN TERMINATIONS (JAN 1999)

In the event a Participating Plan's license to use the Blue Cross and/or Blue Shield service marks is terminated, thereby rendering it ineligible to participate in this Contract, the costs of transitioning the terminated Plan's Service Benefit Plan subscribers to a successor Plan shall be subject to advance approval. The Carrier shall submit to OPM a proposed transition plan, together with a detailed estimate of costs, prior to the incurrence of any significant transition costs. OPM and the Carrier shall negotiate an advance agreement pursuant to FAR 31.109 that covers the extent of allowable transition costs.

SECTION 4.13
PAYMENT BY ELECTRONIC FUNDS TRANSFER-CENTRAL CONTRACTOR REGISTRATION (MAY 1999) (FAR 52.232-33)

The references to the Central Contractor Registration in FAR 52.232-33 are not applicable to this contract.

SECTION 4.14
FEDERAL INCOME TAX RELATED TO HEALTH INSURANCE PROVIDERS' FEE (JANUARY 2015)

(a) Notwithstanding FAR 31.205-41(b)(1) and this Contract Section 3.2(b)(1)(ii), a charge for an incremental amount of Federal income tax liability incurred as the result of compliance with the Health Insurance Providers Fee (HIP Fee) provision of the Affordable Care Act section 9010 (hereafter referred to as the "HIP Tax Cost") by a participating local plan (Local Plan) that administers the Service Benefit Plan on behalf of the Blue Cross and Blue Shield Association (Carrier), and that is a covered entity within the meaning of 26 CFR Part 57, is an allowable cost to the Carrier under this contract under the criteria set forth below.

(1) The allowable cost to the Carrier for a year is the sum of the HIP Tax Cost for each Local Plan. The HIP Tax Cost for each Local Plan equals:
the amount reimbursed by OPM to the Carrier for the HIP Fee attributable to the Local Plan (Local Plan HIP Fee) for the year, divided by one minus the tax rate for the Local Plan specified under section (2) below, (Local Plan Tax Rate), less the Local Plan HIP Fee. In mathematical terms, the allowable charge to the Carrier for the HIP Tax Cost is the sum of each Local Plan's application of the formula below:

$$\left[\frac{\text{Local Plan HIP Fee}}{1 - \text{Local Plan Tax Rate}}\right] - \text{Local Plan HIP Fee}$$

(2) The Local Plan Tax Rate for purposes of the formula specified in section (1) is the lowest of the following:
(a) the rate specified at 26 USC §11 (b) (1) (D),
(b) the rate specified at 26 USC § 55(b)(1)(B)(i), for any year in which the Local Plan is entitled to the special deduction under 26 USC § 833(a)(2), or
(c) zero, for any year in which the Local Plan experiences a Net Operating Loss or other circumstance resulting in no tax liability. For a year in which the Local Plan experiences a Net Operating Loss resulting in no tax liability, the Carrier will charge the HIP Tax Cost attributable to the Local Plan in the first subsequent year in which the Local Plan's tax liability is greater than zero. The Local Plan will calculate the HIP Tax Cost in this circumstance by applying the formula using the HIP Fee for the year of the loss and the Local Plan Tax Rate for the year in which the tax liability is greater than zero. This charge by the Carrier is in addition to the charge allowed by the Carrier for the Local Plan Tax Cost for the year in which the tax liability is greater than zero.

(d) If the Local Plan Tax Rate reflected on the Local Plan's tax return actually filed for the contract year (which normally occurs the following year) differs from the Local Plan Tax Rate that was anticipated when the costs were drawn down by the Carrier for the contract year as allowable administrative expenses, the Carrier will make a commensurate adjustment to its current year drawdown of administrative expenses.

(b) The Contracting Officer or an authorized representative of the Contracting Officer shall have the right to examine and audit all books and records, including tax filings, relating to the calculation of the HIP Tax Cost charge for each Local Plan.

Part IV - Attachment I
SECTION 4.14
FEDERAL INCOME TAX RELATED TO HEALTH INSURER'S PROVIDER FEE

Examples of Allowable 9010 Tax Cost:

C is an experience rated FEHB carrier consisting of participating Local Plans F and G who underwrite and administer C in different geographic areas.

In 2015, F reports $900 on IRS Form 8963 and pays $500 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the $500 HIP Fee, F's Form 8963 reflects that $300 is attributable to F's FEHBP business.

Also in 2015, G reports $950 on IRS Form 8963 and pays $550 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the $550 HIP Fee, G's Form 8963 reflects that $325 is attributable to G's FEHBP business.

In 2015, C draws down a 2015 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2014 health risks, which is calculated as the sum of F and G's HIP Fee, or $300 +325 = $725, which is an allowable cost, from its FEHB letter of credit account (LOCA). C reimburses F for its HIP Fee of 300 and G for its HIP Fee of 325.

F records income of $300 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by $300. F records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, F pays quarterly payments to the IRS for its' 2015 tax liability. F's 2015 tax rate is 35 percent.

G records income of $325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by $325. G records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, G pays quarterly payments to the IRS for its' 2015 tax liability. Because G claims a special deduction under 26 USC § 833(a)(2), G's 2015 tax rate is 20 percent.

In 2015, C also draws down from its LOCA a 2015 HIP Tax Cost reimbursement for the 2015 income tax expense accrued and paid by F & G in 2015. C's 2015 HIP Tax cost reimbursement is calculated as follows:

Local Plan F HIP Tax Cost: ($300/1-.35)-$300 = $162
Local Plan G HIP Tax Cost: ($325/1-.20)-$325 = $81
Sum which is C's allowable HIP Tax Cost for 2015 = $243

In 2016, F & G report the same HIP Fee expense for 2015 health risks.

In 2016, F experiences the same tax rate as for 2015, but G incurs a net operating loss, resulting in a zero percent tax rate for 2016.

In 2016, C draws down a 2016 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2015 health risks of 300 + 325 = $725, which is an allowable cost, from C's FEHB letter of credit account (LOCA). C reimburses F for 300 and G for 325.

In 2016, F proceeds as in 2015 and C may charge 162 as an allowable HIP Tax Cost attributable to F in 2016.

In 2016 G records income of $325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by $325. Because G determines that its 2016 tax liability will be zero as it will have a Net Operating Loss for 2016, C does not incur an allowable 2016 HIP Tax Cost attributable to G. C must refund any such amounts drawn down during 2016.

Local Plan F HIP Tax Cost for 2016 = 162
Local Plan G HIP Tax Cost for 2016 = 0
Reimbursement attributable to G = adjustment for amounts drawn down by C, if any
Sum = C's allowable HIP Tax Cost for 2016 = 162 less adjustment.

In 2017, F proceeds as in 2015. C's allowable 2017 HIP Tax Cost includes $162 attributable to F. In 2017, G has an operating gain and reports the same HIP Fee amount and experiences the same 20% tax rate as in 2015. C's allowable 2017 HIP Tax Cost includes $81 attributable to G.

In addition, in 2017, because G's operating gain results in a tax rate higher than zero, G incurs economic disadvantage. This is because the 2016 HIP Fee reimbursement of $325 has reduced G's otherwise applicable Net Operating Loss carry-forward amount. G calculates the economic disadvantage as the difference between its 2017 tax liability with and without the 2016 HIP Fee reimbursement. This disadvantage is included in the Carrier's 2017 charge as an allowable HIP Tax Cost with respect to 2016. This is calculated as $325 (2016 HIP Fee) divided by 1-20% (application of 2017 Local Plan Tax Rate), less $325.]

Local Plan F HIP Tax Cost for 2017 = 162
Local Plan G HIP Tax Cost for 2017 = 81
Local Plan G HIP Tax Cost for 2017 due to 2016 HIP Fee reimbursement = apply formula using 2016 Fee Reimbursement amount and 2017 tax rate of 20% =81
Sum = C's allowable HIP Tax Cost for 2017 = 162 + 81 + 81 = $324

APPENDIX A

ATTACH

2021 FEHB BROCHURE

APPENDIX B

SUBSCRIPTION RATES, CHARGES, ALLOWANCES AND LIMITATIONS

Fee-For-Service Carrier

(Blue Cross and Blue Shield Association)
CONTRACT NO. CS 1039
Effective January 1, 2021

(a) Biweekly net-to-Carrier rates, with appropriate adjustments for Enrollees paid on other than a biweekly basis, are as follows:

Basic Option:	$302.33 Self, $679.45 Self Plus One, and $734.15 Family
Standard Option:	$350.99 Self, $767.57 Self Plus One, and $829.20 Family
FEP Blue Focus:	$204.40 Self, $439.44 Self Plus One, and $483.37 Family

(b) The amount of administrative expenses and charges to be included in the Annual Accounting Statement required by Section 3.2 shall be as set out in the schedule below:

Item	Amount
(i) Administrative Expenses	Actual, but not to exceed the Contractual Expense Limitation for 2021,* plus an amount sufficient to cover the costs needed to pay the Plan's Independent Public Accountant to undertake the audits and agreed upon procedures required in the "FEHBP Experienced-Rated Carrier and Service Organization Audit Guide."
(ii) Taxes	Actual (except that premium taxes as defined are not allowable).
(iii) Service Charge**	[redacted]

*The Contractual Expense Limitation for 2021 is [redacted] Notwithstanding Section 3.2(b) of this Contract, costs of "activities that improve healthcare quality" as determined in accordance with the medical loss ratio provision of the Affordable Care Act (Section 2718 of the Public Health Service act; 42 U.S.C. 300gg-18 and its implementing regulations), are accounted for as benefits and not counted toward the Contractual Expense Limit.

** The Service Charge for the 2021 contract year is based on the Overall Performance Score calculated in accordance with the 2020 Appendix F. The Service Charge for the 2022 contract year will be based on the Overall Performance Score calculated in accordance with the 2021 Appendix F.

APPENDIX E
SMALL BUSINESS SUBCONTRACTING PLAN (JUN 2020)

(a) This clause does not apply to small business concerns.

(b) *Definitions*. As used in this clause—

"Alaska Native Corporation (ANC)" means any Regional Corporation, Village Corporation, Urban Corporation, or Group Corporation organized under the laws of the State of Alaska in accordance with the Alaska Native Claims Settlement Act, as amended (43 U.S.C.

1601, et seq.) and which is considered a minority and economically disadvantaged concern under the criteria at 43 U.S.C. 1626(e)(1). This definition also includes ANC direct and indirect subsidiary corporations, joint ventures, and partnerships that meet the requirements of 43 U.S.C. 1626(e)(2).

"Commercial item" means a product or service that satisfies the definition of commercial item in Federal Acquisition Regulation (FAR) 2.101.

"Commercial plan" means a subcontracting plan (including goals) that covers the offeror's fiscal year and that applies to the entire production of commercial items sold by either the entire company or a portion thereof (*e.g.,* division, plant, or product line).

"Indian tribe" means any Indian tribe, band, group, pueblo, or community, including native villages and native groups (including corporations organized by Kenai, Juneau, Sitka, and Kodiak) as defined in the Alaska Native Claims Settlement Act (43 U.S.C.A. 1601 et seq.), that is recognized by the Federal Government as eligible for services from the Bureau of Indian Affairs in accordance with 25 U.S.C. 1452(c). This definition also includes Indian-owned economic enterprises that meet the requirements of 25 U.S.C. 1452(e).

"Individual subcontracting plan" means a subcontracting plan that covers the entire contract period (including option periods), applies to a specific contract, and has goals that are based on the offeror's planned subcontracting in support of the specific contract, except that indirect costs incurred for common or joint purposes may be allocated on a prorated basis to the contract.

"Master subcontracting plan" means a subcontracting plan that contains all the required elements of an individual subcontracting plan, except goals, and may be incorporated into individual subcontracting plans, provided the master subcontracting plan has been approved.

"Reduced payment" means a payment that is for less than the amount agreed upon in a subcontract in accordance with its terms and conditions, for supplies and services for which the Government has paid the prime contractor.

"Subcontract" means any agreement (other than one involving an employer-employee relationship) entered into by a Federal Government prime Contractor or subcontractor calling for supplies or services required for performance of the contract or subcontract.

"Total contract dollars" means the final anticipated dollar value, including the dollar value of all options. "Untimely payment" means a payment to a subcontractor that is more than 90 days past due under the terms and conditions of a subcontract for supplies and services for which the Government has paid the prime contractor.

(c) (1) The Offeror, upon request by the Contracting Officer, shall submit and negotiate a subcontracting plan, where applicable, that separately addresses subcontracting

with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns. If the Offeror is submitting an individual subcontracting plan, the plan must separately address subcontracting with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns, with a separate part for the basic contract and separate parts for each option (if any). The subcontracting plan shall be included in and made a part of the resultant contract. The subcontracting plan shall be negotiated within the time specified by the Contracting Officer. Failure to submit and negotiate the subcontracting plan shall make the Offeror ineligible for award of a contract.

(2)(i) The Contractor may accept a subcontractor's written representations of its size and socioeconomic status as a small business, small disadvantaged business, veteran-owned small business, service-disabled veteran-owned small business, or a women-owned small business if the subcontractor represents that the size and socioeconomic status representations with its offer are current, accurate, and complete as of the date of the offer for the subcontract.

(ii) The Contractor may accept a subcontractor's representations of its size and socioeconomic status as a small business, small disadvantaged business, veteran-owned small business, service-disabled veteran-owned small business, or a women-owned small business in the System for Award Management (SAM) if–

(A) The subcontractor is registered in SAM; and

(B) The subcontractor represents that the size and socioeconomic status representations made in SAM are current, accurate and complete as of the date of the offer for the subcontract.

(iii) The Contractor may not require the use of SAM for the purposes of representing size or socioeconomic status in connection with a subcontract.

(iv) In accordance with 13 CFR 121.411, 124.1015, 125.29, 126.900, and 127.700, a contractor acting in good faith is not liable for misrepresentations made by its subcontractors regarding the subcontractor's size or socioeconomic status.

(d) The offeror's subcontracting plan shall include the following:

(1) Separate goals, expressed in terms of total dollars subcontracted, and as a percentage of total planned subcontracting dollars, for the use of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns as subcontractors. For individual subcontracting plans, and if required by the Contracting Officer, goals shall also be expressed in terms of percentage of total contract dollars, in addition to the goals expressed as a percentage of total subcontract dollars. The Offeror shall include all subcontracts that contribute to contract performance, and may include a proportionate share of products and services that are normally allocated as indirect costs. In accordance with 43 U.S.C. 1626–

(i) Subcontracts awarded to an ANC or Indian tribe shall be counted towards the subcontracting goals for small business and small disadvantaged business concerns, regardless of the size or Small Business Administration certification status of the ANC or Indian tribe; and

(ii) Where one or more subcontractors are in the subcontract tier between the

prime Contractor and the ANC or Indian tribe, the ANC or Indian tribe shall designate the appropriate Contractor(s) to count the subcontract towards its small business and small disadvantaged business subcontracting goals.

(A) In most cases, the appropriate Contractor is the Contractor that awarded the subcontract to the ANC or Indian tribe.

(B) If the ANC or Indian tribe designates more than one Contractor to count the subcontract toward its goals, the ANC or Indian tribe shall designate only a portion of the total subcontract award to each Contractor. The sum of the amounts designated to various Contractors cannot exceed the total value of the subcontract.

(C) The ANC or Indian tribe shall give a copy of the written designation to the Contracting Officer, the prime Contractor, and the subcontractors in between the prime Contractor and the ANC or Indian tribe within 30 days of the date of the subcontract award.

(D) If the Contracting Officer does not receive a copy of the ANC's or the Indian tribe's written designation within 30 days of the subcontract award, the Contractor that awarded the subcontract to the ANC or Indian tribe will be considered the designated Contractor.

(2) A statement of—

(i) Total dollars planned to be subcontracted for an individual subcontracting plan; or the Offeror's total projected sales, expressed in dollars, and the total value of projected subcontracts to support the sales for a commercial plan;

(ii) Total dollars planned to be subcontracted to small business concerns (including ANC and Indian tribes); and

(iii) Total dollars planned to be subcontracted to veteran-owned small business concerns;

(iv) Total dollars planned to be subcontracted to service-disabled veteran-owned small business;

(v) Total dollars planned to be subcontracted to HUBZone small business concerns;

(vi) Total dollars planned to be subcontracted to small disadvantaged business concerns (including ANC and Indian tribes); and

(vii) Total dollars planned to be subcontracted to women-owned small business concerns.

(3) A description of the principal types of supplies and services to be subcontracted, and an identification of the types planned for subcontracting to—

(i) Small business concerns;

(ii) Veteran-owned small business concerns;

(iii) Service-disabled veteran-owned small business concerns;

(iv) HUBZone small business concerns;

(v) Small disadvantaged business concerns; and

(vi) Women-owned small business concerns.

(4) A description of the method used to develop the subcontracting goals in paragraph (d)(1) of this clause.

(5) A description of the method used to identify potential sources for solicitation purposes (*e.g.,* existing company source lists, SAM, veterans service organizations, the National Minority Purchasing Council Vendor Information Service, the Research and Information Division of the Minority Business Development Agency in the Department of Commerce, or small, HUBZone, small disadvantaged, and women-owned small business

trade associations). A firm may rely on the information contained in SAM as an accurate representation of a concern's size and ownership characteristics for the purposes of maintaining a small, veteran-owned small, service-disabled veteran-owned small, HUBZone small, small disadvantaged, and women-owned small business source list. Use of SAM as its source list does not relieve a firm of its responsibilities (*e.g.,* outreach, assistance, counseling, or publicizing subcontracting opportunities) in this clause.

(6) A statement as to whether or not the Offeror included indirect costs in establishing subcontracting goals, and a description of the method used to determine the proportionate share of indirect costs to be incurred with—

(i) Small business concerns (including ANC and Indian tribes);

(ii) Veteran-owned small business concerns;

(iii) Service-disabled veteran-owned small business concerns;

(iv) HUBZone small business concerns;

(v) Small disadvantaged business concerns; and

(vi) Women-owned small business concerns.

(7) The name of the individual employed by the Offeror who will administer the Offeror's subcontracting program, and a description of the duties of the individual.

(8) A description of the efforts the Offeror will make to assure that small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns have an equitable opportunity to compete for subcontracts.

(9) Assurances that the Offeror will include the clause of this contract entitled "Utilization of Small Business Concerns" in all subcontracts that offer further subcontracting opportunities, and that the Offeror will require all subcontractors (except small business concerns) that receive subcontracts in excess of the applicable threshold specified in FAR 19.702(a) on the date of subcontract award, with further subcontracting possibilities to adopt a subcontracting plan that complies with the requirements of this clause.

(10) Assurances that the Offeror will—

(i) Cooperate in any studies or surveys as may be required;

(ii) Submit periodic reports so that the Government can determine the extent of compliance by the Offeror with the subcontracting plan;

(iii) After November 30, 2017, include subcontracting data for each order when reporting subcontracting achievements for indefinite-delivery, indefinite-quantity contracts with individual subcontracting plans where the contract is intended for use by multiple agencies;

(iv) Submit Standard Form (SF) 294 Subcontracting Report for Individual Contract in accordance with paragraph (l) of this clause. Submit the Summary Subcontract Report (SSR), in accordance with paragraph (l) of this clause. The reports shall provide information on subcontract awards to small business concerns (including ANCs and Indian tribes that are not small businesses), veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns (including ANCs and Indian tribes that have not been certified by the Small Business Administration as small disadvantaged businesses), women-owned small business concerns, and for NASA only, Historically Black Colleges and Universities and Minority Institutions. Reporting shall be in accordance with this clause, or as provided in

agency regulations;

(v) Ensure that its subcontractors with subcontracting plans agree to submit the SF 294 in accordance with paragraph (l) of this clause. Ensure that its subcontractors with subcontracting plans agree to submit the SSR in accordance with paragraph (l) of this clause

(vi) [RESERVED]; and

(vii) Require that each subcontractor with a subcontracting plan provide the prime contract number, its own unique entity identifier, and the e-mail address of the subcontractor's official responsible for acknowledging receipt of or rejecting the Standard Forms 294, to its subcontractors with subcontracting plans.

(11) A description of the types of records that will be maintained concerning procedures that have been adopted to comply with the requirements and goals in the plan, including establishing source lists; and a description of the offeror's efforts to locate small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns and award subcontracts to them. The records shall include at least the following (on a plant-wide or company-wide basis, unless otherwise indicated):

(i) Source lists (*e.g.,* SAM), guides, and other data that identify small business, veteran- owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns.

(ii) Organizations contacted in an attempt to locate sources that are small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, or women-owned small business concerns.

(iii) Records on each subcontract solicitation resulting in an award of more than the simplified acquisition threshold, as defined in FAR 2.101 on the date of subcontract award, indicating—

(A) Whether small business concerns were solicited and, if not, why not;

(B) Whether veteran-owned small business concerns were solicited and, if not, why not;

(C) Whether service-disabled veteran-owned small business concerns were solicited and, if not, why not;

(D) Whether HUBZone small business concerns were solicited and, if not, why not;

(E) Whether small disadvantaged business concerns were solicited and, if not, why not;

(F) Whether women-owned small business concerns were solicited and, if not, why not; and

(G) If applicable, the reason award was not made to a small business concern.

(iv) Records of any outreach efforts to contact—

(A) Trade associations;

(B) Business development organizations;

(C) Conferences and trade fairs to locate small, HUBZone small, small disadvantaged service-disabled veteran-owned, and women-owned small business sources; and

(D) Veterans service organizations.

(v) Records of internal guidance and encouragement provided to buyers through—

(A) Workshops, seminars, training, etc.; and

(B) Monitoring performance to evaluate compliance with the program's

requirements.

(vi) On a contract-by-contract basis, records to support award data submitted by the offeror to the Government, including the name, address, and business size of each subcontractor. Contractors having commercial plans need not comply with this requirement.

(12) Assurances that the Offeror will make a good faith effort to acquire articles, equipment, supplies, services, or materials, or obtain the performance of construction work from the small business concerns that it used in preparing the bid or proposal, in the same or greater scope, amount, and quality used in preparing and submitting the bid or proposal. Responding to a request for a quote does not constitute use in preparing a bid or proposal. The Offeror used a small business concern in preparing the bid or proposal if–

(i) The Offeror identifies the small business concern as a subcontractor in the bid or proposal or associated small business subcontracting plan, to furnish certain supplies or perform a portion of the subcontract; or

(ii) The Offeror used the small business concern's pricing or cost information or technical expertise in preparing the bid or proposal, where there is written evidence of an intent or understanding that the small business concern will be awarded a subcontract for the related work if the Offeror is awarded the contract.

(13) Assurances that the Contractor will provide the Contracting Officer with a written explanation if the Contractor fails to acquire articles, equipment, supplies, services or materials or obtain the performance of construction work as described in (d)(12) of this clause. This written explanation must be submitted to the Contracting Officer within 30 days of contract completion.

(14) Assurances that the Contractor will not prohibit a subcontractor from discussing with the Contracting Officer any material matter pertaining to payment to or utilization of a subcontractor.

(15) Assurances that the Offeror will pay its small business subcontractors on time and in accordance with the terms and conditions of the underlying subcontract, and notify the contracting officer when the prime contractor makes either a reduced or an untimely payment to a small business subcontractor (see 52.242-5).

(e) In order to effectively implement this plan to the extent consistent with efficient contract performance, the Contractor shall perform the following functions:

(1) Assist small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns by arranging solicitations, time for the preparation of bids, quantities, specifications, and delivery schedules so as to facilitate the participation by such concerns. Where the Contractor's lists of potential small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business subcontractors are excessively long, reasonable effort shall be made to give all such small business concerns an opportunity to compete over a period of time.

(2) Provide adequate and timely consideration of the potentialities of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns in all "make-or-buy" decisions.

(3) Counsel and discuss subcontracting opportunities with representatives of small business, veteran-owned small business, service-disabled veteran-owned small business,

HUBZone small business, small disadvantaged business, and women-owned small business firms.

(4) Confirm that a subcontractor representing itself as a HUBZone small business concern is certified by SBA as a HUBZone small business concern in accordance with 52.219-8(d)(2).

(5) Provide notice to subcontractors concerning penalties and remedies for misrepresentations of business status as small, veteran-owned small business, HUBZone small, small disadvantaged, or women-owned small business for the purpose of obtaining a subcontract that is to be included as part or all of a goal contained in the Contractor's subcontracting plan.

(6) For all competitive subcontracts over the simplified acquisition threshold, as defined in FAR 2.101 on the date of subcontract award, in which a small business concern received a small business preference, upon determination of the successful subcontract Offeror, prior to award of the subcontract the Contractor must inform each unsuccessful small business subcontract Offeror in writing of the name and location of the apparent successful Offeror and if the successful subcontract Offeror is a small business, veteran-owned small business, service-disabled veteran- owned small business, HUBZone small business, small disadvantaged business, or women- owned small business concern.

(7) Assign each subcontract the NAICS code and corresponding size standard that best describes the principal purpose of the subcontract.

(f) A master subcontracting plan on a plant or division-wide basis that contains all the elements required by paragraph (d) of this clause, except goals, may be incorporated by reference as a part of the subcontracting plan required of the Offeror by this clause; provided—

(1) The master subcontracting plan has been approved;

(2) The Offeror ensures that the master subcontracting plan is updated as necessary and provides copies of the approved master subcontracting plan, including evidence of its approval, to the Contracting Officer; and

(3) Goals and any deviations from the master subcontracting plan deemed necessary by the Contracting Officer to satisfy the requirements of this contract are set forth in the individual subcontracting plan.

(g) A commercial plan is the preferred type of subcontracting plan for contractors furnishing commercial items. The commercial plan shall relate to the offeror's planned subcontracting generally, for both commercial and Government business, rather than solely to the Government contract. Once the Contractor's commercial plan has been approved, the Government will not require another subcontracting plan from the same Contractor while the plan remains in effect, as long as the product or service being provided by the Contractor continues to meet the definition of a commercial item. A Contractor with a commercial plan shall comply with the reporting requirements stated in paragraph (d)(10) of this clause by submitting one SSR for all contracts covered by its commercial plan. This report shall be acknowledged or rejected by the Contracting Officer who approved the plan. This report shall be submitted within 30 days after the end of the Government's fiscal year.

(h) Prior compliance of the offeror with other such subcontracting plans under previous contracts will be considered by the Contracting Officer in determining the responsibility of the offeror for award of the contract.

(i) A contract may have no more than one subcontracting plan. When a contract

modification exceeds the subcontracting plan threshold in 19.702(a), or an option is exercised, the goals of the existing subcontracting plan shall be amended to reflect any new subcontracting opportunities. When the goals in a subcontracting plan are amended, these goal changes do not apply retroactively.

(j) Subcontracting plans are not required from subcontractors when the prime contract contains the clause at 52.212-5, Contract Terms and Conditions Required to Implement Statutes or Executive Orders—Commercial Items, or when the subcontractor provides a commercial item subject to the clause at 52.244-6, Subcontracts for Commercial Items, under a prime contract.

(k)The failure of the Contractor or subcontractor to comply in good faith with—

(1) the clause of this contract entitled "Utilization Of Small Business Concerns," or

(2) an approved plan required by this clause, shall be a material breach of the contract and may be considered in any past performance evaluation of the Contractor.

(l) The Contractor shall submit a SF 294. Purchases from a corporation, company, or subdivision that is an affiliate of the Contractor or subcontractor are not included in these reports. Subcontract awards by affiliates shall be treated as subcontract awards by the Contractor. Subcontract award data reported by the Contractor and subcontractors shall be limited to awards made to their immediate next-tier subcontractors. Credit cannot be taken for awards made to lower tier subcontractors, unless the Contractor or subcontractor has been designated to receive a small business or small disadvantaged business credit from an ANC or Indian tribe. Only subcontracts involving performance in the U.S. or its outlying areas should be included in these reports with the exception of subcontracts under a contract awarded by the State Department or any other agency that has statutory or regulatory authority to require subcontracting plans for subcontracts performed outside the United States and its outlying areas.

(1) SF 294. This report is not required for commercial plans. The report is required for each contract containing an individual subcontracting plan.

(i) The report shall be submitted semi-annually during contract performance for the periods ending March 31 and September 30. A report is also required for each contract within 30 days of contract completion. Reports are due 30 days after the close of each reporting period, unless otherwise directed by the Contracting Officer. Reports are required when due, regardless of whether there has been any subcontracting activity since the inception of the contract or the previous reporting period. When a Contracting Officer rejects a report, the Contractor shall submit a revised report within 30 days of receiving the notice of report rejection.

(ii) (A) When a subcontracting plan contains separate goals for the basic contract and each option, as prescribed by FAR 19.704(c), the dollar goal inserted on this report shall be the sum of the base period through the current option; for example, for a report submitted after the second option is exercised, the dollar goal would be the sum of the goals for the basic contract, the first option, and the second option.

(B) If a subcontracting plan has been added to the contract pursuant to 19.702(a)(3) or 19.301-2(e), the Contractor's achievements must be reported in the report on a cumulative basis from the date of incorporation of the subcontracting plan into the contract.

(iii) When a subcontracting plan includes indirect costs in the goals, these costs must be included in this report.

(iv) The authority to acknowledge receipt or reject the SF 294 resides–

(A) In the case of the prime Contractor, with the Contracting Officer; and

(B) In the case of a subcontract with a subcontracting plan, with the entity that awarded the subcontract.

(2) SSR. (i) Reports submitted under individual contract plans.

(A) This report encompasses all subcontracting under prime contracts and subcontracts with an executive agency, regardless of the dollar value of the subcontracts. This report also includes indirect costs on a prorated basis when the indirect costs are excluded from the subcontracting goals.

(B) The report may be submitted on a corporate, company or subdivision (e.g., plant or division operating as a separate profit center) basis, unless otherwise directed by the agency.

(C) If the Contractor and/or a subcontractor is performing work for more than one executive agency, a separate report shall be submitted to each executive agency covering only that agency's contracts, provided at least one of that agency's contracts is over the applicable threshold specified in FAR 19.702(a), and the contract contains a subcontracting plan. For DoD, a consolidated report shall be submitted for all contracts awarded by military departments/agencies and/or subcontracts awarded by DoD prime contractors.

(D) The report shall be submitted annually by October 30, for the twelve month period ending September 30. When a Contracting Officer rejects an SSR, the Contractor is required to submit a revised SSR within 30 days of receiving the notice of report rejection.

(E) Subcontract awards that are related to work for more than one executive agency shall be appropriately allocated.

(F) The authority to acknowledge or reject SSRs, including SSRs submitted by subcontractors with subcontracting plans, resides with the Government agency awarding the prime contracts unless stated otherwise in the contract.

(ii) Reports submitted under a commercial plan.

(A) The report shall include all subcontract awards under the commercial plan in effect during the Government's fiscal year and all indirect costs.

(B) The report shall be submitted annually, within 30 days after the end of the Government's fiscal year.

(C) If a Contractor has a commercial plan and is performing work for more than one executive agency, the Contractor shall specify the percentage of dollars attributable to each agency.

(D) The authority to acknowledge or reject SSRs for commercial plans resides with the Contracting Officer who approved the commercial plan.

APPENDIX F

Measures and contributions to performance areas and scores for 2021 Performance and 2022 Service Charge

To be performed in accordance with the 2021 FEHB Plan Performance Assessment Procedure Manual and the FEHB Plan Performance Assessment Methodology Carrier Letter (CL 2020-15). The Service Charge for the 2022 contract year will be based on the Overall Performance Score calculated in accordance with this Appendix F.

1. Performance Area Contributions to Overall Performance Score (OPS)

Performance Area	Contribution to Overall Performance Score
Clinical Quality, Customer Service, and Resource Use	65%
Contract Oversight	35%

2. Clinical Quality, Customer Service, and Resource Use (QCR) Performance Area Measures

Performance Area	Measure	Abbrv	Measure Source	Priority Level	Measure Weight
Clinical Quality	Controlling High Blood Pressure	CBP	HEDIS	1	2.50
	Comprehensive Diabetes Care (HbA1c <8.0%)	CDC	HEDIS	1	2.50
	Prenatal and Postpartum Care (Timeliness of Prenatal Care)	PPC	HEDIS	1	2.50
	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)	AAB(18-64)	HEDIS	2	1.25
	Asthma Medication Ratio	AMR	HEDIS	2	1.25
	Breast Cancer Screening	BCS	HEDIS	2	1.25

	Cervical Cancer Screening	CCS	HEDIS	2	1.25
	Colorectal Cancer Screening	COL	HEDIS	2	1.25
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dep. (30 Day)	FUA30	HEDIS	2	1.25
	Follow-Up After Emergency Department Visit for Mental Illness (30 Day)	FUM30	HEDIS	2	1.25
	Flu Vaccinations for Adults (18-64)	FVA	CAHPS	2	1.25
	Statin Therapy for Patients with Cardiovascular Disease (Adherence)	SPC	HEDIS	2	1.25
	Well-Child Visits in the First 30 Months of Life (First 15 Months)	W30(15)	HEDIS	2	1.25
Customer Service	Coordination of Care	CoC	CAHPS	3	1.00
	Claims Processing	CP	CAHPS	3	1.00
	Getting Care Quickly	GCQ	CAHPS	3	1.00
	Getting Needed Care	GNC	CAHPS	3	1.00
	Overall Health Plan Rating	RHP	CAHPS	3	1.00
	Overall Personal Doctor Rating	RPD	CAHPS	3	1.00
Resource Use	Use of Imaging Studies for Low Back Pain	LBP	HEDIS	1	2.50

EXHIBIT G

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Standard Contract Amendment

For

Fee-For-Service Carriers

2023

AMENDMENT TO CONTRACT CS XXXX

CONTRACT NO: 1039
EFFECTIVE: January 1, 2023

AMENDMENT NO. 2023A
EFFECTIVE: January 1, 2023

BETWEEN: THE UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
hereafter called the OPM, the Agency, or the Government

Address: 1900 E Street, NW
Washington, DC 20415-3610

AND

CONTRACTOR: Blue Cross and Blue Shield Association
hereafter also called the Carrier

Address: 1310 G Street, NW
Washington, DC 20005

In consideration of payment by the Agency of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract, including Appendix A.

FOR THE CARRIER	FOR THE GOVERNMENT
William A. Breskin	Sylvia V. Pulley
Name of Person Authorized to Execute Contract	Name of Contracting Officer
Title: Senior Vice President Government Programs	Title: Contracting Officer
William A. Breskin	Sylvia V. Pulley
Signature	Signature
12/19/2022	12/28/2022
Date Signed	*Date Signed*

1. **Section 1.5 Enrollment Records and Information**

This section changes the title of Section 1.5 and adds a new paragraph (f) that links the quality and timeliness of a Carrier's Master Enrollment Index (MEI) file submissions to its score for the Contract Oversight performance area of the Plan Performance Assessment.

SECTION 1.5
ENROLLMENT RECORDS AND INFORMATION (JAN 2023)

(a) OPM shall maintain or cause to be maintained records from which the Carrier may determine the names and social security numbers of all Enrollees. OPM, other agencies of the Federal Government, Tribal Employer, or the FEHB Clearinghouse shall furnish the information to the Carrier at such times and in such form and detail as will enable the Carrier to maintain a currently accurate record of all Enrollees.

(b) The Carrier is entitled to rely on information furnished to it under paragraph (a). OPM agrees that any liabilities incurred under this contract in reliance upon such information shall be a valid charge against the contract. Errors or delays in keeping or reporting data relating to coverage shall not invalidate coverage that would otherwise be validly in force and shall not continue coverage that would otherwise be terminated. OPM shall make an equitable adjustment of premiums upon discovery of errors or delays under this Section.

(c) Clerical error (whether by OPM, any other agency, Tribal Employer, the FEHB Clearinghouse, or the Carrier) in keeping records pertaining to coverage under this contract, delays in making entries thereon, or failure to make or account for any deduction of enrollment charges, shall not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. OPM shall make an equitable adjustment of premiums when an error, delay, or failure is discovered. If any person finds relevant facts pertaining to a person covered under this contract to be misstated, and if the misstatement affects the existence, amount, or extent of coverage, the actual facts shall determine whether coverage is in force under the terms of this contract and in what amount or to what extent. Any claim payments the Carrier makes before an adjustment or determination shall be a valid charge against this contract.

(d) The OPM shall direct the agencies and Tribal Employers to provide the Carrier or the FEHB Clearinghouse, not less often than quarterly, the names of Enrollees enrolled under the contract by payroll office and the premium paid for those Enrollees for the current pay cycle. The Carrier shall at least quarterly reconcile its enrollment records with those provided by the Government, the Tribal Employer, or the FEHB Clearinghouse.

(e) In instances of erroneous enrollments where benefit payments have been made in error, the Carrier must inform Enrollees within forty-five days of when the Carrier receives notification from the agency or the Tribal Employer that the Carrier will collect for these benefit payments. The Carrier shall provide notice to the Enrollees that they have the right to contest their enrollment change with their agency, Tribal Employer, or their retirement system.

(f) The Carrier shall submit enrollment data files on an ongoing basis to OPM's Master Enrollment Index (MEI) in a form and manner prescribed by OPM. The Carrier's enrollment data files must provide timely, accurate, and complete information to the MEI.

2. **Section 2.2 Benefits Provided**

This section amends (h)(2)(ii) that references the 2013 HHS regulation (45 C.FR. 146.136).

SECTION 2.2
BENEFITS PROVIDED (JAN 2023)

(a) The Carrier shall provide the benefits as described in the agreed upon brochure text found in Appendix A.

(b) In addition to providing benefits in accordance with (a) above, the Carrier shall be authorized to modify them as follows:

(1) To permit methods of treatment not expressly provided for, but not prohibited by law, rule or Federal policy, if otherwise contractually appropriate, and if such treatment is medically necessary and is as cost effective as providing benefits to which the Member may otherwise be entitled.

(2) To pay for or provide a health service or supply in an individual case which does not come within the specific benefit provisions of the contract, if the Carrier determines the benefit is within the intent of the contract, and the Carrier determines that the provision of such benefit is in the best interests of the Federal Employees Health Benefits Program.

(3) To offer in individual cases, after consultation with and concurrence by the Member and provider(s), a benefit alternative not ordinarily covered under this contract which will result in equally effective medical treatment at no greater benefit cost. An alternative benefit will be made available for a limited time period and is subject to the Carrier's ongoing review. Members must cooperate with the Carrier's review process.

(c)The decision to offer, deny, or withdraw coverage for a modified benefit provided in accordance with (b) above is solely within the Carrier's discretion (unless the Carrier and Member have entered into an alternative benefits agreement that expressly modifies this authority), and is not subject to OPM review under the disputed claims process.

(d) In each case when the Carrier provides a non-covered benefit in accordance with the authority of (b) above, the Carrier shall document in writing prior to the provision of such benefit the reasons and justification for its determination. The writing may be in the form of an alternative benefit agreement with the Member. Such payment or provision of services or supplies while a valid charge under the contract shall not be considered to be a precedent in the disposition of similar cases or extensions in the same case beyond the approved period.

(e) Except as provided for in (b) above, the Carrier shall provide benefits for services or supplies in accordance with Appendix A.

(f) The Carrier, subject to (g) below, shall determine whether in its judgment a service or supply is medically necessary or payable under this contract.

(g) The Carrier agrees to pay for or provide a health service or supply in an individual case if OPM finds that the Member is entitled thereto under the terms of the contract.

(h) (1) Notwithstanding (b) and (e) above, in accordance with the Rehabilitation Act of 1973, in the case of a Member who is a qualified individual with a disability, the Carrier shall pay for or provide a covered health service or supply as an alternative benefit appropriate to the Member's needs, when required by OPM following OPM consultation with the Carrier, pursuant to paragraph 2.2(g), above.

(2)(i) An OPM requirement under (h)(1) is subject to ongoing review by OPM and the Carrier. Members must cooperate with the review process. If, in the Carrier's judgment, the conditions for the OPM requirement are no longer satisfied, the Carrier may request that OPM modify or terminate the requirement. OPM's decision to modify or terminate a requirement shall be subject to judicial review.

(ii) The Carrier agrees that its benefits as described in the brochure found at Appendix A, are reasonably and in good faith expected to result in coverage that satisfies the Mental Health Parity and Addiction Equity Act, as amended.

(i) In accordance with Section 2706(a) of the Public Health Service Act as added by the Affordable Care Act, the Carrier shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require the Carrier to contract with any health care provider willing to abide by the terms and conditions for participation established by the carrier. Nothing in this section shall be construed as preventing a Carrier from establishing varying reimbursement rates based on quality or performance measures.

3. Section 4.1 Alterations in Contract

Updated to correct typographical error and to align with terms used in FAR 52.232-33 and Section 5.58 of the contract.

SECTION 4.1
ALTERATIONS IN CONTRACT (JAN 1998) (FAR 52.252-4)

Portions of this contract are altered as follows:

(--) Section 3.2(b)(2)(ii) of this contract is amended to comply with 5 U.S.C. 8909(f) as follows:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(--) Section 1.14, *Misleading, Deceptive, or Unfair Advertising*, is amended by removing the reference to the NAIC Advertisements of Accident and Sickness Insurance Model Regulation. Carrier should continue to use the FEHB Supplemental Literature Guidelines (now at the renumbered Appendix C) along with FEHBAR 1603.7002.

(--) Section 5.58. The reference to System for Award Management (SAM) in FAR 52.232-33, Payment by Electronic Funds Transfer-System for Award Management (SAM), is not applicable to this contract.

4. Section 5.44 Authorized Deviations in Clauses

Correction to the FAR Citation Date

SECTION 5.44
AUTHORIZED DEVIATIONS IN CLAUSES (NOV 2020) (FAR 52.252-6)

5. **Section 5.47 Protecting the Government's Interest when Subcontracting With Contractors Debarred, Suspended or Proposed For Debarment**

Updated per changes to the FAR

SECTION 5.47
PROTECTING THE GOVERNMENT'S INTEREST WHEN SUBCONTRACTING WITH CONTRACTORS DEBARRED, SUSPENDED OR PROPOSED FOR DEBARMENT (NOV 2021) (FAR 52.209-6)

(a) Definition. "Commercially available off-the-shelf (COTS)" item, as used in this clause—

(1) Means any item of supply (including construction material) that is—

(i) A commercial product (as defined in paragraph (1) of the definition of "commercial product" in Federal Acquisition Regulation (FAR) 2.101);

(ii) Sold in substantial quantities in the commercial marketplace; and

(iii) Offered to the Government, under a contract or subcontract at any tier, without modification, in the same form in which it is sold in the commercial marketplace; and

(2) Does not include bulk cargo, as defined in 46 U.S.C. 40102(4), such as agricultural products and petroleum products.

(b) The Government suspends or debars Contractors to protect the Government's interests. Other than a subcontract for a commercially available off-the-shelf item, the Contractor shall not enter into any subcontract, in excess of the threshold specified in FAR 9.405-2(b) on the date of subcontract award with a Contractor that is debarred, suspended, or proposed for debarment by any executive agency unless there is a compelling reason to do so.

(c) The Contractor shall require each proposed subcontractor whose subcontract will exceed the threshold specified in FAR 9.405-2(b) on the date of subcontract award, other than a subcontractor providing a commercially available off-the-shelf item, to disclose to the Contractor, in writing, whether as of the time of award of the subcontract, the subcontractor, or its principals, is or is not debarred, suspended, or proposed for debarment by the Federal Government.

(d) A corporate officer or a designee of the Contractor shall notify the Contracting Officer, in writing, before entering into a subcontract with a party (other than a subcontractor providing a commercially available off-the-shelf item) that is debarred, suspended, or proposed for debarment (see FAR 9.404 for information on the System for Award Management (SAM) Exclusions). The notice must include the following:

(1) The name of the subcontractor.

(2) The Contractor's knowledge of the reasons for the subcontractor being listed with an exclusion in SAM.

(3) The compelling reason(s) for doing business with the subcontractor notwithstanding its being listed with an exclusion in SAM.

(4) The systems and procedures the Contractor has established to ensure that it is fully protecting the Government's interests when dealing with such subcontractor in view of the specific basis for the party's debarment, suspension, or proposed debarment.

(e) Subcontracts. Unless this is a contract for the acquisition of commercial products or commercial services, the Contractor shall include the requirements of this clause, including this paragraph (e) (appropriately modified for the identification of the parties), in each subcontract that—

(1) Exceeds the threshold specified in FAR 9.405-2(b) on the date of subcontract award; and

(2) Is not a subcontract for commercially available off-the-shelf items.

6. **Section 5.56 Authorization and Consent**

Correction to the FAR Citation Date

SECTION 5.56
AUTHORIZATION AND CONSENT (JUN 2020) (FAR 52.227-1)

7. **Section 5.60 Subcontracts for Commercial Products and Commercial Services**

Updated per changes to the FAR

SECTION 5.60
SUBCONTRACTS FOR COMMERCIAL PRODUCTS AND COMMERCIAL SERVICES (JAN 2022) (FAR 52.244-6)

(a) Definitions. As used in this clause —

"Commercial product," "commercial service," and "commercially available off-the-shelf item" have the meanings contained in Federal Acquisition Regulation 2.101.

"Subcontract" includes a transfer of commercial products or commercial services between divisions, subsidiaries, or affiliates of the Contractor or subcontractor at any tier.

(b) To the maximum extent practicable, the Contractor shall incorporate, and require its subcontractors at all tiers to incorporate, commercial products, commercial services, or non-developmental items as components of items to be supplied under this contract.

(c)(1) The Contractor shall insert the following clauses in subcontracts for commercial products or commercial services:

(i) 52.203-13, Contractor Code of Business Ethics and Conduct (NOV 2021) (41 U.S.C. 3509), if the subcontract exceeds the threshold specified in FAR 3.1004(a) on the date of subcontract award, and has a performance period of more than 120 days. In altering this clause to identify the appropriate parties, all disclosures of violation of the civil False Claims Act or of Federal criminal law shall be directed to the agency Office of the Inspector General, with a copy to the Contracting Officer.

(ii) 52.203-15, Whistleblower Protections Under the American Recovery and Reinvestment Act of 2009 (Jun 2010) (Section 1553 of Pub. L. 111-5), if the subcontract is funded under the Recovery Act.

(iii) 52.203-19, Prohibition on Requiring Certain Internal Confidentiality Agreements or Statements (JAN 2017).

(iv) 52.204–21, Basic Safeguarding of Covered Contractor Information Systems (NOV 2021), other than subcontracts for commercially available off-the-shelf items, if flow down is required in accordance with paragraph (c) of FAR clause 52.204–21.

(v) 52.204-23, Prohibition on Contracting for Hardware, Software, and Services Developed or Provided by Kaspersky Lab and Other Covered Entities (NOV 2021) (Section 1634 of Pub. L. 115-91).

(vi) 52.204-25, Prohibition on Contracting for Certain Telecommunications and Video Surveillance Services or Equipment. (NOV 2021) (Section 889(a)(1)(A) of Pub. L. 115-232).

(vii) 52.219-8, Utilization of Small Business Concerns (OCT 2018) (15 U.S.C. 637(d)(2) and (3)) if the subcontract offers further subcontracting opportunities. If the subcontract (except subcontracts to small business concerns) exceeds, the applicable threshold specified in FAR 19.702(a) on the date of subcontract award, the subcontractor must include 52.219-8 in lower tier subcontracts that offer subcontracting opportunities.

(viii) 52.222-21 Prohibition of Segregated Facilities (Apr 2015)

(ix) 52.222-26, Equal Opportunity (Sep 2015) (E.O. 11246).

(x) 52.222-35, Equal Opportunity for Veterans (Jun 2020) (38 U.S.C. 4212(a).

(xi) 52.222-36, Equal Opportunity for Workers with Disabilities (Jun 2020) (29 U.S.C. 793).

(xii) 52.222-37, Employment Reports on Veterans (Jun 2020) (38 U.S.C. 4212).

(xiii) 52.222-40, Notification of Employee Rights Under the National Labor Relations Act (Dec 2010) (E.O. 13496), if flow down is required in accordance with paragraph (f) of FAR clause 52.222-40.

(xiv)(A) 52.222-50, Combating Trafficking in Persons (NOV 2021) (22 U.S.C. chapter 78 and E.O. 13627).

(B) Alternate I (MAR 2015) of 52.222-50 (22 U.S.C. chapter 78 and E.O. 13627).

(xv) 52.222-55 , Minimum Wages for Contractor Workers under Executive Order 14026 (JAN 2022), if flow down is required in accordance with paragraph (k) of FAR clause 52.222-55.

(xvi) 52.222-62, Paid Sick Leave Under Executive Order 13706 (JAN 2022) (E.O. 13706), if flowdown is required in accordance with paragraph (m) of FAR clause 52.222-62.

(xvii) (A) 52.224-3, Privacy Training (Jan 2017) (5 U.S.C. 552a) if flow down is required in accordance with 52.224-3(f).

(B) Alternate I (Jan 2017) of 52.224-3, if flow down is required in accordance with 52.224-3(f) and the agency specifies that only its agency-provided training is acceptable).

(xviii) 52.225-26, Contractors Performing Private Security Functions Outside the United States (Oct 2016) (Section 862, as amended, of the National Defense Authorization Act for Fiscal Year 2008; 10 U.S.C. 2302 Note).

(xix) 52.232-40, Providing Accelerated Payments to Small Business Subcontractors (NOV 2021) if flow down is required in accordance with paragraph (c) of FAR clause 52.232-40.

(xx) 52.247-64, Preference for Privately Owned U.S.-Flag Commercial Vessels (NOV 2021) 46 U.S.C. 55305 and 10 U.S.C. 2631), if flow down is required in accordance with paragraph (d) of FAR clause 52.247-64).

(2) While not required, the Contractor may flow down to subcontracts for commercial products or commercial services a minimal number of additional clauses necessary to satisfy its contractual obligations.

(d) The Contractor shall include the terms of this clause, including this paragraph (d), in subcontracts awarded under this contract.

8. Section 5.64 Contractor Code of Business Ethics and Conduct

Updated per changes to the FAR

SECTION 5.64
CONTRACTOR CODE OF BUSINESS ETHICS AND CONDUCT (NOV 2021) (FAR 52.203–13).

(a) *Definitions*. As used in this clause--

Agent means any individual, including a director, an officer, an employee, or an independent Contractor, authorized to act on behalf of the organization.

Full cooperation--(1) Means disclosure to the Government of the information sufficient for law enforcement to identify the nature and extent of the offense and the individuals responsible for the conduct. It includes providing timely and complete response to Government auditors' and investigators' request for documents and access to employees with information;

(2) Does not foreclose any Contractor rights arising in law, the FAR, or the terms of the contract. It does not require--

(i) A Contractor to waive its attorney-client privilege or the protections afforded by the attorney work product doctrine; or

(ii) Any officer, director, owner, or employee of the Contractor, including a sole proprietor, to waive his or her attorney client privilege or Fifth Amendment rights; and

(3) Does not restrict a Contractor from--

(i) Conducting an internal investigation; or

(ii) Defending a proceeding or dispute arising under the contract or related to a potential or disclosed violation.

"*Principal*" means an officer, director, owner, partner, or a person having primary management or supervisory responsibilities within a business entity (e.g., general manager; plant manager; head of a division, or business segment; and similar positions).

"*Subcontract*" means any contract entered into by a subcontractor to furnish supplies or services for performance of a prime contract or a subcontract.

"*Subcontractor*" means any supplier, distributor, vendor, or firm that furnished supplies or services to or for a prime contractor or another subcontractor.

"*United States*" means the 50 States, the District of Columbia, and outlying areas.

(b) *Code of business ethics and conduct*.

(1) Within 30 days after contract award, unless the Contracting Officer establishes a longer time period, the Contractor shall—

(i) Have a written code of business ethics and conduct; and

(ii) Make a copy of the code available to each employee engaged in performance of the contract.

(2) The Contractor shall--

(i) Exercise due diligence to prevent and detect criminal conduct; and

(ii) Otherwise promote an organizational culture that encourages ethical conduct and a commitment to compliance with the law.

(3)(i) The Contractor shall timely disclose, in writing, to the agency Office of the Inspector General (OIG), with a copy to the Contracting Officer, whenever, in connection with the award, performance, or closeout of this contract or any subcontract thereunder, the Contractor has credible evidence that a principal, employee, agent, or subcontractor of the Contractor has committed--

(A) A violation of Federal criminal law involving fraud, conflict of interest, bribery, or gratuity violations found in Title 18 of the United States Code; or

(B) A violation of the civil False Claims Act (31 U.S.C. 3729-3733).

(ii) The Government, to the extent permitted by law and regulation, will safeguard and treat information obtained pursuant to the Contractor's disclosure as confidential where the information has been marked ``confidential" or ``proprietary" by the company. To the extent permitted by law and regulation, such information will not be released by the Government to the public pursuant to a Freedom of Information Act request, 5 U.S.C. Section 552, without prior notification to the Contractor. The Government may transfer documents provided by the Contractor to any department or agency within the Executive Branch if the information relates to matters within the organization's jurisdiction.

(iii) If the violation relates to an order against a Governmentwide acquisition contract, a multi-agency contract, a multiple-award schedule contract such as the Federal Supply Schedule, or any other procurement instrument intended for use by multiple agencies, the Contractor shall notify the OIG of the ordering agency and the IG of the agency responsible for the basic contract.

(c) Business ethics awareness and compliance program and internal control system. This paragraph (c) does not apply if the Contractor has represented itself as a small business concern pursuant to the award of this contract or if this contract is for the acquisition of a commercial product or commercial service as defined at FAR 2.101. The Contractor shall establish the following within 90 days after contract award, unless the Contracting Officer establishes a longer time period:

(1) An ongoing business ethics awareness and compliance program.

(i) This program shall include reasonable steps to communicate periodically and in a practical manner the Contractor's standards and procedures and other aspects of the Contractor's business ethics awareness and compliance program and internal control system, by conducting effective training programs and otherwise disseminating information appropriate to an individual's respective roles and responsibilities.

(ii) The training conducted under this program shall be provided to the Contractor's principals and employees, and as appropriate, the Contractor's agents and subcontractors.

(2) An internal control system.

(i) The Contractor's internal control system shall--

(A) Establish standards and procedures to facilitate timely discovery of improper conduct in connection with Government contracts; and

(B) Ensure corrective measures are promptly instituted and carried out.

(ii) At a minimum, the Contractor's internal control system shall provide for the following:

(A) Assignment of responsibility at a sufficiently high level and adequate resources to ensure effectiveness of the business ethics awareness and compliance program and internal control system.

(B) Reasonable efforts not to include an individual as a principal, whom due diligence would have exposed as having engaged in conduct that is in conflict with the Contractor's code of business ethics and conduct.

(C) Periodic reviews of company business practices, procedures, policies, and internal controls for compliance with the Contractor's code of business ethics and conduct and the special requirements of Government contracting, including--

(1) Monitoring and auditing to detect criminal conduct;

(2) Periodic evaluation of the effectiveness of the business ethics awareness and compliance program and internal control system, especially if criminal conduct has been detected; and

(3) Periodic assessment of the risk of criminal conduct, with appropriate steps to design, implement, or modify the business ethics awareness and compliance program and the internal control system as necessary to reduce the risk of criminal conduct identified through this process.

(D) An internal reporting mechanism, such as a hotline, which allows for anonymity or confidentiality, by which employees may report suspected instances of improper conduct, and instructions that encourage employees to make such reports.

(E) Disciplinary action for improper conduct or for failing to take reasonable steps to prevent or detect improper conduct.

(F) Timely disclosure, in writing, to the agency OIG, with a copy to the Contracting Officer, whenever, in connection with the award, performance, or closeout of any Government contract performed by the Contractor or a subcontract thereunder, the Contractor has credible evidence that a principal, employee, agent, or subcontractor of the Contractor has committed a violation of Federal criminal law involving fraud, conflict of interest, bribery, or gratuity violations found in Title 18 U.S.C. or a violation of the civil False Claims Act (31 U.S.C. 3729-3733).

(1) If a violation relates to more than one Government contract, the Contractor may make the disclosure to the agency OIG and Contracting Officer responsible for the largest dollar value contract impacted by the violation.

(2) If the violation relates to an order against a Governmentwide acquisition contract, a multi-agency contract, a multiple-award schedule contract such as the Federal Supply Schedule, or any other procurement instrument intended for use by multiple agencies, the contractor shall notify the OIG of the ordering agency and the IG of the agency responsible for the basic contract, and the respective agencies' contracting officers.

(3) The disclosure requirement for an individual contract continues until at least 3 years after final payment on the contract.

(4) The Government will safeguard such disclosures in accordance with paragraph (b)(3)(ii) of this clause.

(G) Full cooperation with any Government agencies responsible for audits, investigations, or corrective actions.

(d) Subcontracts. (1) The Contractor shall include the substance of this clause, including this paragraph (d), in subcontracts that exceed the threshold specified in FAR 3.1004(a) on the date of subcontract award and a performance period of more than 120 days.

(2) In altering this clause to identify the appropriate parties, all disclosures of violation of the civil False Claims Act or of Federal criminal law shall be directed to the agency Office of the Inspector General, with a copy to the Contracting Officer.

9. Section 5.65 Employment Eligibility Verification

Updated per changes to the FAR

SECTION 5.65
EMPLOYMENT ELIGIBILITY VERIFICATION (MAY 2022) (FAR 52.222-54).

(a) Definitions. As used in this clause–

"Commercially available off-the-shelf (COTS) item"—

(1) Means any item of supply that is–

(i) A commercial product (as defined in paragraph (1) of the definition of "commercial product" at Federal Acquisition Regulation (FAR) 2.101;

(ii) Sold in substantial quantities in the commercial marketplace; and

(iii) Offered to the Government, without modification, in the same form in which it is sold in the commercial marketplace; and

(2) Does not include bulk cargo, as defined in 46 U.S.C. 40102(4), such as agricultural products and petroleum products. Per 46 CFR 525.1(c)(2), "bulk cargo" means cargo that is loaded and carried in bulk onboard ship without mark or count, in a loose unpackaged form, having homogenous characteristics. Bulk cargo loaded into intermodal equipment, except LASH or Seabee barges, is subject to mark and count and, therefore, ceases to be bulk cargo.

Employee assigned to the contract means an employee who was hired after November 6, 1986 (after November 27, 2009, in the Commonwealth of the Northern Mariana Islands), who is directly performing work, in the United States, under a contract that is required to include the clause prescribed at 22.1803. An employee is not considered to be directly performing work under a contract if the employee-

(1) Normally performs support work, such as indirect or overhead functions; and

(2) Does not perform any substantial duties applicable to the contract.

Subcontract means any contract, as defined in 2.101, entered into by a subcontractor to furnish supplies or services for performance of a prime contract or a subcontract. It includes but is not limited to purchase orders, and changes and modifications to purchase orders.

Subcontractor means any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime Contractor or another subcontractor.

United States, as defined in 8 U.S.C. 1101(a)(38), means the 50 States, the District of Columbia, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, and the U.S. Virgin Islands.

(b) Enrollment and verification requirements.

(1) If the Contractor is not enrolled as a Federal Contractor in E-Verify at time of contract award, the Contractor shall—

(i) Enroll. Enroll as a Federal Contractor in the E-Verify program within 30 calendar days of contract award;

(ii) Verify all new employees. Within 90 calendar days of enrollment in the E-Verify program, begin to use E-Verify to initiate verification of employment eligibility of all new hires of the Contractor, who are working in the United States, whether or not assigned to the contract, within 3 business days after the date of hire (but see paragraph (b)(3) of this section); and

(iii) Verify employees assigned to the contract. For each employee assigned to the contract, initiate verification within 90 calendar days after date of enrollment or within 30

calendar days of the employee's assignment to the contract, whichever date is later (but see paragraph (b)(4) of this section).

(2) If the Contractor is enrolled as a Federal Contractor in E-Verify at time of contract award, the Contractor shall use E-Verify to initiate verification of employment eligibility of—

(i) All new employees.

(A) Enrolled 90 calendar days or more. The Contractor shall initiate verification of all new hires of the Contractor, who are working in the United States, whether or not assigned to the contract, within 3 business days after the date of hire (but see paragraph (b)(3) of this section); or

(B) Enrolled less than 90 calendar days. Within 90 calendar days after enrollment as a Federal Contractor in E-Verify, the Contractor shall initiate verification of all new hires of the Contractor, who are working in the United States, whether or not assigned to the contract, within 3 business days after the date of hire (but see paragraph (b)(3) of this section); or

(ii) Employees assigned to the contract. For each employee assigned to the contract, the Contractor shall initiate verification within 90 calendar days after date of contract award or within 30 days after assignment to the contract, whichever date is later (but see paragraph (b)(4) of this section).

(3) If the Contractor is an institution of higher education (as defined at 20 U.S.C. 1001(a)); a State or local government or the government of a Federally recognized Indian tribe; or a surety performing under a takeover agreement entered into with a Federal agency pursuant to a performance bond, the Contractor may choose to verify only employees assigned to the contract, whether existing employees or new hires. The Contractor shall follow the applicable verification requirements at (b)(1) or (b)(2) respectively, except that any requirement for verification of new employees applies only to new employees assigned to the contract.

(4) Option to verify employment eligibility of all employees. The Contractor may elect to verify all existing employees hired after November 6, 1986 (after November 27, 2009, in the Commonwealth of the Northern Mariana Islands), rather than just those employees assigned to the contract. The Contractor shall initiate verification for each existing employee working in the United States who was hired after November 6, 1986 (after November 27, 2009, in the Commonwealth of the Northern Mariana Islands), within 180 calendar days of-

(i) Enrollment in the E-Verify program; or

(ii) Notification to E-Verify Operations of the Contractor's decision to exercise this option, using the contact information provided in the E-Verify program Memorandum of Understanding (MOU).

(5) The Contractor shall comply, for the period of performance of this contract, with the requirements of the E-Verify program MOU.

(i) The Department of Homeland Security (DHS) or the Social Security Administration (SSA) may terminate the Contractor's MOU and deny access to the E-Verify system in accordance with the terms of the MOU. In such case, the Contractor will be referred to a suspension or debarment official.

(ii) During the period between termination of the MOU and a decision by the suspension or debarment official whether to suspend or debar, the Contractor is excused from its obligations under paragraph (b) of this clause. If the suspension or debarment official determines not to suspend or debar the Contractor, then the Contractor must reenroll in E-Verify.

(c) Web site. Information on registration for and use of the E-Verify program can be obtained via the Internet at the Department of Homeland Security Web site: *https://www.e-Verify.gov*.

(d) Individuals previously verified. The Contractor is not required by this clause to perform additional employment verification using E-Verify for any employee –

(1) Whose employment eligibility was previously verified by the Contractor through the E-Verify program;

(2) Who has been granted and holds an active U.S. Government security clearance for access to confidential, secret, or top secret information in accordance with the National Industrial Security Program Operating Manual; or

(3) Who has undergone a completed background investigation and been issued credentials pursuant to Homeland Security Presidential Directive (HSPD)-12, Policy for a Common Identification Standard for Federal Employees and Contractors.

(e) Subcontracts. The Contractor shall include the requirements of this clause, including this paragraph (e) (appropriately modified for identification of the parties), in each subcontract that -

(1) Is for

(i) Services (except for commercial services that are part of the purchase of a COTS item (or an item that would be a COTS item, but for minor modifications), performed by the COTS provider, and are normally provided for that COTS item); or

(ii) Construction;

(2) Has a value of more than $3,500; and

(3) Includes work performed in the United States.

10. Section 5.71 Combating Trafficking in Persons

Updated per changes to the FAR

SECTION 5.71
COMBATING TRAFFICKING IN PERSONS (NOV 2021) (FAR 52.222-50)

(a) Definitions. As used in this clause—

"Agent" means any individual, including a director, an officer, an employee, or an independent contractor, authorized to act on behalf of the organization.

"Coercion" means—

(1) Threats of serious harm to or physical restraint against any person;

(2) Any scheme, plan, or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to or physical restraint against any person; or

(3) The abuse or threatened abuse of the legal process. "Commercial sex act" means any sex act on account of which anything of value is given to or received by any person.

"Commercially available off-the-shelf (COTS) item"

(1) Means any item of supply (including construction material) that is-

(i) A commercial product (as defined in paragraph (1) of the definition of "commercial product" at Federal Acquisition Regulation (FAR) 2.101;

(ii) Sold in substantial quantities in the commercial marketplace; and

(iii) Offered to the Government, under a contract or subcontract at any tier, without modification, in the same form in which it is sold in the commercial marketplace; and

(2) Does not include bulk cargo, as defined in 46 U.S.C. 40102(4), such as agricultural products and petroleum products.

"Debt bondage" means the status or condition of a debtor arising from a pledge by the debtor of his or her personal services or of those of a person under his or her control as a security for debt, if the value of those services as reasonably assessed is not applied toward the liquidation of the debt or the length and nature of those services are not respectively limited and defined.

"Employee" means an employee of the Contractor directly engaged in the performance of work under the contract who has other than a minimal impact or involvement in contract performance.

"Forced Labor" means knowingly providing or obtaining the labor or services of a person—

(1) By threats of serious harm to, or physical restraint against, that person or another person;

(2) By means of any scheme, plan, or pattern intended to cause the person to believe that, if the person did not perform such labor or services, that person or another person would suffer serious harm or physical restraint; or

(3) By means of the abuse or threatened abuse of law or the legal process.

"Involuntary servitude" includes a condition of servitude induced by means of—

(1) Any scheme, plan, or pattern intended to cause a person to believe that, if the person did not enter into or continue in such conditions, that person or another person would suffer serious harm or physical restraint; or

(2) The abuse or threatened abuse of the legal process.

"Recruitment fees" means fees of any type, including charges, costs, assessments, or other financial obligations, that are associated with the recruiting process, regardless of the time, manner, or location of imposition or collection of the fee.

(1) Recruitment fees include, but are not limited to, the following fees (when they are associated with the recruiting process) for—

(i) Soliciting, identifying, considering, interviewing, referring, retaining, transferring, selecting, training, providing orientation to, skills testing, recommending, or placing employees or potential employees;

(ii) Advertising;

(iii) Obtaining permanent or temporary labor certification, including any associated fees;

(iv) Processing applications and petitions;

(v) Acquiring visas, including any associated fees;

(vi) Acquiring photographs and identity or immigration documents, such as passports, including any associated fees;

(vii) Accessing the job opportunity, including required medical examinations and immunizations; background, reference, and security clearance checks and examinations; and additional certifications;

(viii) An employer's recruiters, agents or attorneys, or other notary or legal fees;

(ix) Language interpretation or translation, arranging for or accompanying on travel, or providing other advice to employees or potential employees;

(x) Government-mandated fees, such as border crossing fees, levies, or worker welfare funds;

(xi) Transportation and subsistence costs—

(A) While in transit, including, but not limited to, airfare or costs of other modes of transportation, terminal fees, and travel taxes associated with travel from the country of origin to the country of performance and the return journey upon the end of employment; and

(B) From the airport or disembarkation point to the worksite;

(xii) Security deposits, bonds, and insurance; and

(xiii) Equipment charges.

(2) A recruitment fee, as described in the introductory text of this definition, is a recruitment fee, regardless of whether the payment is—

(i) Paid in property or money;

(ii) Deducted from wages;

(iii) Paid back in wage or benefit concessions;

(iv) Paid back as a kickback, bribe, in-kind payment, free labor, tip, or tribute; or

(v) Collected by an employer or a third party, whether licensed or unlicensed, including, but not limited to—

(A) Agents;

(B) Labor brokers;

(C) Recruiters;

(D) Staffing firms (including private employment and placement firms);

(E) Subsidiaries/affiliates of the employer;

(F) Any agent or employee of such entities; and

(G) Subcontractors at all tiers.

"Severe forms of trafficking in persons" means—

(1) Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or

(2) The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

"Sex trafficking" means the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act.

"Subcontract" means any contract entered into by a subcontractor to furnish supplies or services for performance of a prime contract or a subcontract.

"Subcontractor" means any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime contractor or another subcontractor.

"United States" means the 50 States, the District of Columbia, and outlying areas.

(b) Policy. The United States Government has adopted a policy prohibiting trafficking in persons including the trafficking-related activities of this clause. Contractors, contractor employees, and their agents shall not—

(1) Engage in severe forms of trafficking in persons during the period of performance of the contract;

(2) Procure commercial sex acts during the period of performance of the contract; or

(3) Use forced labor in the performance of the contract.

(4) Destroy, conceal, confiscate, or otherwise deny access by an employee to the employee's identity or immigration documents, such as passports or drivers' licenses, regardless of issuing authority;

(5)(i) Use misleading or fraudulent practices during the recruitment of employees or offering of employment, such as failing to disclose, in a format and language understood by the employee or potential employee, basic information or making material misrepresentations during the recruitment of employees regarding the key terms and conditions of employment, including wages and fringe benefits, the location of work, the living conditions, housing and associated costs (if employer or agent provided or arranged), any significant cost to be charged to the employee or potential employee, and, if applicable, the hazardous nature of the work;

(ii) Use recruiters that do not comply with local labor laws of the country in which the recruiting takes place;

(6) Charge employees or potential employees recruitment fees;

(7)(i) Fail to provide return transportation or pay for the cost of return transportation upon the end of employment-

(A) For an employee who is not a national of the country in which the work is taking place and who was brought into that country for the purpose of working on a U.S. Government contract or subcontract (for portions of contracts performed outside the United States); or

(B) For an employee who is not a United States national and who was brought into the United States for the purpose of working on a U.S. Government contract or subcontract, if the payment of such costs is required under existing temporary worker programs or pursuant to a written agreement with the employee (for portions of contracts performed inside the United States); except that-

(ii) The requirements of paragraphs (b)(7)(i) of this clause shall not apply to an employee who is-

(A) Legally permitted to remain in the country of employment and who chooses to do so; or

(B) Exempted by an authorized official of the contracting agency from the requirement to provide return transportation or pay for the cost of return transportation;

(iii) The requirements of paragraph (b)(7)(i) of this clause are modified for a victim of trafficking in persons who is seeking victim services or legal redress in the country of employment, or for a witness in an enforcement action related to trafficking in persons. The contractor shall provide the return transportation or pay the cost of return transportation in a way that does not obstruct the victim services, legal redress, or witness activity. For example, the contractor shall not only offer return transportation to a witness at a time when the witness is still needed to testify. This paragraph does not apply when the exemptions at paragraph (b)(7)(ii) of this clause apply.

(8) Provide or arrange housing that fails to meet the host country housing and safety standards; or

(9) If required by law or contract, fail to provide an employment contract, recruitment agreement, or other required work document in writing. Such written work document shall be in a language the employee understands. If the employee must relocate to perform the work, the work document shall be provided to the employee at least five days prior to the employee relocating. The employee's work document shall include, but is not limited to, details about work description, wages, prohibition on charging recruitment fees, work location(s), living accommodations and associated costs, time off, roundtrip transportation arrangements, grievance process, and the content of applicable laws and regulations that prohibit trafficking in persons.

(c) Contractor requirements. The Contractor shall—

(1) Notify its employees and agents of—

(i) The United States Government's policy prohibiting trafficking in persons, described in paragraph (b) of this clause; and

(ii) The actions that will be taken against employees or agents for violations of this policy. Such actions for employees may include, but are not limited to, removal from the contract, reduction in benefits, or termination of employment; and

(2) Take appropriate action, up to and including termination, against employees, agents, or subcontractors that violate the policy in paragraph (b) of this clause.

(d) *Notification.*

(1) The Contractor shall inform the Contracting Officer and the agency Inspector General immediately of—

(i)Any credible information it receives from any source (including host country law enforcement) that alleges a Contractor employee, subcontractor, subcontractor employee, or their agent has engaged in conduct that violates the policy; in in paragraph (b) of this clause (see also 18 U.S.C. 1351, Fraud in Foreign Labor Contracting, and 52.203-13(b)(3)(i)(A), if that clause is included in the solicitation or contract, which requires disclosure to the agency Office of the Inspector General when the Contractor has credible evidence of fraud) ; and

(ii) Any actions taken against a Contractor employee, subcontractor, or subcontractor employee, or their agent pursuant to this clause.

(2) If the allegation may be associated with more than one contract, the Contractor shall inform the contracting officer for the contract with the highest dollar value.

(e) *Remedies*. In addition to other remedies available to the Government, the Contractor's failure to comply with the requirements of paragraphs (c), (d), (g), (h) or (i) of this clause may result in—

(1) Requiring the Contractor to remove a Contractor employee or employees from the performance of the contract;

(2) Requiring the Contractor to terminate a subcontract;

(3) Suspension of contract payments until the Contractor has taken appropriate remedial action;

(4) Loss of award fee, consistent with the award fee plan, for the performance period in which the Government determined Contractor non-compliance;

(5) Declining to exercise available options under the contract;

(6) Termination of the contract for default or cause, in accordance with the termination clause of this contract; or

(7) Suspension or debarment.

(f) Mitigating and aggravating factors. When determining remedies, the Contracting Officer may consider the following:

(1) Mitigating factors. The Contractor had a Trafficking in Persons compliance plan or an awareness program at the time of the violation, was in compliance with the plan, and has taken appropriate remedial actions for the violation, that may include reparation to victims for such violations.

(2) Aggravating factors. The Contractor failed to abate an alleged violation or enforce the requirements of a compliance plan, when directed by the Contracting Officer to do so.

(g) Full cooperation.

(1) The Contractor shall, at a minimum-

(i) Disclose to the agency Inspector General information sufficient to identify the nature and extent of an offense and the individuals responsible for the conduct;

(ii) Provide timely and complete responses to Government auditors' and investigators' requests for documents;

(iii) Cooperate fully in providing reasonable access to its facilities and staff (both inside and outside the U.S.) to allow contracting agencies and other responsible Federal agencies to conduct audits, investigations, or other actions to ascertain compliance with the Trafficking Victims Protection Act of 2000 (22 U.S.C. chapter 78), E.O. 13627, or any other applicable law or regulation establishing restrictions on trafficking in persons, the procurement of commercial sex acts, or the use of forced labor; and

(iv) Protect all employees suspected of being victims of or witnesses to prohibited activities, prior to returning to the country from which the employee was recruited, and shall not prevent or hinder the ability of these employees from cooperating fully with Government authorities.

(2) The requirement for full cooperation does not foreclose any Contractor rights arising in law, the FAR, or the terms of the contract. It does not-

(i) Require the Contractor to waive its attorney-client privilege or the protections afforded by the attorney work product doctrine;

(ii) Require any officer, director, owner, employee, or agent of the Contractor, including a sole proprietor, to waive his or her attorney client privilege or Fifth Amendment rights; or

(iii) Restrict the Contractor from-

(A) Conducting an internal investigation; or

(B) Defending a proceeding or dispute arising under the contract or related to a potential or disclosed violation.

(h) Compliance plan.

(1) This paragraph (h) applies to any portion of the contract that-

(i) Is for supplies, other than commercially available off-the-shelf items, acquired outside the United States, or services to be performed outside the United States; and

(ii) Has an estimated value that exceeds $550,000.

(2) The Contractor shall maintain a compliance plan during the performance of the contract that is appropriate-

(i) To the size and complexity of the contract; and

(ii) To the nature and scope of the activities to be performed for the Government, including the number of non-United States citizens expected to be employed and the risk that the contract or subcontract will involve services or supplies susceptible to trafficking in persons.

(3) Minimum requirements. The compliance plan must include, at a minimum, the following:

(i) An awareness program to inform contractor employees about the Government's policy prohibiting trafficking-related activities described in paragraph (b) of this clause, the activities prohibited, and the actions that will be taken against the employee for violations. Additional information about Trafficking in Persons and examples of awareness programs can be found at the website for the Department of State's Office to Monitor and Combat Trafficking in Persons at http://www.state.gov/j/tip/.

(ii) A process for employees to report, without fear of retaliation, activity inconsistent with the policy prohibiting trafficking in persons, including a means to make available to all

employees the hotline phone number of the Global Human Trafficking Hotline at 1-844-888-FREE and its email address at help@befree.org.

(iii) A recruitment and wage plan that only permits the use of recruitment companies with trained employees, prohibits charging recruitment fees to the employees or potential employees, and ensures that wages meet applicable host-country legal requirements or explains any variance.

(iv) A housing plan, if the Contractor or subcontractor intends to provide or arrange housing, that ensures that the housing meets host-country housing and safety standards.

(v) Procedures to prevent agents and subcontractors at any tier and at any dollar value from engaging in trafficking in persons (including activities in paragraph (b) of this clause) and to monitor, detect, and terminate any agents, subcontracts, or subcontractor employees that have engaged in such activities.

(4) Posting.

(i) The Contractor shall post the relevant contents of the compliance plan, no later than the initiation of contract performance, at the workplace (unless the work is to be performed in the field or not in a fixed location) and on the Contractor's Web site (if one is maintained). If posting at the workplace or on the Web site is impracticable, the Contractor shall provide the relevant contents of the compliance plan to each worker in writing.

(ii) The Contractor shall provide the compliance plan to the Contracting Officer upon request.

(5) Certification. Annually after receiving an award, the Contractor shall submit a certification to the Contracting Officer that-

(i) It has implemented a compliance plan to prevent any prohibited activities identified at paragraph (b) of this clause and to monitor, detect, and terminate any agent, subcontract or subcontractor employee engaging in prohibited activities; and

(ii) After having conducted due diligence, either-

(A) To the best of the Contractor's knowledge and belief, neither it nor any of its agents, subcontractors, or their agents is engaged in any such activities; or

(B) If abuses relating to any of the prohibited activities identified in paragraph (b) of this clause have been found, the Contractor or subcontractor has taken the appropriate remedial and referral actions.

(i) *Subcontracts*.

(1) The Contractor shall include the substance of this clause, including this paragraph (f), in all subcontracts and in all contracts with agents. The requirements in paragraph (h) of this clause apply only to any portion of the subcontract that-

(i) Is for supplies, other than commercially available off-the-shelf items, acquired outside the United States, or services to be performed outside the United States; and

(ii) Has an estimated value that exceeds $550,000.

(2) If any subcontractor is required by this clause to submit a certification, the Contractor shall require submission prior to the award of the subcontract and annually thereafter. The certification shall cover the items in paragraph (h)(5) of this clause.

11. <u>Section 5.72 Basic Safeguarding of Covered Contractor Information Systems</u>
Updated per changes to the FAR

SECTION 5.72

BASIC SAFEGUARDING OF COVERED CONTRACTOR INFORMATION SYSTEMS (NOV 2021) (FAR 52.204-21)

(a) Definitions. As used in this clause Covered contractor information system means an information system that is owned or operated by a contractor that processes, stores, or transmits Federal contract information.

Federal contract information means information, not intended for public release, that is provided by or generated for the Government under a contract to develop or deliver a product or service to the Government, but not including information provided by the Government to the public (such as on public websites) or simple transactional information, such as necessary to process payments.

Information means any communication or representation of knowledge such as facts, data, or opinions, in any medium or form, including textual, numerical, graphic, cartographic, narrative, or audiovisual (Committee on National Security Systems Instruction (CNSSI) 4009).

Information system means a discrete set of information resources organized for the collection, processing, maintenance, use, sharing, dissemination, or disposition of information (44 U.S.C. 3502).

Safeguarding means measures or controls that are prescribed to protect information systems.

(b) Safeguarding requirements and procedures. (1) The Contractor shall apply the following basic safeguarding requirements and procedures to protect covered contractor information systems. Requirements and procedures for basic safeguarding of covered contractor information systems shall include, at a minimum, the following security controls:

(i) Limit information system access to authorized users, processes acting on behalf of authorized users, or devices (including other information systems).

(ii) Limit information system access to the types of transactions and functions that authorized users are permitted to execute.

(iii) Verify and control/limit connections to and use of external information systems.

(iv) Control information posted or processed on publicly accessible information systems.

(v) Identify information system users, processes acting on behalf of users, or devices.

(vi) Authenticate (or verify) the identities of those users, processes, or devices, as a prerequisite to allowing access to organizational information systems.

(vii) Sanitize or destroy information system media containing Federal Contract Information before disposal or release for reuse.

(viii) Limit physical access to organizational information systems, equipment, and the respective operating environments to authorized individuals.

(ix) Escort visitors and monitor visitor activity; maintain audit logs of physical access; and control and manage physical access devices.

(x) Monitor, control, and protect organizational communications (i.e., information transmitted or received by organizational information systems) at the external boundaries and key internal boundaries of the information systems.

(xi) Implement subnetworks for publicly accessible system components that are physically or logically separated from internal networks.

(xii) Identify, report, and correct information and information system flaws in a timely manner.

(xiii) Provide protection from malicious code at appropriate locations within organizational information systems.

(xiv) Update malicious code protection mechanisms when new releases are available.

(xv) Perform periodic scans of the information system and real-time scans of files from external sources as files are downloaded, opened, or executed.

(2) Other requirements. This clause does not relieve the Contractor of any other specific safeguarding requirements specified by Federal agencies and departments relating to covered contractor information systems generally or other Federal safeguarding requirements for controlled unclassified information (CUI) as established by Executive Order 13556.

(c) Subcontracts. The Contractor shall include the substance of this clause, including this paragraph (c), in subcontracts under this contract (including subcontracts for the acquisition of commercial products or commercial services, other than commercially available off-the-shelf items), in which the subcontractor may have Federal contract information residing in or transiting through its information system.

12. <u>Section 5.74 Prohibition On Contracting For Hardware, Software, And Services Developed Or Provided By Kaspersky Lab And Other Covered Entities</u>

Updated per changes to the FAR

SECTION 5.74
PROHIBITION ON CONTRACTING FOR HARDWARE, SOFTWARE, AND SERVICES DEVELOPED OR PROVIDED BY KASPERSKY LAB AND OTHER COVERED ENTITIES (NOV 2021) (FAR 52.204-23).

(a) *Definitions*. As used in this clause—

"Covered article" means any hardware, software, or service that–

(1) Is developed or provided by a covered entity;

(2) Includes any hardware, software, or service developed or provided in whole or in part by a covered entity; or

(3) Contains components using any hardware or software developed in whole or in part by a covered entity.

"Covered entity" means–

(1) Kaspersky Lab;

(2) Any successor entity to Kaspersky Lab;

(3) Any entity that controls, is controlled by, or is under common control with Kaspersky Lab; or

(4) Any entity of which Kaspersky Lab has a majority ownership.

(b) *Prohibition.* Section 1634 of Division A of the National Defense Authorization Act for Fiscal Year 2018 (Pub. L. 115-91) prohibits Government use of any covered article. The Contractor is prohibited from—

(1) Providing any covered article that the Government will use on or after October 1, 2018; and

(2) Using any covered article on or after October 1, 2018, in the development of data or deliverables first produced in the performance of the contract.

(c) *Reporting requirement.*

(1) In the event the Contractor identifies a covered article provided to the Government during contract performance, or the Contractor is notified of such by a subcontractor at any tier or any other source, the Contractor shall report, in writing, to the Contracting Officer or, in the case of the Department of Defense, to the website at https://dibnet.dod.mil. For indefinite delivery contracts, the Contractor shall report to the Contracting Officer for the indefinite delivery contract and the Contracting Officer(s) for any affected order or, in the case of the Department of Defense, identify both the indefinite delivery contract and any affected orders in the report provided at https://dibnet.dod.mil.

(2) The Contractor shall report the following information pursuant to paragraph (c)(1) of this clause:

(i) Within 1 business day from the date of such identification or notification: the contract number; the order number(s), if applicable; supplier name; brand; model number (Original Equipment Manufacturer (OEM) number, manufacturer part number, or wholesaler number); item description; and any readily available information about mitigation actions undertaken or recommended.

(ii) Within 10 business days of submitting the report pursuant to paragraph (c)(1) of this clause: any further available information about mitigation actions undertaken or recommended. In addition, the Contractor shall describe the efforts it undertook to prevent use or submission of a covered article, any reasons that led to the use or submission of the covered article, and any additional efforts that will be incorporated to prevent future use or submission of covered articles.

(d) Subcontracts. The Contractor shall insert the substance of this clause, including this paragraph (d), in all subcontracts including subcontracts for the acquisition of commercial products or commercial services.

13. Section 5.75 Prohibition on Contracting for Certain Telecommunications and Video Surveillance Services or Equipment

Updated per changes to the FAR

SECTION 5.75
PROHIBITION ON CONTRACTING FOR CERTAIN TELECOMMUNICATIONS AND VIDEO SURVEILLANCE SERVICES OR EQUIPMENT (NOV 2021) (FAR 52.204-25).

(a) *Definitions.* As used in this clause—

"Backhaul" means intermediate links between the core network, or backbone network, and the small subnetworks at the edge of the network (e.g., connecting cell phones/towers to the core telephone network). Backhaul can be wireless (e.g., microwave) or wired (e.g., fiber optic, coaxial cable, Ethernet).

"Covered foreign country" means The People's Republic of China.

"Covered telecommunications equipment or services" means–

(1) Telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities);

(2) For the purpose of public safety, security of Government facilities, physical security surveillance of critical infrastructure, and other national security purposes, video surveillance and telecommunications equipment produced by Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities);

(3) Telecommunications or video surveillance services provided by such entities or using such equipment; or

(4) Telecommunications or video surveillance equipment or services produced or provided by an entity that the Secretary of Defense, in consultation with the Director of National Intelligence or the Director of the Federal Bureau of Investigation, reasonably believes to be an entity owned or controlled by, or otherwise connected to, the government of a covered foreign country.

"Critical technology" means–

(1) Defense articles or defense services included on the United States Munitions List set forth in the International Traffic in Arms Regulations under subchapter M of chapter I of title 22, Code of Federal Regulations;

(2) Items included on the Commerce Control List set forth in Supplement No. 1 to part 774 of the Export Administration Regulations under subchapter C of chapter VII of title 15, Code of Federal Regulations, and controlled-

(i) Pursuant to multilateral regimes, including for reasons relating to national security, chemical and biological weapons proliferation, nuclear nonproliferation, or missile technology; or

(ii) For reasons relating to regional stability or surreptitious listening;

(3) Specially designed and prepared nuclear equipment, parts and components, materials, software, and technology covered by part 810 of title 10, Code of Federal Regulations (relating to assistance to foreign atomic energy activities);

(4) Nuclear facilities, equipment, and material covered by part 110 of title 10, Code of Federal Regulations (relating to export and import of nuclear equipment and material);

(5) Select agents and toxins covered by part 331 of title 7, Code of Federal Regulations, part 121 of title 9 of such Code, or part 73 of title 42 of such Code; or

(6) Emerging and foundational technologies controlled pursuant to section 1758 of the Export Control Reform Act of 2018 (50 U.S.C. 4817).

"Interconnection arrangements" means arrangements governing the physical connection of two or more networks to allow the use of another's network to hand off traffic where it is ultimately delivered (e.g., connection of a customer of telephone provider A to a customer of telephone company B) or sharing data and other information resources.

"Reasonable inquiry" means an inquiry designed to uncover any information in the entity's possession about the identity of the producer or provider of covered

telecommunications equipment or services used by the entity that excludes the need to include an internal or third- party audit.

"Roaming" means cellular communications services (e.g., voice, video, data) received from a visited network when unable to connect to the facilities of the home network either because signal coverage is too weak or because traffic is too high.

"Substantial or essential component" means any component necessary for the proper function or performance of a piece of equipment, system, or service.

(b) *Prohibition.* (1) Section 889(a)(1)(A) of the John S. McCain National Defense Authorization Act for Fiscal Year 2019 (Pub. L. 115–232) prohibits the head of an executive agency on or after August 13, 2019, from procuring or obtaining, or extending or renewing a contract to procure or obtain, any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system. The Contractor is prohibited from providing to the Government any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system, unless an exception at paragraph (c) of this clause applies or the covered telecommunication equipment or services are covered by a waiver described in FAR 4.2104.

(2) Section 889(a)(1)(B) of the John S. McCain National Defense Authorization Act for Fiscal Year 2019 (Pub. L. 115–232) prohibits the head of an executive agency on or after August 13, 2020, from entering into a contract, or extending or renewing a contract, with an entity that uses any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system, unless an exception at paragraph (c) of this clause applies or the covered telecommunication equipment or services are covered by a waiver described in FAR 4.2104. This prohibition applies to the use of covered telecommunications equipment or services, regardless of whether that use is in performance of work under a Federal contract.

(c) *Exceptions.* This clause does not prohibit contractors from providing—

(1) A service that connects to the facilities of a third-party, such as backhaul, roaming, or interconnection arrangements; or

(2) Telecommunications equipment that cannot route or redirect user data traffic or permit visibility into any user data or packets that such equipment transmits or otherwise handles.

(d) Reporting requirement. (1)In the event the Contractor identifies covered telecommunications equipment or services used as a substantial or essential component of any system, or as critical technology as part of any system, during contract performance, or the Contractor is notified of such by a subcontractor at any tier or by any other source, the Contractor shall report the information in paragraph (d)(2) of this clause to the Contracting Officer, unless elsewhere in this contract are established procedures for reporting the information; in the case of the Department of Defense, the Contractor shall report to the website at https://dibnet.dod.mil. For indefinite delivery contracts, the Contractor shall report to the Contracting Officer for the indefinite delivery contract and the Contracting Officer(s) for any affected order or, in the case of the Department of Defense, identify both the indefinite delivery contract and any affected orders in the report provided at https://dibnet.dod.mil.

(2) The Contractor shall report the following information pursuant to paragraph (d)(1) of this clause

(i) Within one business day from the date of such identification or notification: the contract number; the order number(s), if applicable; supplier name; supplier unique entity identifier (if known); supplier Commercial and Government Entity (CAGE) code (if known); brand; model number (original equipment manufacturer number, manufacturer part number, or wholesaler number); item description; and any readily available information about mitigation actions undertaken or recommended.

(ii) Within 10 business days of submitting the information in paragraph (d)(2)(i) of this clause: any further available information about mitigation actions undertaken or recommended. In addition, the Contractor shall describe the efforts it undertook to prevent use or submission of covered telecommunications equipment or services, and any additional efforts that will be incorporated to prevent future use or submission of covered telecommunications equipment or services.

(a) *Subcontracts.* The Contractor shall insert the substance of this clause, including this paragraph (e) and excluding paragraph (b)(2), in all subcontracts and other contractual instruments, including subcontracts for the acquisition of commercial products or commercial services.

Part IV-SPECIAL PROVISIONS is deleted and replaced with the following:

SECTION 4.1
ALTERATIONS IN CONTRACT (JAN 2019) (FAR 52.252-4)

Portions of this contract are altered as follows:

(a) Section 1.6 Confidentiality of Records. The following subsection is added:

(d) Local Blue Cross and/or Blue Shield Plans may combine the personal data and medical records of Federal subscribers, and information relating thereto, with the same information of other individuals who have health benefits coverage under the Local Blue Cross and/or Blue Shield Plan. This combined data may only be used and disclosed for the Plan's health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501). Such activities include, but are not limited to: care management; prevention, detection, and recovery of funds subject to fraud and abuse; and negotiation of provider contracts.

(e) As used in subsection (b)(1) of this section, "administration of this contract" means health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501).

(b) Section 1.9 Plan Performance - Experience-Rated FFS Contracts.

The Carrier may use the appropriate systems for measurement and/or collection of data on the quality of the health care services as described in subparagraph 1.9(b).

(c) Section 1.14, Misleading, Deceptive, or Unfair Advertising, is amended by removing the reference to the NAIC Advertisements of Accident and Sickness Insurance Model Regulation (Appendix D-b). Carrier should continue to use the FEHB Supplemental Literature Guidelines (now at the renumbered Appendix C) along with FEHBAR 1603.7002.

(d) Section 1.15 Renewal and Withdrawal of Approval (FEHBAR). The following subsections are added:

(d) If the agency suspends payment of the subscription charges for any reason, the Carrier may (1) suspend making benefit payments until payment of all subscription charges due is fully restored; or (2) terminate the contract without prior notice.

(e) Section 1.21 Patient Bill of Rights. For the purpose of compliance with this Section, the Carrier will conduct the following minimum activities: (1) the Carrier will provide subscribers with a Fact Sheet that includes information about the disenrollment rate in the Blue Cross and Blue Shield Service Benefit Plan, as well as Local Plan-specific information including compliance with Federal and State financial requirements, public corporate information, years in existence, and accreditation status; (2) Provider

Directories will include language advising subscribers to contact their providers directly to obtain information about the providers, including but not limited to board certifications, languages spoken, availability of interpreters, facility accessibility, and whether the provider is accepting new patients.

(f) Section 1.30 Health Information Technology Privacy and Security. Subsections (b), (c) and the introductory paragraph of Subsection (d) of Section 1.30 are amended to read as follows:

(b) The Carrier will promote consumer transparency by ensuring that at the point where the Federal member enters the subcontractor's, large provider's, or vendor's website or web portal the link to the subcontractor's, large provider's, or vendor's notice of privacy practices and/or privacy policies is displayed on the bottom, or prominently displayed elsewhere, on the website or web portal.

(c) Notice of privacy practices and/or privacy policies disclosures must describe the uses of individually identifiable protected health information and any potential disclosure to other entities as described in the HIPAA Privacy Rule.

(d) The Carrier will participate with the Contracting Officer or an authorized representative of the Contracting Officer in credential vulnerability scans and configuration compliance audits conducted in accordance with rules of engagement agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The rules of engagement will include the software and hardware used for vulnerability scanning; the specific process used to conduct vulnerability scanning; precautions taken to prevent negative disruption on the systems being scanned; restrictions on the release of documents and artifacts; and how the results of the scanning will be reviewed and reported.

(g) Section 2.2 Benefits Provided. The following paragraph is added to subsection 2.2(a):

(4) The Carrier may pay the Preferred Provider Organization level of benefits under this contract to ease the hardship of members affected by natural disasters such as earthquakes, floods, etc., when because of the natural disaster members have difficulty gaining access to Preferred network providers. The Carrier may pay the Preferred level of benefits without regard to the provider's contractual relationship with the Carrier and will determine an appropriate time frame based on local conditions during which the provision of this paragraph will apply. Benefits provided under this paragraph will be made available to all members similarly affected by the natural disaster.

(h) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Notwithstanding subsection (f) of Section 2.3, benefits provided under the contract are not assignable by the Member to any person without express written approval of the carrier, and in the absence of such approval, any such assignment shall be void. Notwithstanding such approval, no assignment of benefits may be made in any case prior to the time that a valid claim for benefits arises.

(i) Section 2.3 Payment of Benefits and Provision of Services and Supplies. The introductory paragraph of Subsection 2.3(g) is amended to read as follows:

(g) *Erroneous Payments*.

(i) If the Carrier or OPM determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider; the recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment under 48 C.F.R. 1631.201-70(h) regardless of any time period limitations in the written agreement with the provider.

(ii) The Carrier shall be deemed to have satisfied the requirements of Subsection (g) (i) above by complying with Subsections (ii), (iii), and (iv). Local Blue Cross and Blue Shield Plans which have time period limitations in their provider contracts which prevent the Plan from recovering erroneous benefit payments made to providers will participate in an action plan. The action plan shall be developed by the Blue Cross and Blue Shield Association by December 31, 2008 and agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield Association and the Contracting Officer shall utilize standards of commercial reasonableness and neither shall unreasonably withhold agreement. The action plan shall be designed to reduce the occurrence of erroneous benefit payments, to identify and recover erroneous benefit payments within the time limits stipulated in their provider contracts, and to demonstrate due diligence in making an attempt to identify and recover within that provider contract timeframe such erroneous benefit payments.

(iii) The Blue Cross and Blue Shield Association shall be responsible for monitoring and determining whether each Blue Cross and Blue Shield Plan participating in the action plan is complying with its obligations under the action plan.

(iv) A Blue Cross and Blue Shield Plan which is in compliance with its obligations under the action plan shall be found to be in compliance with its obligation under this Section 2.3(g) to make a prompt and diligent effort to recover erroneous benefit payments. In the event that any Plan with such time period limitations is determined to be not in substantial compliance with the action plan, and that Plan is determined not to have pursued material benefit payments with promptness and diligence, then the Plan shall return the erroneous benefit payments to the Program.

(v) The Carrier shall follow general business practices and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall—

(j) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(7)(ii) of Section 2.3 is amended to read as follows:

Notwithstanding (g)(7)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that

caused erroneous benefit payments) when the errors are egregious and repeated. These costs are deemed to be unreasonable and unallowable under Section 3.2(b). The term "repeated" in the previous sentence does not apply to situations in which a claims processing system error causes multiple erroneous payments or to situations that involve audit findings on errors that are endemic to the provision of insurance and claims processing.

(k) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(10) of Section 2.3 is amended to read as follows:

(10) In compliance with the Contracts Disputes Act, the Carrier shall return to the Program an amount equal to the uncollected erroneous benefit payment where the Contracting Officer determines that the Carrier failed to make a prompt and diligent effort, as that term is described above, to recover the erroneous benefit payment. This provision applies to benefit payments which have been paid in error for any reason (except in the case of fraud or abuse).

(l) Section 2.4 Termination of Coverage and Conversion Privileges. The conversion contract set forth in Section 2.4(c) may be a contract that is regularly offered by the local Blue Cross and/or Blue Shield Plan.

(m) Section 2.5 Subrogation. The following subsections are added:

(c) To the extent that a Member has received benefits for covered services under this contract for an injury or illness caused by a third party, the Carrier shall have the right to be subrogated and succeed to any rights of recovery against any person or organization from whom the Member is legally entitled to receive all or part of those same benefits, including insurers of individuals (non-group) policies of liability insurance that are issued to and in the name of the Member. The obligation of the Carrier to recover amounts through subrogation is limited to making a reasonable effort to seek recovery of amounts to which it is entitled to recover in cases which are brought to its attention. The Carrier shall not be required to recover any amounts from any person or organization who causes an injury or illness for which the Member makes claims for benefits.

(d) The Carrier may also recover directly from the Member all amounts received by the Member by suit, settlement, or otherwise from any third party or its insurer, or the Member's insurer under an individual policy or liability insurance, for benefits which have also been paid under this contract.

(e) The Member shall take such action, furnish such information and assistance, and execute such papers as the Carrier or its representative believes are necessary to facilitate enforcement of its rights, and shall take no action which would prejudice the interests of the Carrier to subrogation.

(f) Effective January 1, 1997, all Participating Plans shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under the contract.

(n) Section 2.6 Coordination of Benefits (FEHBAR). The following subsections are added:

(g) The benefits payable by this Plan shall be determined, on a claim by claim basis, only for those claims in excess of $100, except where Medicare is the primary payer of benefits, claims in excess of $50.

(h) Whenever payments which should have been made under this contract in accordance with this provision have been made under any other group health coverage, the Carrier shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amount it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this contract and, to the extent of such payments discharged from liability under the contract.

(o) Section 3.1 Payments (FEHBAR). The following sentence is added to the end of Section 3.1(a):

OPM will withhold from the subscription charges amounts for other obligations due under the contract only to the extent that OPM and the Carrier have agreed in writing to specific deductions for such other obligations.

(p) Section 3.1 Payments (FEHBAR). The following subsection is added:

(g) Except as required pursuant to Sections 1.25 and 2.12, in the event this contract is terminated or not renewed, the agency shall be liable for all sums due and unpaid, including subscription charges, for the period up to the last day of the Member's entitlement to benefits.

(q) Section 3.2 Accounting and Allowable Cost (FEHBAR). Section 3.2(b)(2)(ii) of this contract is amended to comply with 5 U.S.C. 8909(f) as follows:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(r) Section 3.2 Accounting and Allowable Cost (FEHBAR). The provision in Section 3.2 (b)(2)(iv)(A) is supplemented as follows:

Charges for mandatory statutory reserves (Section 3.2(b)(2)(iv)(A)) to satisfy mandatory

statutory reserve requirements of Participating Plans are allowable to the extent that such requirements exceed that portion of the service charge at Appendix B, Subscription Rates, Charges, Allowances and Limitations applicable to such Plans.

(s) Section 3.2 Accounting and Allowable Cost (FEHBAR). This section is modified as follows:

The Carrier, as required by the Blue Cross and Blue Shield Service Benefit Plan Workplan, shall furnish OPM an accounting of its operations under the contract not less than 120 days after the end of the calendar year contract period.

(t) Section 3.3 Special Reserve. The provision in Section 3.3(a) is supplemented as follows:

The Special reserve held by or on behalf of the Carrier is to be used only for payment of charges against this contract, including advance payments to Participating Plans and to hospitals.

(u) Section 3.10, Audit, Financial, and Other Information. Compliance by the Carrier and Participating Blue Cross and Blue Shield Plans with the Blue Cross Blue Shield Service Benefit Plan Workplan, as agreed upon between the Carrier and OPM, will constitute compliance with the Audit Guide referred to in Sections 3.2 and 3.10.

SECTION 4.2
HOSPITAL (FACILITY) BENEFIT PAYMENTS AND CONDITIONS (JAN 1991)

(a) Benefits described in the agreed upon brochure text shall be provided to the extent practicable in the form of services rendered by hospitals, freestanding ambulatory facilities, and home health care agencies, and payment, therefore, by or on behalf of the carrier shall constitute a complete discharge of their obligations under this contract to the extent of services rendered in accordance with the terms and conditions of the contract.

(b) Benefits for inpatient hospital care shall be available only to a Member admitted to the hospital on the recommendation, and while under the active medical supervision of a duly licensed physician or alternative provider as described in section 8902(k)(1) of title 5 U.S.C. who is a member of the staff of, or acceptable to, the hospital selected.

(c) Hospital service is subject to all the rules and regulations of the hospital selected including rules governing admissions.

(d) While a Member may elect to be hospitalized in any hospital, the Carrier does not undertake to guarantee the admission of such Member to the hospital, nor the availability of any accommodations or services therein requested by the Member or his physician.

SECTION 4.3
DEFINITION OF CARRIER (JAN 1991)

The Carrier is the Blue Cross and Blue Shield Association, an Illinois not-for-profit corporation, acting on behalf of participating Blue Cross and Blue Shield Plans and

pursuant to authority specified in Exhibit A for and in behalf of the organizations specified in Exhibit A (hereinafter sometimes referred to as "Participating Plans").

SECTION 4.4
AUDIT DISPUTES (JAN 2000)

(a) Any questioned costs or issues documented by or on behalf of OPM's Office of the Inspector General (OIG) in draft or final audit reports examining the Carrier's and Participating Plans' performance under this contract, that are provided to the Carrier and that were initially raised in the timeframe set forth in subsection (c) below, remain open until resolved. Audit issues related to monetary findings for which extensions of the waiver period for the issuance of final decisions and processing of prior period adjustments were obtained in previous contract terms also remain open until resolved.

(b) Resolution of a questioned cost or issue can be the result of a resolution letter or the issuance of a final decision by the Contracting Officer, or by the processing of a prior period adjustment, an adjustment to the Special reserve, or submission of a claim to OPM (as appropriate) by the Carrier or Participating Plan. A prior period adjustment intended to partially or fully resolve an audit finding will not be considered closed until properly reported on the calendar year Annual Accounting Statement.

(c) A claim seeking, as a matter of right, the payment of money, in a sum certain, pursuant to 48 CFR section 52.233-1, shall not be made more than five years following the last day prescribed by the contract for filing the calendar year Annual Accounting Statement for the year with respect to which the claim arises. A claim includes, in the case of the carrier, a charge against the contract.

SECTION 4.5
ASSOCIATION DUES (JAN 2004)

A Participating local Blue Cross and Blue Shield Plan may charge to this contract Association Dues, with the exception of dues related to those lobbying costs and Special Assessments determined to be unallowable. In calculating the unallowable portion of dues related to lobbying costs for a contract year, the Blue Cross and Blue Shield Plan will rely on the percentage of dues, less any special assessments, as determined by the BCBSA for IRS purposes, to be not tax deductible from the previous contract year.

SECTION 4.6
TRAVEL COSTS (JAN 1996)

The Carrier may charge and account for travel expenses related to administration of the contract on a per diem basis, subject to the maximums prescribed by the Federal Travel Regulations. For those travel costs for each contract term that are subject to the Federal per diem rates set forth at 48 CFR section 31.205-46, the Carrier shall charge to the contract an amount equal to the lesser of:

(i) the actual aggregate charges for those costs, or
(ii) the aggregate charges calculated using the per diem rates set forth in the Federal Travel Regulations.

SECTION 4.7
MARKET RESEARCH COSTS (JAN 1996)

(a) Costs of market research surveys or studies are generally allowable if the survey or study is:

1. directed to current Members and Members who left the Blue Cross and Blue Shield Service Benefit Plan in the most recent Open season, or
2. focused on long-range planning, industry state-of-the-art developments, or product development issues for which a direct benefit or potential benefit to the FEHB Program can be identified, or
3. pre-approved by the Contracting Officer.

(b) Costs of market research surveys or studies are generally not allowable if the primary purpose is to survey or study an otherwise unallowable cost item, such as: to determine the effectiveness of advertising or sales strategies; to evaluate image effectiveness or ways to achieve image enhancement; or to perform a competitive analysis with other carriers in the FEHB Program. Such costs are unallowable, regardless of who receives the research surveys or studies.

(c) This provision does not supersede other contract requirements, such as prior approval for subcontracts under Section 1.16 Subcontracts (FEHBAR 1652.244-70).

SECTION 4.8
PRESCRIPTION DRUG BENEFITS WAIVER PROVISIONS (JAN 2009)

(a) For the purposes of applying the special provisions in this section, the Standard Option Mail Service Prescription Drug Program service standards are:

(1) When a prescription order is placed that does not require additional information or clarification (i.e., a clean or non-diverted prescription), the prescription order shall be dispensed within three business days from the date of receipt so the enrollee may expect to receive the medication within 7 calendar days.

(2) When a prescription order is placed that does require additional information, clarification or resolution of payment issues (i.e., a diverted prescription), the prescription order shall be dispensed within seven business days from the date of receipt so the enrollee may expect to receive the medication within 14 calendar days. However the following situations will not be considered a diverted prescription for the purposes of this section:

(i) Prescriptions for refrigerated products that require prior arrangements between the mail order pharmacy and a Member before the Member can receive the Prescription;

(ii) Prescriptions requiring specific counseling obligations imposed by the pharmaceutical manufacturer, distributor or the FDA;

(iii) Prescriptions requiring "registration" with a pharmaceutical manufacturer.

(b) The special provisions described in paragraphs (c)(1), (2), and (3) shall become effective automatically when less than 98 percent of the prescriptions are filled within the

service standards described in either paragraph (a)(1) or (a)(2) for 7 consecutive business days. The special provisions shall terminate when for 7 consecutive business days 98 percent or more of the prescriptions are filled within the service standards described in paragraphs (a)(1) and (a)(2) of this section.

(c) The special provisions are:

(1) The Carrier shall waive during the effective periods in paragraph (b) the coinsurance for a 21 day prescription filled at a Preferred retail pharmacy when the Mail Service Prescription Drug Program vendor is unable to fill the prescription within the service standards. This waiver of the coinsurance shall be in effect for 14 calendar days after notice to the enrollee as described in paragraph (c)(2) below.

(2) The Carrier shall deliver to the enrollee a written or telephone notice no later than 5 days from the date of receipt for clean or non-diverted prescriptions and no later than 12 days from the date of receipt for diverted prescriptions.

This notice shall:

(i) advise the enrollee that the Mail Service Prescription Drug Program may not be able to fill the prescription(s) within the service standard timeframes;

(ii) advise the enrollee that any applicable coinsurance will be waived for a 21 day supply of the medication(s) when filled at a Preferred retail pharmacy;

(iii) provide the enrollee with instructions on how to use the waiver, and

(iv) advise the enrollee when the waiver will expire.

(3) The Carrier may use next day delivery service at no additional cost to the enrollee in order to meet the service standards in (a)(1) and (a)(2).

SECTION 4.9
SMALL BUSINESS SUBCONTRACTING PLAN (JAN 2002) (FAR 52.219-9) (AS AMENDED)

An amended clause 52.219-9, Small Business Subcontracting Plan, is attached to Appendix E.

SECTION 4.10
LETTER OF CREDIT (JAN 1997)

As of January 1, 1997, OPM will administer Letter of Credit drawdowns directly with the local Plans.

SECTION 4.11
PILOTING OF COST CONTAINMENT PROGRAMS (JAN 2001)

Upon approval by the Contracting Officer, the Carrier may design and implement pilot programs in one or more local Plan areas that test the feasibility and examine the impact of various managed care initiatives. The Carrier shall brief the Contracting Officer on a pilot program prior to its implementation, advise the Contracting Officer of the progress of the pilot program and provide a written evaluation at the conclusion of the pilot program. The evaluation of the pilot program shall, at a minimum, assess the cost effectiveness, effect on quality of care and/or quality of life, and customer satisfaction, and recommend whether the pilot program should be continued or expanded.

SECTION 4.12
TRANSITION COSTS FOR PLAN TERMINATIONS (JAN 1999)

In the event a Participating Plan's license to use the Blue Cross and/or Blue Shield service marks is terminated, thereby rendering it ineligible to participate in this Contract, the costs of transitioning the terminated Plan's Service Benefit Plan subscribers to a successor Plan shall be subject to advance approval. The Carrier shall submit to OPM a proposed transition plan, together with a detailed estimate of costs, prior to the incurrence of any significant transition costs. OPM and the Carrier shall negotiate an advance agreement pursuant to FAR 31.109 that covers the extent of allowable transition costs.

SECTION 4.13
PAYMENT BY ELECTRONIC FUNDS TRANSFER-CENTRAL CONTRACTOR REGISTRATION (MAY 1999) (FAR 52.232-33)

The references to the Central Contractor Registration in FAR 52.232-33 are not applicable to this contract.

SECTION 4.14
FEDERAL INCOME TAX RELATED TO HEALTH INSURANCE PROVIDERS' FEE (JANUARY 2015)

(a) Notwithstanding FAR 31.205-41(b)(1) and this Contract Section 3.2(b)(1)(ii), a charge for an incremental amount of Federal income tax liability incurred as the result of compliance with the Health Insurance Providers Fee (HIP Fee) provision of the Affordable Care Act section 9010 (hereafter referred to as the "HIP Tax Cost") by a participating local plan (Local Plan) that administers the Service Benefit Plan on behalf of the Blue Cross and Blue Shield Association (Carrier), and that is a covered entity within the meaning of 26 CFR Part 57, is an allowable cost to the Carrier under this contract under the criteria set forth below.

(1) The allowable cost to the Carrier for a year is the sum of the HIP Tax Cost for each Local Plan. The HIP Tax Cost for each Local Plan equals:
the amount reimbursed by OPM to the Carrier for the HIP Fee attributable to the Local Plan (Local Plan HIP Fee) for the year, divided by one minus the tax rate for the Local Plan specified under section (2) below, (Local Plan Tax Rate), less the Local Plan HIP Fee. In mathematical terms, the allowable charge to the Carrier for the HIP Tax Cost is the sum of each Local Plan's application of the formula below:

$$\left[\frac{\text{Local Plan HIP Fee}}{1 - \text{Local Plan Tax Rate}}\right] - \text{Local Plan HIP Fee}$$

(2) The Local Plan Tax Rate for purposes of the formula specified in section (1) is the lowest of the following:
(a) the rate specified at 26 USC §11 (b) (1) (D),

(b) the rate specified at 26 USC § 55(b)(1)(B)(i), for any year in which the Local Plan is entitled to the special deduction under 26 USC § 833(a)(2), or
(c) zero, for any year in which the Local Plan experiences a Net Operating Loss or other circumstance resulting in no tax liability. For a year in which the Local Plan experiences a Net Operating Loss resulting in no tax liability, the Carrier will charge the HIP Tax Cost attributable to the Local Plan in the first subsequent year in which the Local Plan's tax liability is greater than zero. The Local Plan will calculate the HIP Tax Cost in this circumstance by applying the formula using the HIP Fee for the year of the loss and the Local Plan Tax Rate for the year in which the tax liability is greater than zero. This charge by the Carrier is in addition to the charge allowed by the Carrier for the Local Plan Tax Cost for the year in which the tax liability is greater than zero.

(d) If the Local Plan Tax Rate reflected on the Local Plan's tax return actually filed for the contract year (which normally occurs the following year) differs from the Local Plan Tax Rate that was anticipated when the costs were drawn down by the Carrier for the contract year as allowable administrative expenses, the Carrier will make a commensurate adjustment to its current year drawdown of administrative expenses.

(b) The Contracting Officer or an authorized representative of the Contracting Officer shall have the right to examine and audit all books and records, including tax filings, relating to the calculation of the HIP Tax Cost charge for each Local Plan.

Part IV - Attachment I
SECTION 4.14
FEDERAL INCOME TAX RELATED TO HEALTH INSURER'S PROVIDER FEE

Examples of Allowable 9010 Tax Cost:

C is an experience rated FEHB carrier consisting of participating Local Plans F and G who underwrite and administer C in different geographic areas.

In 2015, F reports $900 on IRS Form 8963 and pays $500 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the $500 HIP Fee, F's Form 8963 reflects that $300 is attributable to F's FEHBP business.

Also in 2015, G reports $950 on IRS Form 8963 and pays $550 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the $550 HIP Fee, G's Form 8963 reflects that $325 is attributable to G's FEHBP business.

In 2015, C draws down a 2015 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2014 health risks, which is calculated as the sum of F and G's HIP Fee, or $300 +325 = $725, which is an allowable cost, from its FEHB letter of credit account (LOCA). C reimburses F for its HIP Fee of 300 and G for its HIP Fee of 325.

F records income of $300 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by $300. F records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, F pays quarterly payments to the IRS for its' 2015 tax liability. F's 2015 tax rate is 35 percent.

G records income of $325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by $325. G records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, G pays quarterly payments to the IRS for its' 2015 tax liability. Because G claims a special deduction under 26 USC § 833(a)(2), G's 2015 tax rate is 20 percent.

In 2015, C also draws down from its LOCA a 2015 HIP Tax Cost reimbursement for the 2015 income tax expense accrued and paid by F & G in 2015. C's 2015 HIP Tax cost reimbursement is calculated as follows:

Local Plan F HIP Tax Cost: ($300/1-.35)-$300 = $162
Local Plan G HIP Tax Cost: ($325/1-.20)-$325 = $81
Sum which is C's allowable HIP Tax Cost for 2015 = $243

In 2016, F & G report the same HIP Fee expense for 2015 health risks.

In 2016, F experiences the same tax rate as for 2015, but G incurs a net operating loss, resulting in a zero percent tax rate for 2016.

In 2016, C draws down a 2016 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2015 health risks of 300 + 325 = $725, which is an allowable cost, from C's FEHB letter of credit account (LOCA). C reimburses F for 300 and G for 325.

In 2016, F proceeds as in 2015 and C may charge 162 as an allowable HIP Tax Cost attributable to F in 2016.

In 2016 G records income of $325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by $325. Because G determines that its 2016 tax liability will be zero as it will have a Net Operating Loss for 2016, C does not incur an allowable 2016 HIP Tax Cost attributable to G. C must refund any such amounts drawn down during 2016.

Local Plan F HIP Tax Cost for 2016 = 162
Local Plan G HIP Tax Cost for 2016 = 0
Reimbursement attributable to G = adjustment for amounts drawn down by C, if any
Sum = C's allowable HIP Tax Cost for 2016 = 162 less adjustment.

In 2017, F proceeds as in 2015. C's allowable 2017 HIP Tax Cost includes $162 attributable to F. In 2017, G has an operating gain and reports the same HIP Fee amount and experiences the same 20% tax rate as in 2015. C's allowable 2017 HIP Tax Cost includes $81 attributable to G.

In addition, in 2017, because G's operating gain results in a tax rate higher than zero, G incurs economic disadvantage. This is because the 2016 HIP Fee reimbursement of $325 has reduced G's otherwise applicable Net Operating Loss carry-forward amount. G calculates the economic disadvantage as the difference between its 2017 tax liability with and without the 2016 HIP Fee reimbursement. This disadvantage is included in the Carrier's 2017 charge as an allowable HIP Tax Cost with respect to 2016. This is calculated as $325 (2016 HIP Fee) divided by 1-20% (application of 2017 Local Plan Tax Rate), less $325.]

Local Plan F HIP Tax Cost for 2017 = 162
Local Plan G HIP Tax Cost for 2017 = 81
Local Plan G HIP Tax Cost for 2017 due to 2016 HIP Fee reimbursement = apply formula using 2016 Fee Reimbursement amount and 2017 tax rate of 20% =81
Sum = C's allowable HIP Tax Cost for 2017 = 162 + 81 + 81 = $324

APPENDIX A

ATTACH

2023 FEHB BROCHURE

APPENDIX B

SUBSCRIPTION RATES, CHARGES, ALLOWANCES AND LIMITATIONS

Fee-For-Service Carrier
(Blue Cross and Blue Shield Association)

CONTRACT NO. CS 1039
Effective January 1, 2023

(a) Biweekly net-to-Carrier rates, with appropriate adjustments for Enrollees paid on other than a biweekly basis, are as follows:

$333.07 Self, $748.48 Self Plus One, and $816.66 Family BASIC Option
$386.65 Self, $845.55 Self Plus One, and $922.41 Family STANDARD Option
$208.52 Self, $448.25 Self Plus One, and $493.06 Family FOCUS Option

(b) The amount of administrative expenses and charges to be included in the Annual Accounting Statement required by Section 3.2 shall be as set out in the schedule below:

Item	Amount
(i) Administrative Expenses	Actual, but not to exceed the Contractual Expense Limitation for 2023, * plus an amount sufficient to cover the costs needed to pay the Plan's Independent Public Accountant to undertake the audits and agreed upon procedures required in the "FEHBP Experienced-Rated Carrier and Service Organization Audit Guide."
(ii) Taxes	Actual (except that premium taxes as defined are not allowable).
(iii) Service Charge**	[redacted]

*The Contractual Expense Limitation for 2023 is [redacted]. Notwithstanding Section 3.2(b) of this Contract, costs of "activities that improve healthcare quality" as determined in accordance with the medical loss ratio provision of the Affordable Care Act (Section 2718 of the Public Health Service act; 42 U.S.C. 300gg-18 and its implementing regulations), are accounted for as benefits and not counted toward the Contractual Expense Limit.

** The Service Charge for the 2023 contract year is based on the Overall Performance Score calculated in accordance with the 2022 Appendix F. The Service Charge for the 2024 contract year will be based on the Overall Performance Score calculated in accordance with the 2023 Appendix F.

APPENDIX E

Small Business Subcontracting Plan (NOV 2021) (FAR 52.219-9)

(a) This clause does not apply to small business concerns.

(b) *Definitions*. As used in this clause—

"Alaska Native Corporation (ANC)" means any Regional Corporation, Village Corporation, Urban Corporation, or Group Corporation organized under the laws of the State of Alaska in accordance with the Alaska Native Claims Settlement Act, as amended (43 U.S.C. 1601, et seq.) and which is considered a minority and economically disadvantaged concern under the criteria at 43 U.S.C. 1626(e)(1). This definition also includes ANC direct and indirect subsidiary corporations, joint ventures, and partnerships that meet the requirements of 43 U.S.C. 1626(e)(2).

"Commercial plan" means a subcontracting plan (including goals) that covers the offeror's fiscal year and that applies to the entire production of commercial products and commercial services sold by either the entire company or a portion thereof (*e.g.,* division, plant, or product line).

"Commercial product" means a product that satisfies the definition of "commercial product" in the Federal Acquisition Regulation (FAR) 2.101.

"Commercial service" means a service that satisfies the definition of "commercial service" in FAR 2.101.

"Indian tribe" means any Indian tribe, band, group, pueblo, or community, including native villages and native groups (including corporations organized by Kenai, Juneau, Sitka, and Kodiak) as defined in the Alaska Native Claims Settlement Act (43 U.S.C.A. 1601 et seq.), that is recognized by the Federal Government as eligible for services from the Bureau of Indian Affairs in accordance with 25 U.S.C. 1452(c). This definition also includes Indian-owned economic enterprises that meet the requirements of 25 U.S.C. 1452(e).

"Individual subcontracting plan" means a subcontracting plan that covers the entire contract period (including option periods), applies to a specific contract, and has goals that are based on the offeror's planned subcontracting in support of the specific contract, except that indirect costs incurred for common or joint purposes may be allocated on a prorated basis to the contract.

"Master subcontracting plan" means a subcontracting plan that contains all the required elements of an individual subcontracting plan, except goals, and may be incorporated into individual subcontracting plans, provided the master subcontracting plan has been approved.

"Reduced payment" means a payment that is for less than the amount agreed upon in a subcontract in accordance with its terms and conditions, for supplies and services for which the Government has paid the prime contractor.

"Subcontract" means any agreement (other than one involving an employer-employee relationship) entered into by a Federal Government prime Contractor or subcontractor calling for supplies or services required for performance of the contract or subcontract.

"Total contract dollars" means the final anticipated dollar value, including the dollar value of all options.

"Untimely payment" means a payment to a subcontractor that is more than 90 days past due under the terms and conditions of a subcontract for supplies and services for which the Government has paid the prime contractor.

(c) (1) The Offeror, upon request by the Contracting Officer, shall submit and negotiate a subcontracting plan, where applicable, that separately addresses subcontracting with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns. If the Offeror is submitting an individual subcontracting plan, the plan must separately address subcontracting with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns, with a separate part for the basic contract and separate parts for each option (if any). The subcontracting plan shall be included in and made a part of the resultant contract. The subcontracting plan shall be negotiated within the time specified by the Contracting Officer. Failure to submit and negotiate the subcontracting plan shall make the Offeror ineligible for award of a contract.

2)(i) The Contractor may accept a subcontractor's written representations of its size and socioeconomic status as a small business, small disadvantaged business, veteran-owned small business, service-disabled veteran-owned small business, or a women-owned small business if the subcontractor represents that the size and socioeconomic status representations with its offer are current, accurate, and complete as of the date of the offer for the subcontract.

(ii) The Contractor may accept a subcontractor's representations of its size and socioeconomic status as a small business, small disadvantaged business, veteran-owned small business, service-disabled veteran-owned small business, or a women-owned small business in the System for Award Management (SAM) if–

(A) The subcontractor is registered in SAM; and

(B) The subcontractor represents that the size and socioeconomic status representations made in SAM are current, accurate and complete as of the date of the offer for the subcontract.

(iii) The Contractor may not require the use of SAM for the purposes of representing size or socioeconomic status in connection with a subcontract.

(iv) In accordance with 13 CFR 121.411, 124.1015, 125.29, 126.900, and 127.700, a contractor acting in good faith is not liable for misrepresentations made by its subcontractors regarding the subcontractor's size or socioeconomic status.

(d) The offeror's subcontracting plan shall include the following:

(1) Separate goals, expressed in terms of total dollars subcontracted, and as a percentage of total planned subcontracting dollars, for the use of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns as subcontractors. For individual subcontracting plans, and if required by the Contracting Officer, goals shall also be expressed in terms of percentage of total contract dollars, in addition to the goals expressed as a percentage of total subcontract dollars. The Offeror shall include all subcontracts that contribute to contract performance, and may include a proportionate share of products and services that are normally allocated as indirect costs. In accordance with 43 U.S.C. 1626–

(i) Subcontracts awarded to an ANC or Indian tribe shall be counted towards the subcontracting goals for small business and small disadvantaged business concerns, regardless of the size or Small Business Administration certification status of the ANC or Indian tribe; and

(ii) Where one or more subcontractors are in the subcontract tier between the prime Contractor and the ANC or Indian tribe, the ANC or Indian tribe shall designate the appropriate Contractor(s) to count the subcontract towards its small business and small disadvantaged business subcontracting goals.

(A) In most cases, the appropriate Contractor is the Contractor that awarded the subcontract to the ANC or Indian tribe.

(B) If the ANC or Indian tribe designates more than one Contractor to count the subcontract toward its goals, the ANC or Indian tribe shall designate only a portion of the total subcontract award to each Contractor. The sum of the amounts designated to various Contractors cannot exceed the total value of the subcontract.

(C) The ANC or Indian tribe shall give a copy of the written designation to the Contracting Officer, the prime Contractor, and the subcontractors in between the prime Contractor and the ANC or Indian tribe within 30 days of the date of the subcontract award.

(D) If the Contracting Officer does not receive a copy of the ANC's or the Indian tribe's written designation within 30 days of the subcontract award, the Contractor that awarded the subcontract to the ANC or Indian tribe will be considered the designated Contractor.

(2) A statement of—

(i) Total dollars planned to be subcontracted for an individual subcontracting plan; or the Offeror's total projected sales, expressed in dollars, and the total value of projected subcontracts, including all indirect costs except as described in paragraph (g) of this clause, to support the sales for a commercial plan;

(ii) Total dollars planned to be subcontracted to small business concerns (including ANC and Indian tribes); and

(iii) Total dollars planned to be subcontracted to veteran-owned small business concerns;

(iv) Total dollars planned to be subcontracted to service-disabled veteran-owned small business;

(v) Total dollars planned to be subcontracted to HUBZone small business concerns;

(vi) Total dollars planned to be subcontracted to small disadvantaged business concerns (including ANC and Indian tribes); and

(vii) Total dollars planned to be subcontracted to women-owned small business concerns

(3) A description of the principal types of supplies and services to be subcontracted, and an identification of the types planned for subcontracting to—

(i) Small business concerns;

(ii) Veteran-owned small business concerns;

(iii) Service-disabled veteran-owned small business concerns;

(iv) HUBZone small business concerns;

(v) Small disadvantaged business concerns; and

(vi) Women-owned small business concerns.

(4) A description of the method used to develop the subcontracting goals in paragraph (d)(1) of this clause.

(5) A description of the method used to identify potential sources for solicitation purposes (*e.g.,* existing company source lists, SAM, veterans service organizations, the National Minority Purchasing Council Vendor Information Service, the Research and Information Division of the Minority Business Development Agency in the Department of Commerce, or small, HUBZone, small disadvantaged, and women-owned small business trade associations). A firm may rely on the information contained in SAM as an accurate representation of a concern's size and ownership characteristics for the purposes of maintaining a small, veteran-owned small, service-disabled veteran-owned small, HUBZone small, small disadvantaged, and women-owned small business source list. Use of SAM as its source list does not relieve a firm of its

responsibilities (*e.g.,* outreach, assistance, counseling, or publicizing subcontracting opportunities) in this clause.

(6) A statement as to whether or not the Offeror included indirect costs in establishing subcontracting goals, and a description of the method used to determine the proportionate share of indirect costs to be incurred with—

(i) Small business concerns (including ANC and Indian tribes);

(ii) Veteran-owned small business concerns;

(iii) Service-disabled veteran-owned small business concerns;

(iv) HUBZone small business concerns;

(v) Small disadvantaged business concerns; and

(vi) Women-owned small business concerns.

(7) The name of the individual employed by the Offeror who will administer the Offeror's subcontracting program, and a description of the duties of the individual.

(8) A description of the efforts the Offeror will make to assure that small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns have an equitable opportunity to compete for subcontracts.

(9) Assurances that the Offeror will include the clause of this contract entitled "Utilization of Small Business Concerns" in all subcontracts that offer further subcontracting opportunities, and that the Offeror will require all subcontractors (except small business concerns) that receive subcontracts in excess of the applicable threshold specified in FAR 19.702(a) on the date of subcontract award, with further subcontracting possibilities to adopt a subcontracting plan that complies with the requirements of this clause.

(10) Assurances that the Offeror will—

(i) Cooperate in any studies or surveys as may be required;

(ii) Submit periodic reports so that the Government can determine the extent of compliance by the Offeror with the subcontracting plan;

(iii) After November 30, 2017, include subcontracting data for each order when reporting subcontracting achievements for indefinite-delivery, indefinite-quantity contracts with individual subcontracting plans where the contract is intended for use by multiple agencies;

(iv) Submit Standard Form (SF) 294 Subcontracting Report for Individual Contract in accordance with paragraph (l) of this clause. Submit the Summary Subcontract Report (SSR), in accordance with paragraph (l) of this clause. The reports shall provide information on subcontract awards to small business concerns (including ANCs and Indian tribes that are not small businesses), veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns (including ANCs and Indian tribes that have not been certified by the Small Business Administration as small disadvantaged businesses), women-owned small business concerns, and for NASA only, Historically Black Colleges and Universities and Minority Institutions. Reporting shall be in accordance with this clause, or as provided in agency regulations;

(v) Ensure that its subcontractors with subcontracting plans agree to submit the SF 294 in accordance with paragraph (l) of this clause. Ensure that its subcontractors with subcontracting plans agree to submit the SSR in accordance with paragraph (l) of this clause

(vi) [RESERVED]; and

(vii) Require that each subcontractor with a subcontracting plan provide the prime contract number, its own unique entity identifier, and the e-mail address of the subcontractor's

official responsible for acknowledging receipt of or rejecting the Standard Forms 294, to its subcontractors with subcontracting plans.

(11) A description of the types of records that will be maintained concerning procedures that have been adopted to comply with the requirements and goals in the plan, including establishing source lists; and a description of the offeror's efforts to locate small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns and award subcontracts to them. The records shall include at least the following (on a plant-wide or company-wide basis, unless otherwise indicated):

(i) Source lists (*e.g.,* SAM), guides, and other data that identify small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns.

(ii) Organizations contacted in an attempt to locate sources that are small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, or women-owned small business concerns.

(iii) Records on each subcontract solicitation resulting in an award of more than the simplified acquisition threshold, as defined in FAR 2.101 on the date of subcontract award, indicating—

(A) Whether small business concerns were solicited and, if not, why not;

(B) Whether veteran-owned small business concerns were solicited and, if not, why not;

(C) Whether service-disabled veteran-owned small business concerns were solicited and, if not, why not;

(D) Whether HUBZone small business concerns were solicited and, if not, why not;

(E) Whether small disadvantaged business concerns were solicited and, if not, why not;

(F) Whether women-owned small business concerns were solicited and, if not, why not; and

(G) If applicable, the reason award was not made to a small business concern.

(iv) Records of any outreach efforts to contact—

(A) Trade associations;

(B) Business development organizations;

(C) Conferences and trade fairs to locate small, HUBZone small, small disadvantaged service-disabled veteran-owned, and women-owned small business sources; and

(D) Veterans service organizations.

(v) Records of internal guidance and encouragement provided to buyers through—

(A) Workshops, seminars, training, etc.; and

(B) Monitoring performance to evaluate compliance with the program's requirements.

(vi) On a contract-by-contract basis, records to support award data submitted by the offeror to the Government, including the name, address, and business size of each subcontractor. Contractors having commercial plans need not comply with this requirement.

(12) Assurances that the Offeror will make a good faith effort to acquire articles, equipment, supplies, services, or materials, or obtain the performance of construction work from the small business concerns that it used in preparing the bid or proposal, in the same or greater scope, amount, and quality used in preparing and submitting the bid or proposal. Responding to a request for a quote does not constitute use in preparing a bid or proposal. The Offeror used a small business concern in preparing the bid or proposal if–

(i) The Offeror identifies the small business concern as a subcontractor in the bid or proposal or associated small business subcontracting plan, to furnish certain supplies or perform a portion of the subcontract; or

(ii) The Offeror used the small business concern's pricing or cost information or technical expertise in preparing the bid or proposal, where there is written evidence of an intent or understanding that the small business concern will be awarded a subcontract for the related work if the Offeror is awarded the contract.

(13) Assurances that the Contractor will provide the Contracting Officer with a written explanation if the Contractor fails to acquire articles, equipment, supplies, services or materials or obtain the performance of construction work as described in (d)(12) of this clause. This written explanation must be submitted to the Contracting Officer within 30 days of contract completion.

(14) Assurances that the Contractor will not prohibit a subcontractor from discussing with the Contracting Officer any material matter pertaining to payment to or utilization of a subcontractor.

(15) Assurances that the Offeror will pay its small business subcontractors on time and in accordance with the terms and conditions of the underlying subcontract, and notify the contracting officer when the prime contractor makes either a reduced or an untimely payment to a small business subcontractor (see 52.242-5).

(e) In order to effectively implement this plan to the extent consistent with efficient contract performance, the Contractor shall perform the following functions:

(1) Assist small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns by arranging solicitations, time for the preparation of bids, quantities, specifications, and delivery schedules so as to facilitate the participation by such concerns. Where the Contractor's lists of potential small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business subcontractors are excessively long, reasonable effort shall be made to give all such small business concerns an opportunity to compete over a period of time.

(2) Provide adequate and timely consideration of the potentialities of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns in all "make-or-buy" decisions.

(3) Counsel and discuss subcontracting opportunities with representatives of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business firms.

(4) Confirm that a subcontractor representing itself as a HUBZone small business concern is certified by SBA as a HUBZone small business concern in accordance with 52.219-8(d)(2).

(5) Provide notice to subcontractors concerning penalties and remedies for misrepresentations of business status as small, veteran-owned small business, HUBZone small, small disadvantaged, or women-owned small business for the purpose of obtaining a subcontract that is to be included as part or all of a goal contained in the Contractor's subcontracting plan.

(6) For all competitive subcontracts over the simplified acquisition threshold, as defined in FAR 2.101 on the date of subcontract award, in which a small business concern received a small business preference, upon determination of the successful subcontract Offeror, prior to award of the subcontract the Contractor must inform each unsuccessful small business subcontract Offeror

in writing of the name and location of the apparent successful Offeror and if the successful subcontract Offeror is a small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, or women-owned small business concern.

(7) Assign each subcontract the NAICS code and corresponding size standard that best describes the principal purpose of the subcontract.

(f) A master subcontracting plan on a plant or division-wide basis that contains all the elements required by paragraph (d) of this clause, except goals, may be incorporated by reference as a part of the subcontracting plan required of the Offeror by this clause; provided—

(1) The master subcontracting plan has been approved;

(2) The Offeror ensures that the master subcontracting plan is updated as necessary and provides copies of the approved master subcontracting plan, including evidence of its approval, to the Contracting Officer; and

(3) Goals and any deviations from the master subcontracting plan deemed necessary by the Contracting Officer to satisfy the requirements of this contract are set forth in the individual subcontracting plan.

(g) A commercial plan is the preferred type of subcontracting plan for contractors furnishing commercial products and commercial services. The commercial plan shall relate to the offeror's planned subcontracting generally, for both commercial and Government business, rather than solely to the Government contract. Once the Contractor's commercial plan has been approved, the Government will not require another subcontracting plan from the same Contractor while the plan remains in effect, as long as the product or service being provided by the Contractor continues to meet the definition of a commercial product or commercial service. A Contractor with a commercial plan shall comply with the reporting requirements stated in paragraph (d)(10) of this clause by submitting one SSR for all contracts covered by its commercial plan. A Contractor authorized to use a commercial subcontracting plan shall include in its subcontracting goals and in its SSR all indirect costs, with the exception of those such as the following: Employee salaries and benefits; payments for petty cash; depreciation; interest; income taxes; property taxes; lease payments; bank fees; fines, claims, and dues; original equipment manufacturer relationships during warranty periods (negotiated up front with the product); utilities and other services purchased from a municipality or an entity solely authorized by the municipality to provide those services in a particular geographical region; and philanthropic contributions. This report shall be acknowledged or rejected by the Contracting Officer who approved the plan. This report shall be submitted within 30 days after the end of the Government's fiscal year.

(h) Prior compliance of the offeror with other such subcontracting plans under previous contracts will be considered by the Contracting Officer in determining the responsibility of the offeror for award of the contract.

(i) A contract may have no more than one subcontracting plan. When a contract modification exceeds the subcontracting plan threshold in 19.702(a), or an option is exercised, the goals of the existing subcontracting plan shall be amended to reflect any new subcontracting opportunities. When the goals in a subcontracting plan are amended, these goal changes do not apply retroactively.

(j) Subcontracting plans are not required from subcontractors when the prime contract contains the clause at FAR 52.212-5, Contract Terms and Conditions Required to Implement Statutes or Executive Orders—Commercial Products and Commercial Services, or when the

subcontractor provides a commercial product or commercial service subject to the clause at FAR 52.244-6, Subcontracts for Commercial Products and Commercial Services, under a prime contract.

(k)The failure of the Contractor or subcontractor to comply in good faith with—

(1) the clause of this contract entitled "Utilization Of Small Business Concerns," or

(2) an approved plan required by this clause, shall be a material breach of the contract and may be considered in any past performance evaluation of the Contractor.

(l) The Contractor shall submit a SF 294. Purchases from a corporation, company, or subdivision that is an affiliate of the Contractor or subcontractor are not included in these reports. Subcontract awards by affiliates shall be treated as subcontract awards by the Contractor. Subcontract award data reported by the Contractor and subcontractors shall be limited to awards made to their immediate next-tier subcontractors. Credit cannot be taken for awards made to lower tier subcontractors, unless the Contractor or subcontractor has been designated to receive a small business or small disadvantaged business credit from an ANC or Indian tribe. Only subcontracts involving performance in the U.S. or its outlying areas should be included in these reports with the exception of subcontracts under a contract awarded by the State Department or any other agency that has statutory or regulatory authority to require subcontracting plans for subcontracts performed outside the United States and its outlying areas.

(1) SF 294. This report is not required for commercial plans. The report is required for each contract containing an individual subcontracting plan.

(i) The report shall be submitted semi-annually during contract performance for the periods ending March 31 and September 30. A report is also required for each contract within 30 days of contract completion. Reports are due 30 days after the close of each reporting period, unless otherwise directed by the Contracting Officer. Reports are required when due, regardless of whether there has been any subcontracting activity since the inception of the contract or the previous reporting period. When a Contracting Officer rejects a report, the Contractor shall submit a revised report within 30 days of receiving the notice of report rejection.

(ii) (A) When a subcontracting plan contains separate goals for the basic contract and each option, as prescribed by FAR 19.704(c), the dollar goal inserted on this report shall be the sum of the base period through the current option; for example, for a report submitted after the second option is exercised, the dollar goal would be the sum of the goals for the basic contract, the first option, and the second option.

(B) If a subcontracting plan has been added to the contract pursuant to 19.702(a)(3) or 19.301-2(e), the Contractor's achievements must be reported in the report on a cumulative basis from the date of incorporation of the subcontracting plan into the contract.

(i) When a subcontracting plan includes indirect costs in the goals, these costs must be included in this report.

(ii) The authority to acknowledge receipt or reject the SF 294 resides–

(A) In the case of the prime Contractor, with the Contracting Officer; and

(B) In the case of a subcontract with a subcontracting plan, with the entity that awarded the subcontract.

(2) SSR. (i) Reports submitted under individual contract plans.

(A) This report encompasses all subcontracting under prime contracts and subcontracts with an executive agency, regardless of the dollar value of the subcontracts. This report also includes indirect costs on a prorated basis when the indirect costs are excluded from the subcontracting goals.

(B) The report may be submitted on a corporate, company or subdivision (e.g., plant or division operating as a separate profit center) basis, unless otherwise directed by the agency.

(C) If the Contractor and/or a subcontractor is performing work for more than one executive agency, a separate report shall be submitted to each executive agency covering only that agency's contracts, provided at least one of that agency's contracts is over the applicable threshold specified in FAR 19.702(a), and the contract contains a subcontracting plan. For DoD, a consolidated report shall be submitted for all contracts awarded by military departments/agencies and/or subcontracts awarded by DoD prime contractors.

(D) The report shall be submitted annually by October 30, for the twelve month period ending September 30. When a Contracting Officer rejects an SSR, the Contractor is required to submit a revised SSR within 30 days of receiving the notice of report rejection.

(E) Subcontract awards that are related to work for more than one executive agency shall be appropriately allocated.

(F) The authority to acknowledge or reject SSRs, including SSRs submitted by subcontractors with subcontracting plans, resides with the Government agency awarding the prime contracts unless stated otherwise in the contract.

(ii) Reports submitted under a commercial plan.

(A) The report shall include all subcontract awards under the commercial plan in effect during the Government's fiscal year and all indirect costs.

(B) The report shall be submitted annually, within 30 days after the end of the Government's fiscal year.

(C) If a Contractor has a commercial plan and is performing work for more than one executive agency, the Contractor shall specify the percentage of dollars attributable to each agency.

(D) The authority to acknowledge or reject SSRs for commercial plans resides with the Contracting Officer who approved the commercial plan.

APPENDIX F

Measures and contributions to performance areas and scores for 2023 Performance and 2024 Service Charge

To be performed in accordance with the 2023 FEHB Plan Performance Assessment Procedure Manual and the FEHB Plan Performance Assessment Methodology Carrier Letter (CL 2020-15). The Service Charge for the 2024 contract year will be based on the Overall Performance Score calculated in accordance with this Appendix F.

1. Performance Area Contributions to Overall Performance Score (OPS)

Performance Area	Contribution to Overall Performance Score
Clinical Quality, Customer Service, and Resource Use	65%
Contract Oversight	35%

2. Clinical Quality, Customer Service, and Resource Use (QCR) Performance Area Measures

Performance Area	Measure	Abbrv	Measure Source	Priority Level	Measure Weight
	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)	AAB	HEDIS	1	2.50
	Controlling High Blood Pressure	CBP	HEDIS	1	2.50
	Hemoglobin A1c Control for Patients with Diabetes (HbA1c Control <8.0%)	HBD	HEDIS	1	2.50
	Asthma Medication Ratio	AMR	HEDIS	2	1.25
	Breast Cancer Screening	BCS	HEDIS	2	1.25

Clinical Quality	Cervical Cancer Screening	CCS	HEDIS	2	1.25
	Colorectal Cancer Screening	COL	HEDIS	2	1.25
	Follow-Up After Emergency Department Visit for Substance Use (30 Day)	FUA	HEDIS	2	1.25
	Follow-Up After Emergency Department Visit for Mental Illness (30 Day)	FUM	HEDIS	2	1.25
	Flu Vaccinations for Adults (18-64)	FVA	CAHPS	2	1.25
	Prenatal and Postpartum Care (Timeliness of Prenatal Care)	PPC	HEDIS	2	1.25
	Statin Therapy for Patients with Cardiovascular Disease (Statin Adherence 80%)	SPC	HEDIS	2	1.25
	Well Child Visits First 30 Months of Life – Well-Child Visits in the First 15 months: 6 or More Well-Child Visits	W30	HEDIS	2	1.25
Customer Service	Coordination of Care	CoC	CAHPS	3	1.00
	Claims Processing	CP	CAHPS	3	1.00
	Getting Care Quickly	GCQ	CAHPS	3	1.00
	Getting Needed Care	GNC	CAHPS	3	1.00
	Overall Health Plan Rating	RHP	CAHPS	3	1.00

	Overall Personal Doctor Rating	RPD	CAHPS	3	1.00
Resource Use	Use of Imaging Studies for Low Back Pain (18-64)	LBP	HEDIS	1	2.50
	Acute Hospital Utilization	AHU	HEDIS	2	1.25
	Emergency Department Utilization	EDU	HEDIS	2	1.25
	Plan All Cause Readmissions: Observed/Expected (O/E) Ratio	PCR	HEDIS	2	1.25

EXHIBIT H

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Standard Contract Amendment

For

Fee-For-Service Carriers

2024

(FFS – 2024)

AMENDMENT TO CONTRACT CS 1039

CONTRACT NO: CS 1039
EFFECTIVE: January 1, 2024

AMENDMENT NO. 2024A
EFFECTIVE: January 1, 2024

BETWEEN: THE UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
hereafter called the OPM, the Agency, or the Government

Address: 1900 E Street, NW
Washington, DC 20415-3610

AND

CONTRACTOR: Blue Cross Blue Shield Association
hereafter also called the Carrier

Address: 1310 G Street, NW
Washington, DC 20005

In consideration of payment by the Agency of subscription charges set forth in Appendix B, the Carrier agrees to perform all of the services set forth in this contract, including Appendix A.

FOR THE CARRIER	FOR THE GOVERNMENT
David Yoder	Barbara Hansen
Name of Person Authorized to Execute Contract (Type or print)	(Type or print)
Senior Vice President	Contracting Officer, Chief FEHB1
Title	Title
[signature]	Barbara Hansen Digitally signed by BARBARA HANSEN Date: 2024.01.04 13:16:03 -05'00'
Signature	Signature
12/29/2023	01/04/2024
Date Signed	*Date Signed*

(FFS – 2024)

1. Section 1.24 Notice On Termination Of FEHBP Or Provider Contract

Clarifies application to pregnancy per CL 2022-12.

SECTION 1.24
NOTICE ON TERMINATION OF FEHBP OR PROVIDER CONTRACT (JAN 2024)

(a) Members who are undergoing treatment for a chronic or disabling condition or for pregnancy at the time a Carrier terminates (1) its FEHBP contract, or (2) the Members' specialty provider contract, or (3) a Preferred Provider Organization (PPO) or Point of Service (POS) network contract, for reasons other than cause, may be able to continue to see their specialty provider for up to 90 days or through their postpartum care.
(b) The Carrier shall notify its Members in writing of its intent to terminate its FEHBP contract, the Members' specialty provider contract, or a PPO or POS network contract, for reasons other than cause, in order to allow sufficient time for the Members to arrange for continued care after the 90-day period or their postpartum care, whichever applies. The Carrier shall send the required notice to the Member if the Carrier has in its records an address for the Member different from the Enrollee's address; otherwise, the Carrier may send the notice to the Enrollee. The Carrier shall send the notice in time to ensure it is received by the Members no less than 90 days prior to the date it terminates the contract, unless the Carrier demonstrates it was prevented from doing so for reasons beyond its control. The Carrier's prompt notice will ensure that the notification period and the transitional care period run concurrently.

2. Section 1.25 Transitional Care

Clarifies application to pregnancy per CL 2022-12.

SECTION 1.25
TRANSITIONAL CARE (JAN 2024)

(a) "Transitional care" is specialized care provided for up to 90 days or through the postpartum period, whichever is later, to a Member who is undergoing treatment for a chronic or disabling condition or for pregnancy when the Carrier terminates (1) its FEHBP contract, (2) the Member's specialty provider contract, or (3) a Preferred Provider Organization (PPO) or Point of Service (POS) network contract for reasons other than cause. The 90-day period begins the earlier of the date the Member receives the notice required under Section 1.24, Notice on Termination of FEHBP or Provider Contract, or the date the Carrier's or the provider's contract ends.

(b) The Carrier shall ensure the following:

(1) If it terminates a specialty provider contract or a PPO or POS network contract other than for cause, it allows Members who are undergoing treatment for a chronic or disabling condition or for pregnancy to continue treatment under the specialty provider for up to 90 days, or through their postpartum period, whichever is later, under the same terms and conditions that existed at the beginning of the transitional care period; and

(2) If it enrolls a new Member who voluntarily changed Carriers because the Member's former Carrier was no longer available in the FEHB Program, it provides transitional care for the Member if the Member is undergoing treatment for a chronic or disabling condition or for

pregnancy for up to 90 days, or through the postpartum period, whichever is later, under the same terms and conditions the Member had under the prior Carrier.

(c) In addition, the Carrier shall (1) pay for or provide the transitional care required under this clause at no additional cost to Members;

(2) require the specialty provider or network to promptly transfer all medical records to the designated new provider during or upon completion of the transition period, as authorized by the patient; and,

(3) require the specialty provider or network to give all necessary information to the Carrier for quality assurance purposes.

3. Section 1.26 Standards for Arrangements with Pharmacy Benefit Managers

Amends section to allow revisions to take effect before expiration of a current PBM contract or option to extend the contract term.

SECTION 1.26
STANDARDS FOR ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS (JAN 2024)

The Carrier must ensure and report that the following standards are included in new, renewing or amended contracts with Pharmacy Benefit Managers (PBMs) providing services to Enrollees and family Members effective on or after January 1, 2024.
Notwithstanding the foregoing, revisions to Section 1.26 shall not take effect before the expiration of the Carrier's current contract (including the exercise of an existing option to extend the term by not more than one year at a time) but not later than January 2027.
The PBM includes all entities that have a majority ownership interest in or majority control over the PBM. The PBM also includes any other subsidiary of the entity that has majority ownership or control over the PBM.

4. Section 1.26 (a)(8) Standards for Arrangements with Pharmacy Benefit Managers

Clarifies that the term "Third Party" does not include wholesaler and distributor arrangements with retail pharmacies.

STANDARDS FOR ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS (JAN 2024)

(8) "Third Party" means any consultant, partner, administrator, intermediary or other entity outside the scope of the relationships between or among the PBM and the FEHB enrollee, Carrier, and/or OPM. A wholesaler or distributor is not considered to be a Third Party when the wholesaler or distributor acts pursuant to its arrangement with a retail pharmacy.

5. Section 1.26 (a)(9) Standards for Arrangements with Pharmacy Benefit Managers

Adds language to clarify that the requirement extends to pharmacies affiliated with the PBM.

STANDARDS FOR ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS (JAN 2024)

(9) "Total Product Revenue" means the total dollar sales of prescription drugs at the prescription price negotiated with clients and associated administrative fees, either through retail Networks or PBM-owned or controlled mail order pharmacies, with respect to the PBM's entire client base, for the reporting period.

6. Section 1.26 (a)(10) Standards for Arrangements with Pharmacy Benefit Managers

Clarifies that mid-year formulary changes include changes made to the formulary on or after the first day of the plan year. Fixes typographical error by changing "costs sharing" to "cost sharing".

STANDARDS FOR ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS (JAN 2024)

(10) "Mid-year formulary change" means any change that occurs to the formulary effective on a date in a plan year later than the first day of the plan year. Positive mid-year formulary changes enhance formularies by adding drugs or placing a drug on a lower cost sharing tier or removing or relaxing utilization management (UM) requirements for drugs. Restrictive mid-year formulary changes negatively impact formularies by removing drugs, moving drugs to higher tiers, or tightening UM requirements for drugs.

7. Section 1.26 (b) (2) Standards for Arrangements with Pharmacy Benefit Managers

Provides new language in the PBM section regarding transparency standard and the required pass-through of negotiated amounts. Replaces the term "drugs" with the terms "drugs, products, and supplies."

STANDARDS FOR ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS (JAN 2024)
SECTION 1.26(b)

(b) Transparency Standards
(1) The PBM shall not be majority-owned or majority-controlled by a pharmaceutical manufacturing company. The PBM must disclose to the Carrier and OPM the name of any entity that has a majority ownership interest in or majority control over the PBM.
(2) The PBM shall agree to provide Pass-Through Transparent Pricing for the following categories:
(i) Retail Pharmacies: The PBM shall charge the Carrier no more than the amount as determined by Pass-Through Transparent Pricing paid to the pharmacy for each drug, product or supply plus a dispensing fee. The value of the discounts negotiated in each pharmacy agreement must be passed-through to the Carrier including all transaction fees, credits, true-ups, and other amounts collected back from the pharmacies.
(ii) Mail Order or Specialty Pharmacies not owned or affiliated with the PBM: The PBM shall charge the Carrier no more than the amount as determined by Pass Through Transparent Pricing paid to the pharmacy for each drug, product, or supply plus a dispensing fee. The value of the

discounts negotiated in each pharmacy agreement must be passed- through to the Carrier including all transaction fees, credits, true-ups, and other amounts collected back from the pharmacies.
(iii) Mail Order or Specialty Pharmacies owned or affiliated with the PBM: The PBM shall charge the Carrier the cost of drugs, products, and supplies based on the pharmacy's actual acquisition cost, plus a dispensing fee. Actual acquisition cost must include all non-specific drug discounts received from drug wholesalers and manufacturers that are attributable to the FEHBP including, but not limited to, buy side rebates, manufacturer charge backs, prompt payment discounts, market share incentives, bulk purchase/volume incentives, and other direct and indirect credits. Costs shall not be based on industry benchmarks or set pricing, including but not limited to, Average Acquisition Cost, Maximum Allowable Charge (MAC), Average Wholesale Price (AWP), and Wholesale Acquisition Cost (WAC).

8. Section 1.26 (b)(4) Standards for Arrangements with Pharmacy Benefit Managers

Clarifies that the PBM must identify all sources of revenue to the Carrier and OPM.

STANDARDS FOR ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS (JAN 2024)

(4) The PBM must identify all sources of revenue or other consideration to the Carrier and OPM as it relates to the FEHB contract.

9. Section 1.26 (b)(5) Standards for Arrangements with Pharmacy Benefit Managers

Clarifies that the PBM's fees are the only profit source to the PBM.

STANDARDS FOR ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS (JAN 2024)

(5) All of the PBM's fees, including, but not limited to, administrative or dispensing fees, must be clearly identified to retail claims, mail claims, specialty claims, and clinical or other programs, if applicable. The PBM must agree to disclose each fee to the Carrier and OPM. The PBM's fees must represent its sole source of profit for administering the Carrier's pharmacy benefits at Pass-Through Transparent Pricing.

10. Section 1.26 (b)(10) Standards for Arrangements with Pharmacy Benefit Managers

Adds a provision that the PBM must provide to OIG any wholesaler and/or any distributor contracts for PBM owned or affiliated mail order and specialty pharmacies. Fixes typographical error (changes period (.) to semicolon (;)).

STANDARDS FOR ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS (JAN 2024)

(10) In accordance with FEHBAR 1652.204-74, FAR 52.215-2 and FEHBAR 1652.246-70, all contracts and other documentation that support amounts charged and credited to the Carrier contract are fully disclosed to and auditable by the OPM Office of Inspector General (OPM OIG).

The PBM must provide the OPM OIG upon request complete copies of all PBM records including, but not limited to:

(i) All PBM contracts with Participating Pharmacies, including invoices, receipts and credits;

(ii) All PBM contracts with Pharmaceutical Manufacturers, including invoices, receipts, and credits;

(iii) All PBM owned or affiliated mail order and specialty pharmacy contracts with pharmaceutical manufacturers, distributors, and wholesalers, including invoices, receipts, and credits;

(iv) All PBM contracts with Third Parties purchasing or using claims data;

(v) All PBM transmittals in connection with sales of claims data to Third Parties or other entities;

(vi) All PBM Maximum Allowable Cost (MAC) price lists; ;

(vii) All PBM records relating to patient assistance maximizer programs, optimizer programs, or similar arrangements with Third Parties; and

(viii) All PBM records pertaining to arrangements with Third Parties, including Group Purchasing Organizations (GPOs).

(11) The Carrier at the minimum must perform an annual check of the PBM's adherence to the pricing standards outlined in (b)(2)(i), (ii), and (iii).

11. Section 1.26 (c)(6) Standards for Arrangements with Pharmacy Benefit Managers

Addresses additional gag clauses that are not covered in the PBM Transparency Standard. The current gag clause was expanded to include all providers and disclosure of clinical criteria/medical policies on prescription drugs.

STANDARDS FOR ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS (JAN 2024)

(c) Integrity Standards
(6) A PBM, or Carrier, shall not enter into a contract or other agreement that prevents, prohibits or penalizes a PBM, Carrier, or any provider (including a pharmacy or pharmacist) for disclosure of information regarding:
(i) The cost of a prescription medication to the Member; or
(ii). The availability of any therapeutically-equivalent alternative medications; or
alternative methods of purchasing the prescription medication, including but not limited to, paying a cash price that is less expensive to the Member than the cost of the prescription under the Plan; or
(iii) Any medical policies or clinical criteria for coverage of a prescription medication.

12. Section 1.26 (d)(4) Standards for Arrangements with Pharmacy Benefit Managers

Replaces the term "PBM" with "pharmacy" since the PBM is not dispensing the medications.

STANDARDS FOR ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS (JAN 2024)

(4) Dispensing accuracy – The in-network, PBM owned and affiliated mail order pharmacies dispense prescriptions to the correct patient and for the correct drug, drug strength and dosage in accordance with the prescription not less than 99.9 percent of the time.

13. Section 1.26 (d)(5) Standards for Arrangements with Pharmacy Benefit Managers

Replaces the term "PBM" with "pharmacy" since the PBM is not dispensing the medications.

STANDARDS FOR ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS (JAN 2024)

(5) Mail service pharmacy turnaround time – The in-network, PBM owned and affiliated mail order pharmacies promptly dispense and ship at least 98 percent on average of all prescriptions not requiring intervention or clarification within 3 business days or meets an equivalent measure approved by OPM.

14. Section 1.26 (e)(3) Standards for Arrangements with Pharmacy Benefit Managers

Typographical error – update "EHB" to "FEHB"

STANDARDS FOR ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS (JAN 2024)

(3) FEHB Carriers must provide Impacted Members with written notice of a Restrictive mid-year formulary change at least 60 days prior to the date the formulary change becomes effective.

15. SECTION 1.26 (f)(1) Standards for Arrangements with Pharmacy Benefit Managers

Fixes typographical error (removes unnecessary "the").

STANDARDS FOR ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

(1) The PBM must treat the Prescriber, and not itself, as the ultimate decision-maker. Furthermore, to the extent appropriate under the circumstances, the PBM must allow patient input into that decision-making process. At a minimum, the PBM must provide the patient with a written notice in the package sent to the patient that the drug interchange has occurred with the approval of the Prescriber.

16. Section 2.14 Coordination of Prescription Drug Benefits with Medicare

Amends current language based on 2024 Call Letter updates (CL2023-04). Updates Medicare Part B language to include Part B drugs in retail, specialty, and mail order pharmacies (CL2023-04). Includes new EGWP language to accommodate Medicare EGWP coordination (CL2023-02).

SECTION 2.14
COORDINATION OF PRESCRIPTION DRUG BENEFITS WITH MEDICARE (JAN 2024)

(a) The Carrier shall comply with the Center for Medicare and Medicaid Services' (CMS) Part D Coordination of Benefits Guidance. This guidance provides the requirements and procedures for coordination of benefits between Part D plans and other providers of prescription drug coverage.

(b) For Medicare Part B covered prescription drugs, the Carrier will coordinate benefits with Medicare including, but not limited to, when such prescription drugs are purchased from retail, specialty, or mail order pharmacies. OPM may recover funds if upon any future audit(s), it is determined that a drug was inappropriately billed to FEHB when it should have been adjudicated and paid for under the Member's Medicare Part B benefit.

(c) For Medicare Advantage Prescription Drug Employer Group Waiver Plans and stand-alone Prescription Drug Employer Group Waiver Plans (MA-PD EGWPs and PDP-EGWPs), the Carrier shall comply with CMS Guidance on EGWPs and related OPM guidance.

17. Section 2.18 (a) Surprise Billing

Amends section heading and adds section provisions. The Consolidated Appropriations Act, 2021 contained requirements that group health plans and issuers are required to report information about pharmacy benefits and health care spending to the Department of Health and Human Services on a yearly basis. The suggested amendment below to Sec. 2.18 adds this requirement to the FEHB contracts as well.

SECTION 2.18
SURPRISE BILLING AND TRANSPARENCY (JAN 2024)

(a) The Carrier shall comply with requirements described in the provisions of sections 2799A–1, 2799A-2, 2799A-3, 2799A-4, 2799A-5, and 2799A-7, 2799A-8 and 2799A-10(a) of the Public Health Service Act, sections 716, 717, 718, 719, 720, 722, 723 and 725(a) of the Employee Retirement Income Security Act of 1974, and sections 9816, 9817, 9818, 9819, 9820, 9822, 9823 and 9825(a) of the Internal Revenue Code of 1986 (as applicable) in the same manner as such provisions apply to a group health plan or health insurance issuer offering group or individual health insurance coverage, as described in such sections.

18. Section 5.14 Utilization of Small Business Concerns

Updates per changes to the FAR

SECTION 5.14
UTILIZATION OF SMALL BUSINESS CONCERNS (SEP 2023) (FAR 52.219-8)

(a) Definitions. As used in this contract --

"HUBZone small business concern" means a small business concern that meets the requirements described in 13 CFR 126.200, certified by the Small Business Administration (SBA) and designated by SBA as a HUBZone small business concern in the Dynamic Small Business Search (DSBS) and SAM.

"Service-disabled veteran-owned small business concern"

(1) Means a small business concern—

(i) Not less than 51 percent of which is owned by one or more service-disabled veterans or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more service-disabled veterans; and

(ii) The management and daily business operations of which are controlled by one or more service-disabled veterans or, in the case of a service-disabled veteran with permanent and severe disability, the spouse or permanent caregiver of such veteran.

(2) Service-disabled veteran means a veteran, as defined in 38 U.S.C. 101(2), with a disability that is service-connected, as defined in 38 U.S.C. 101(16).

"Small business concern" means a concern, including its affiliates, that is independently owned and operated, not dominant in its field of operation and qualified as a small business under the criteria and size standards in 13 CFR part 121, including the size standard that corresponds to the NAICS code assigned to the contract or subcontract.

"Small disadvantaged business concern", consistent with 13 CFR 124.1001, means a small business concern under the size standard applicable to the acquisition, that--

(1) Is at least 51 percent unconditionally and directly owned (as defined at 13 CFR 124.105) by—

(i) One or more socially disadvantaged (as defined at 13 CFR 124.103) and economically disadvantaged (as defined at 13 CFR 124.104) individuals who are citizens of the United States; and

(ii) Each individual claiming economic disadvantage has a net worth not exceeding the threshold at 13 CFR 124.104(c)(2) after taking into account the applicable exclusions set forth at 13 CFR 124.104(c)(2); and

(2) The management and daily business operations of which are controlled (as defined at 13.CFR 124.106) by individuals, who meet the criteria in paragraphs (1)(i) and (ii) of this definition.

"Veteran-owned small business concern" means a small business concern—

(1) Not less than 51 percent of which is owned by one or more veterans (as defined at 38 U.S.C. 101(2)) or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more veterans; and

(2) The management and daily business operations of which are controlled by one or more veterans.

"Women-owned small business concern" means a small business concern—

(1) That is at least 51 percent owned by one or more women, or, in the case of any publicly owned business, at least 51 percent of the stock of which is owned by one or more women; and

(2) Whose management and daily business operations are controlled by one or more women.

(b) It is the policy of the United States that small business concerns, veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns, and women-owned small business concerns shall have the maximum practicable opportunity to participate in performing contracts let by any Federal agency, including contracts and subcontracts for subsystems, assemblies, components, and related services for major systems. It is further the policy of the United States that its prime contractors establish procedures to ensure the timely payment of amounts due pursuant to the terms of their subcontracts with small business concerns, veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns, and women-owned small business concerns.

(c)(1) A joint venture qualifies as a small business concern if –

(i) Each party to the joint venture qualifies as small under the size standard for the solicitation; or

(ii) The protégé is small under the size standard for the solicitation in a joint venture comprised of a mentor and protégé with an approved mentor-protégé agreement under a SBA mentor-protégé program.

(2) A joint venture qualifies as –

(i) A service-disabled veteran-owned small business concern if it complies with the requirements in 13 CFR part 125; or

(ii) A HUBZone small business concern if it complies with the requirements in 13 CFR 126.616(a) through (c).

(d) The Contractor hereby agrees to carry out this policy in the awarding of subcontracts to the fullest extent consistent with efficient contract performance. The Contractor further agrees to cooperate in any studies or surveys as may be conducted by the United States Small Business Administration or the awarding agency of the United States as may be necessary to determine the extent of the Contractor's compliance with this clause.

(e)(1) The Contractor may accept a subcontractor's written representations of its size and socioeconomic status as a small business, small disadvantaged business, a veteran-owned small business, service-disabled veteran-owned small business or a women-owned small business if the subcontractor represents that the size and socioeconomic status representations with its offer are current, accurate, and complete as of the date of the offer for the subcontract.

(2) The Contractor may accept a subcontractor's representations of its size and socioeconomic status as a small business, small disadvantaged business, veteran-owned small business, service-disabled veteran-owned small business, or a women-owned small business in the System for Award Management (SAM) if–

(i) The subcontractor is registered in SAM; and

(ii) The subcontractor represents that the size and socioeconomic status representations made in SAM are current, accurate and complete as of the date of the offer for the subcontract.

(3) The Contractor may not require the use of SAM for the purposes of representing size or socioeconomic status in connection with a subcontract.

(4) In accordance with 13 CFR 121.411, 126.900, 127.700, and 128.600, a contractor acting in good faith is not liable for misrepresentations made by its subcontractors regarding the subcontractor's size or socioeconomic status.

(5) The Contractor shall confirm that a subcontractor representing itself as a HUBZone small business concern is certified by SBA as a HUBZone small business concern by accessing SAM or by accessing DSBS at https://web.sba.gov/pro-net/search/dsp_dsbs.cfm. If the subcontractor is a joint venture, the Contractor shall confirm that at least one party to the joint venture is certified by SBA as a HUBZone small business concern. The Contractor may confirm the representation by accessing SAM.

19. Section 5.54 Penalties For Unallowable Costs

Updates per changes to the FAR.

SECTION 5.54
PENALTIES FOR UNALLOWABLE COSTS (DEC 2022) (FAR 52.242-3)

(a) Definition. Proposal, as used in this clause, means either --

(1) A final indirect cost rate proposal submitted by the Contractor after the expiration of its fiscal year which--

(i) Relates to any payment made on the basis of billing rates; or

(ii) Will be used in negotiating the final contract price; or

(2) The final statement of costs incurred and estimated to be incurred under the Incentive Price Revision clause (if applicable), which is used to establish the final contract price.

(b) Contractors which include unallowable indirect costs in a proposal may be subject to penalties. The penalties are prescribed in 10 U.S.C. 3748 or 41 U.S.C. chapter 43, as applicable, which is implemented in Section 42.709 of the Federal Acquisition Regulation (FAR).

(c) The Contractor shall not include in any proposal any cost that is unallowable, as defined in subpart 2.1 of the FAR, or an executive agency supplement to the FAR.

(d) If the Contracting Officer determines that a cost submitted by the Contractor in its proposal is expressly unallowable under a cost principle in the FAR, or an executive agency supplement to the FAR, that defines the allowability of specific selected costs, the Contractor shall be assessed a penalty equal to--

(1) The amount of the disallowed cost allocated to this contract; plus

(2) Simple interest, to be computed--

(i) On the amount the Contractor was paid (whether as a progress or billing payment) in excess of the amount to which the Contractor was entitled; and

(ii) Using the applicable rate effective for each six-month interval prescribed by the Secretary of the Treasury pursuant to Pub. L. 92-41 (85 Stat. 97).

(e) If the Contracting Officer determines that a cost submitted by the Contractor in its proposal includes a cost previously determined to be unallowable for that Contractor, then the Contractor will be assessed a penalty in an amount equal to two times the amount of the disallowed cost allocated to this contract.

(f) Determinations under paragraphs (d) and (e) of this clause are final decisions within the meaning of 41 U.S.C. chapter 71, Contract Disputes.

(g) Pursuant to the criteria in FAR 42.709-6, the Contracting Officer may waive the penalties in paragraph (d) or (e) of this clause.

(h) Payment by the Contractor of any penalty assessed under this clause does not constitute repayment to the Government of any unallowable cost which has been paid by the Government to the Contractor.

20. Section 5.60 SUBCONTRACTS FOR COMMERCIAL PRODUCTS AND COMMERCIAL SERVICES (FFS/ER HMO CONTRACTS)

Updating per changes to the FAR

SECTION 5.60
SUBCONTRACTS FOR COMMERCIAL PRODUCTS AND COMMERCIAL SERVICES (SEP 2023) (FAR 52.244-6)

(a) Definitions. As used in this clause —

"Commercial product," "commercial service," and "commercially available off-the-shelf item" have the meanings contained in Federal Acquisition Regulation 2.101.

"Subcontract" includes a transfer of commercial products or commercial services between divisions, subsidiaries, or affiliates of the Contractor or subcontractor at any tier.

(b) To the maximum extent practicable, the Contractor shall incorporate, and require its subcontractors at all tiers to incorporate, commercial products, commercial services, or non-developmental items as components of items to be supplied under this contract.

(c)(1) The Contractor shall insert the following clauses in subcontracts for commercial products or commercial services:

(i) 52.203-13, Contractor Code of Business Ethics and Conduct (Nov 2021) (41 U.S.C. 3509), if the subcontract exceeds the threshold specified in FAR 3.1004(a) on the date of subcontract award, and has a performance period of more than 120 days. In altering this clause to identify the appropriate parties, all disclosures of violation of the civil False Claims Act or of Federal criminal law shall be directed to the agency Office of the Inspector General, with a copy to the Contracting Officer.

(ii) 52.203-15, Whistleblower Protections Under the American Recovery and Reinvestment Act of 2009 (Jun 2010) (Section 1553 of Pub. L. 111-5), if the subcontract is funded under the Recovery Act.

(iii) 52.203-19, Prohibition on Requiring Certain Internal Confidentiality Agreements or Statements (JAN 2017).

(iv) 52.204–21, Basic Safeguarding of Covered Contractor Information Systems (Nov 2021), other than subcontracts for commercially available off-the-shelf items, if flow down is required in accordance with paragraph (c) of FAR clause 52.204–21.

(v) 52.204-23, Prohibition on Contracting for Hardware, Software, and Services Developed or Provided by Kaspersky Lab and Other Covered Entities (Jul 2018) (Section 1634 of Pub. L. 115-91).

(vi) 52.204-25, Prohibition on Contracting for Certain Telecommunications and Video Surveillance Services or Equipment. (Nov 2021) (Section 889(a)(1)(A) of Pub. L. 115-232).

(vii) 52.204-27, Prohibition on a ByteDance Covered Application (JUN 2023) (Section 102 of Division R of Pub.L. 117-328).

(viii) 52.219-8, Utilization of Small Business Concerns (SEP 2023) (15 U.S.C. 637(d)(2) and (3)), if the subcontract offers further subcontracting opportunities. If the subcontract (except subcontracts to small business concerns) exceeds, the applicable threshold

specified in FAR 19.702(a) on the date of subcontract award, the subcontractor must include 52.219-8 in lower tier subcontracts that offer subcontracting opportunities.

(ix) 52.222-21 Prohibition of Segregated Facilities (Apr 2015)

(x) 52.222-26, Equal Opportunity (Sep 2015) (E.O. 11246).

(xi) 52.222-35, Equal Opportunity for Veterans (Jun 2020) (38 U.S.C. 4212(a).

(xii) 52.222-36, Equal Opportunity for Workers with Disabilities (Jun 2020) (29 U.S.C. 793).

(xiii) 52.222-37, Employment Reports on Veterans (Jun 2020) (38 U.S.C. 4212).

(xiv) 52.222-40, Notification of Employee Rights Under the National Labor Relations Act (Dec 2010) (E.O. 13496), if flow down is required in accordance with paragraph (f) of FAR clause 52.222-40.

(xv) (A) 52.222-50, Combating Trafficking in Persons (Nov 2021) (22 U.S.C. chapter 78 and E.O. 13627).

(B) Alternate I (MAR 2015) of 52.222-50 (22 U.S.C. chapter 78 and E.O. 13627).

(xvi) 52.222-55 , Minimum Wages for Contractor Workers under Executive Order 14026 (Jan 2022), if flow down is required in accordance with paragraph (k) of FAR clause 52.222-55.

(xvii) 52.222-62, Paid Sick Leave Under Executive Order 13706 (Jan 2022) (E.O. 13706), if flowdown is required in accordance with paragraph (m) of FAR clause 52.222-62.

(xviii) (A) 52.224-3, Privacy Training (Jan 2017) (5 U.S.C. 552a) if flow down is required in accordance with 52.224-3(f).

(B) Alternate I (Jan 2017) of 52.224-3, if flow down is required in accordance with 52.224-3(f) and the agency specifies that only its agency-provided training is acceptable).

(xix) 52.225-26, Contractors Performing Private Security Functions Outside the United States (Oct 2016) (Section 862, as amended, of the National Defense Authorization Act for Fiscal Year 2008; 10 U.S.C. Subtitle A, Part V, Subpart G Note).

(xx) 52.232-40, Providing Accelerated Payments to Small Business Subcontractors (Mar 2023), if flow down is required in accordance with paragraph (c) of FAR clause 52.232-40.

(xxi) 52.247-64, Preference for Privately Owned U.S.-Flag Commercial Vessels (Nov 2021) 46 U.S.C. 55305 and 10 U.S.C. 2631), if flow down is required in accordance with paragraph (d) of FAR clause 52.247-64).

(2) While not required, the Contractor may flow down to subcontracts for commercial products or commercial services a minimal number of additional clauses necessary to satisfy its contractual obligations.

(d) The Contractor shall include the terms of this clause, including this paragraph (d), in subcontracts awarded under this contract.

21. Addition of Section 5.77 Implementing the No TikTok on Government Devices Act

SECTION 5.77

Prohibition on a Bytedance Covered Application (JUN 2023)

(a) Definitions. As used in this clause—

Covered application means the social networking service TikTok or any successor application or service developed or provided by ByteDance Limited or an entity owned by ByteDance Limited.

Information technology, as defined in 40 U.S.C. 11101(6)—

(1) Means any equipment or interconnected system or subsystem of equipment, used in the automatic acquisition, storage, analysis, evaluation, manipulation, management, movement, control, display, switching, interchange, transmission, or reception of data or information by the executive agency, if the equipment is used by the executive agency directly or is used by a contractor under a contract with the executive agency that requires the use—

(i) Of that equipment; or

(ii) Of that equipment to a significant extent in the performance of a service or the furnishing of a product;

(2) Includes computers, ancillary equipment (including imaging peripherals, input, output, and storage devices necessary for security and surveillance), peripheral equipment designed to be controlled by the central processing unit of a computer, software, firmware and similar procedures, services (including support services), and related resources; but
(3) Does not include any equipment acquired by a Federal contractor incidental to a Federal contract.

(b) Prohibition. Section 102 of Division R of the Consolidated Appropriations Act, 2023 (Pub. L. 117–328), the No TikTok on Government Devices Act, and its implementing guidance under Office of Management and Budget (OMB) Memorandum M–23–13, dated February 27, 2023, "No TikTok on Government Devices" Implementation Guidance, collectively prohibit the presence or use of a covered application on executive agency information technology, including certain equipment used by Federal contractors. The Contractor is prohibited from having or using a covered application on any information technology owned or managed by the Government, or on any information technology used or provided by the Contractor under this contract, including equipment provided by the Contractor's employees; however, this prohibition does not apply if the Contracting Officer provides written notification to the Contractor that an exception has been granted in accordance with OMB Memorandum M–23–13.

(c) Subcontracts. The Contractor shall insert the substance of this clause, including this paragraph (c), in all subcontracts, including subcontracts for the acquisition of commercial products or commercial services.

Part IV-SPECIAL PROVISIONS is deleted and replaced with the following:

SECTION 4.1
ALTERATIONS IN CONTRACT (JAN 2019) (FAR 52.252-4)

Portions of this contract are altered as follows:

(a) Section 1.6 Confidentiality of Records. The following subsection is added:

(d) Local Blue Cross and/or Blue Shield Plans may combine the personal data and medical records of Federal subscribers, and information relating thereto, with the same information of other individuals who have health benefits coverage under the Local Blue Cross and/or Blue Shield Plan. This combined data may only be used and disclosed for the Plan's health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501). Such activities include, but are not limited to: care management; prevention, detection, and recovery of funds subject to fraud and abuse; and negotiation of provider contracts.

(e) As used in subsection (b)(1) of this section, "administration of this contract" means health care operations and payment activities, as such terms and conditions are defined under the Health Insurance Portability and Accountability Act, and its implementing regulations (45 CFR § 164.501).

(b) Section 1.9 Plan Performance - Experience-Rated FFS Contracts.

The Carrier may use the appropriate systems for measurement and/or collection of data on the quality of the health care services as described in subparagraph 1.9(b).

(c) Section 1.14, Misleading, Deceptive, or Unfair Advertising, is amended by removing the reference to the NAIC Advertisements of Accident and Sickness Insurance Model Regulation (Appendix D-b). Carrier should continue to use the FEHB Supplemental Literature Guidelines (now at the renumbered Appendix C) along with FEHBAR 1603.7002.

(d) Section 1.15 Renewal and Withdrawal of Approval (FEHBAR). The following subsections are added:

(d) If the agency suspends payment of the subscription charges for any reason, the Carrier may (1) suspend making benefit payments until payment of all subscription charges due is fully restored; or (2) terminate the contract without prior notice.

(e) Section 1.21 Patient Bill of Rights. For the purpose of compliance with this Section, the Carrier will conduct the following minimum activities: (1) the Carrier will provide subscribers with a Fact Sheet that includes information about the disenrollment rate in the Blue Cross and Blue Shield Service Benefit Plan, as well as Local Plan-specific information including compliance with Federal and State financial requirements, public corporate information, years in existence, and accreditation status; (2) Provider

Directories will include language advising subscribers to contact their providers directly to obtain information about the providers, including but not limited to board certifications, languages spoken, availability of interpreters, facility accessibility, and whether the provider is accepting new patients.

(f) Section 1.30 Health Information Technology Privacy and Security. Subsections (b), (c) and the introductory paragraph of Subsection (d) of Section 1.30 are amended to read as follows:

(b) The Carrier will promote consumer transparency by ensuring that at the point where the Federal member enters the subcontractor's, large provider's, or vendor's website or web portal the link to the subcontractor's, large provider's, or vendor's notice of privacy practices and/or privacy policies is displayed on the bottom, or prominently displayed elsewhere, on the website or web portal.

(c) Notice of privacy practices and/or privacy policies disclosures must describe the uses of individually identifiable protected health information and any potential disclosure to other entities as described in the HIPAA Privacy Rule.

(d) The Carrier will participate with the Contracting Officer or an authorized representative of the Contracting Officer in credential vulnerability scans and configuration compliance audits conducted in accordance with rules of engagement agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The rules of engagement will include the software and hardware used for vulnerability scanning; the specific process used to conduct vulnerability scanning; precautions taken to prevent negative disruption on the systems being scanned; restrictions on the release of documents and artifacts; and how the results of the scanning will be reviewed and reported.

(g) Section 2.2 Benefits Provided. The following paragraph is added to subsection 2.2(a):

(4) The Carrier may pay the Preferred Provider Organization level of benefits under this contract to ease the hardship of members affected by natural disasters such as earthquakes, floods, etc., when because of the natural disaster members have difficulty gaining access to Preferred network providers. The Carrier may pay the Preferred level of benefits without regard to the provider's contractual relationship with the Carrier and will determine an appropriate time frame based on local conditions during which the provision of this paragraph will apply. Benefits provided under this paragraph will be made available to all members similarly affected by the natural disaster.

(h) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Notwithstanding subsection (f) of Section 2.3, benefits provided under the contract are not assignable by the Member to any person without express written approval of the carrier, and in the absence of such approval, any such assignment shall be void. Notwithstanding such approval, no assignment of benefits may be made in any case prior to the time that a valid claim for benefits arises.

(i) Section 2.3 Payment of Benefits and Provision of Services and Supplies. The introductory paragraph of Subsection 2.3(g) is amended to read as follows:

(g) *Erroneous Payments.*

(i) If the Carrier or OPM determines that a Member's claim has been paid in error for any reason (except in the case of fraud or abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider; the recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment under 48 C.F.R. 1631.201-70(h) regardless of any time period limitations in the written agreement with the provider.

(ii) The Carrier shall be deemed to have satisfied the requirements of Subsection (g) (i) above by complying with Subsections (ii), (iii), and (iv). Local Blue Cross and Blue Shield Plans which have time period limitations in their provider contracts which prevent the Plan from recovering erroneous benefit payments made to providers will participate in an action plan. The action plan shall be developed by the Blue Cross and Blue Shield Association by December 31, 2008 and agreed to by the Contracting Officer and the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield Association and the Contracting Officer shall utilize standards of commercial reasonableness and neither shall unreasonably withhold agreement. The action plan shall be designed to reduce the occurrence of erroneous benefit payments, to identify and recover erroneous benefit payments within the time limits stipulated in their provider contracts, and to demonstrate due diligence in making an attempt to identify and recover within that provider contract timeframe such erroneous benefit payments.

(iii) The Blue Cross and Blue Shield Association shall be responsible for monitoring and determining whether each Blue Cross and Blue Shield Plan participating in the action plan is complying with its obligations under the action plan.

(iv) A Blue Cross and Blue Shield Plan which is in compliance with its obligations under the action plan shall be found to be in compliance with its obligation under this Section 2.3(g) to make a prompt and diligent effort to recover erroneous benefit payments. In the event that any Plan with such time period limitations is determined to be not in substantial compliance with the action plan, and that Plan is determined not to have pursued material benefit payments with promptness and diligence, then the Plan shall return the erroneous benefit payments to the Program.

(v) The Carrier shall follow general business practices and procedures in collecting debts owed under the Federal Employees Health Benefits Program. Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall—

(j) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(7)(ii) of Section 2.3 is amended to read as follows:

Notwithstanding (g)(7)(i), the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments (or to correct processes or procedures that

caused erroneous benefit payments) when the errors are egregious and repeated. These costs are deemed to be unreasonable and unallowable under Section 3.2(b). The term "repeated" in the previous sentence does not apply to situations in which a claims processing system error causes multiple erroneous payments or to situations that involve audit findings on errors that are endemic to the provision of insurance and claims processing.

(k) Section 2.3 Payment of Benefits and Provision of Services and Supplies. Subsection (g)(10) of Section 2.3 is amended to read as follows:

(10) In compliance with the Contracts Disputes Act, the Carrier shall return to the Program an amount equal to the uncollected erroneous benefit payment where the Contracting Officer determines that the Carrier failed to make a prompt and diligent effort, as that term is described above, to recover the erroneous benefit payment. This provision applies to benefit payments which have been paid in error for any reason (except in the case of fraud or abuse).

(l) Section 2.4 Termination of Coverage and Conversion Privileges. The conversion contract set forth in Section 2.4(c) may be a contract that is regularly offered by the local Blue Cross and/or Blue Shield Plan.

(m) Section 2.5 Subrogation. The following subsections are added:

(c) To the extent that a Member has received benefits for covered services under this contract for an injury or illness caused by a third party, the Carrier shall have the right to be subrogated and succeed to any rights of recovery against any person or organization from whom the Member is legally entitled to receive all or part of those same benefits, including insurers of individuals (non-group) policies of liability insurance that are issued to and in the name of the Member. The obligation of the Carrier to recover amounts through subrogation is limited to making a reasonable effort to seek recovery of amounts to which it is entitled to recover in cases which are brought to its attention. The Carrier shall not be required to recover any amounts from any person or organization who causes an injury or illness for which the Member makes claims for benefits.

(d) The Carrier may also recover directly from the Member all amounts received by the Member by suit, settlement, or otherwise from any third party or its insurer, or the Member's insurer under an individual policy or liability insurance, for benefits which have also been paid under this contract.

(e) The Member shall take such action, furnish such information and assistance, and execute such papers as the Carrier or its representative believes are necessary to facilitate enforcement of its rights, and shall take no action which would prejudice the interests of the Carrier to subrogation.

(f) Effective January 1, 1997, all Participating Plans shall subrogate under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under the contract.

(n) Section 2.6 Coordination of Benefits (FEHBAR). The following subsections are added:

(g) The benefits payable by this Plan shall be determined, on a claim by claim basis, only for those claims in excess of $100, except where Medicare is the primary payer of benefits, claims in excess of $50.

(h) Whenever payments which should have been made under this contract in accordance with this provision have been made under any other group health coverage, the Carrier shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amount it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this contract and, to the extent of such payments discharged from liability under the contract.

(o) Section 3.1 Payments (FEHBAR). The following sentence is added to the end of Section 3.1(a):

OPM will withhold from the subscription charges amounts for other obligations due under the contract only to the extent that OPM and the Carrier have agreed in writing to specific deductions for such other obligations.

(p) Section 3.1 Payments (FEHBAR). The following subsection is added:

(g) Except as required pursuant to Sections 1.25 and 2.12, in the event this contract is terminated or not renewed, the agency shall be liable for all sums due and unpaid, including subscription charges, for the period up to the last day of the Member's entitlement to benefits.

(q) Section 3.2 Accounting and Allowable Cost (FEHBAR). Section 3.2(b)(2)(ii) of this contract is amended to comply with 5 U.S.C. 8909(f) as follows:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a Carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any Carrier or subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such Carrier or underwriting or plan administration subcontractor from business conducted under this Chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(r) Section 3.2 Accounting and Allowable Cost (FEHBAR). The provision in Section 3.2 (b)(2)(iv)(A) is supplemented as follows:

Charges for mandatory statutory reserves (Section 3.2(b)(2)(iv)(A)) to satisfy mandatory

statutory reserve requirements of Participating Plans are allowable to the extent that such requirements exceed that portion of the service charge at Appendix B, Subscription Rates, Charges, Allowances and Limitations applicable to such Plans.

(s) Section 3.2 Accounting and Allowable Cost (FEHBAR). This section is modified as follows:

The Carrier, as required by the Blue Cross and Blue Shield Service Benefit Plan Workplan, shall furnish OPM an accounting of its operations under the contract not less than 120 days after the end of the calendar year contract period.

(t) Section 3.3 Special Reserve. The provision in Section 3.3(a) is supplemented as follows:

The Special reserve held by or on behalf of the Carrier is to be used only for payment of charges against this contract, including advance payments to Participating Plans and to hospitals.

(u) Section 3.10, Audit, Financial, and Other Information. Compliance by the Carrier and Participating Blue Cross and Blue Shield Plans with the Blue Cross Blue Shield Service Benefit Plan Workplan, as agreed upon between the Carrier and OPM, will constitute compliance with the Audit Guide referred to in Sections 3.2 and 3.10.

SECTION 4.2
HOSPITAL (FACILITY) BENEFIT PAYMENTS AND CONDITIONS (JAN 1991)

(a) Benefits described in the agreed upon brochure text shall be provided to the extent practicable in the form of services rendered by hospitals, freestanding ambulatory facilities, and home health care agencies, and payment, therefore, by or on behalf of the carrier shall constitute a complete discharge of their obligations under this contract to the extent of services rendered in accordance with the terms and conditions of the contract.

(b) Benefits for inpatient hospital care shall be available only to a Member admitted to the hospital on the recommendation, and while under the active medical supervision of a duly licensed physician or alternative provider as described in section 8902(k)(1) of title 5 U.S.C. who is a member of the staff of, or acceptable to, the hospital selected.

(c) Hospital service is subject to all the rules and regulations of the hospital selected including rules governing admissions.

(d) While a Member may elect to be hospitalized in any hospital, the Carrier does not undertake to guarantee the admission of such Member to the hospital, nor the availability of any accommodations or services therein requested by the Member or his physician.

SECTION 4.3
DEFINITION OF CARRIER (JAN 1991)

The Carrier is the Blue Cross and Blue Shield Association, an Illinois not-for-profit corporation, acting on behalf of participating Blue Cross and Blue Shield Plans and

pursuant to authority specified in Exhibit A for and in behalf of the organizations specified in Exhibit A (hereinafter sometimes referred to as "Participating Plans").

SECTION 4.4
AUDIT DISPUTES (JAN 2000)

(a) Any questioned costs or issues documented by or on behalf of OPM's Office of the Inspector General (OIG) in draft or final audit reports examining the Carrier's and Participating Plans' performance under this contract, that are provided to the Carrier and that were initially raised in the timeframe set forth in subsection (c) below, remain open until resolved. Audit issues related to monetary findings for which extensions of the waiver period for the issuance of final decisions and processing of prior period adjustments were obtained in previous contract terms also remain open until resolved.

(b) Resolution of a questioned cost or issue can be the result of a resolution letter or the issuance of a final decision by the Contracting Officer, or by the processing of a prior period adjustment, an adjustment to the Special reserve, or submission of a claim to OPM (as appropriate) by the Carrier or Participating Plan. A prior period adjustment intended to partially or fully resolve an audit finding will not be considered closed until properly reported on the calendar year Annual Accounting Statement.

(c) A claim seeking, as a matter of right, the payment of money, in a sum certain, pursuant to 48 CFR section 52.233-1, shall not be made more than five years following the last day prescribed by the contract for filing the calendar year Annual Accounting Statement for the year with respect to which the claim arises. A claim includes, in the case of the carrier, a charge against the contract.

SECTION 4.5
ASSOCIATION DUES (JAN 2004)

A Participating local Blue Cross and Blue Shield Plan may charge to this contract Association Dues, with the exception of dues related to those lobbying costs and Special Assessments determined to be unallowable. In calculating the unallowable portion of dues related to lobbying costs for a contract year, the Blue Cross and Blue Shield Plan will rely on the percentage of dues, less any special assessments, as determined by the BCBSA for IRS purposes, to be not tax deductible from the previous contract year.

SECTION 4.6
TRAVEL COSTS (JAN 1996)

The Carrier may charge and account for travel expenses related to administration of the contract on a per diem basis, subject to the maximums prescribed by the Federal Travel Regulations. For those travel costs for each contract term that are subject to the Federal per diem rates set forth at 48 CFR section 31.205-46, the Carrier shall charge to the contract an amount equal to the lesser of:

(i) the actual aggregate charges for those costs, or
(ii) the aggregate charges calculated using the per diem rates set forth in the Federal Travel Regulations.

SECTION 4.7
MARKET RESEARCH COSTS (JAN 1996)

(a) Costs of market research surveys or studies are generally allowable if the survey or study is:

1. directed to current Members and Members who left the Blue Cross and Blue Shield Service Benefit Plan in the most recent Open season, or
2. focused on long-range planning, industry state-of-the-art developments, or product development issues for which a direct benefit or potential benefit to the FEHB Program can be identified, or
3. pre-approved by the Contracting Officer.

(b) Costs of market research surveys or studies are generally not allowable if the primary purpose is to survey or study an otherwise unallowable cost item, such as: to determine the effectiveness of advertising or sales strategies; to evaluate image effectiveness or ways to achieve image enhancement; or to perform a competitive analysis with other carriers in the FEHB Program. Such costs are unallowable, regardless of who receives the research surveys or studies.

(c) This provision does not supersede other contract requirements, such as prior approval for subcontracts under Section 1.16 Subcontracts (FEHBAR 1652.244-70).

SECTION 4.8
PRESCRIPTION DRUG BENEFITS WAIVER PROVISIONS (JAN 2009)

(a) For the purposes of applying the special provisions in this section, the Standard Option Mail Service Prescription Drug Program service standards are:

(1) When a prescription order is placed that does not require additional information or clarification (i.e., a clean or non-diverted prescription), the prescription order shall be dispensed within three business days from the date of receipt so the enrollee may expect to receive the medication within 7 calendar days.

(2) When a prescription order is placed that does require additional information, clarification or resolution of payment issues (i.e., a diverted prescription), the prescription order shall be dispensed within seven business days from the date of receipt so the enrollee may expect to receive the medication within 14 calendar days. However the following situations will not be considered a diverted prescription for the purposes of this section:

(i) Prescriptions for refrigerated products that require prior arrangements between the mail order pharmacy and a Member before the Member can receive the Prescription;

(ii) Prescriptions requiring specific counseling obligations imposed by the pharmaceutical manufacturer, distributor or the FDA;

(iii) Prescriptions requiring "registration" with a pharmaceutical manufacturer.

(b) The special provisions described in paragraphs (c)(1), (2), and (3) shall become effective automatically when less than 98 percent of the prescriptions are filled within the

service standards described in either paragraph (a)(1) or (a)(2) for 7 consecutive business days. The special provisions shall terminate when for 7 consecutive business days 98 percent or more of the prescriptions are filled within the service standards described in paragraphs (a)(1) and (a)(2) of this section.

(c) The special provisions are:

(1) The Carrier shall waive during the effective periods in paragraph (b) the coinsurance for a 21 day prescription filled at a Preferred retail pharmacy when the Mail Service Prescription Drug Program vendor is unable to fill the prescription within the service standards. This waiver of the coinsurance shall be in effect for 14 calendar days after notice to the enrollee as described in paragraph (c)(2) below.

(2) The Carrier shall deliver to the enrollee a written or telephone notice no later than 5 days from the date of receipt for clean or non-diverted prescriptions and no later than 12 days from the date of receipt for diverted prescriptions.

This notice shall:

(i) advise the enrollee that the Mail Service Prescription Drug Program may not be able to fill the prescription(s) within the service standard timeframes;

(ii) advise the enrollee that any applicable coinsurance will be waived for a 21 day supply of the medication(s) when filled at a Preferred retail pharmacy;

(iii) provide the enrollee with instructions on how to use the waiver, and

(iv) advise the enrollee when the waiver will expire.

(3) The Carrier may use next day delivery service at no additional cost to the enrollee in order to meet the service standards in (a)(1) and (a)(2).

SECTION 4.9
SMALL BUSINESS SUBCONTRACTING PLAN (JAN 2002) (FAR 52.219-9) (AS AMENDED)

An amended clause 52.219-9, Small Business Subcontracting Plan, is attached to Appendix E.

SECTION 4.10
LETTER OF CREDIT (JAN 1997)

As of January 1, 1997, OPM will administer Letter of Credit drawdowns directly with the local Plans.

SECTION 4.11
PILOTING OF COST CONTAINMENT PROGRAMS (JAN 2001)

Upon approval by the Contracting Officer, the Carrier may design and implement pilot programs in one or more local Plan areas that test the feasibility and examine the impact of various managed care initiatives. The Carrier shall brief the Contracting Officer on a pilot program prior to its implementation, advise the Contracting Officer of the progress of the pilot program and provide a written evaluation at the conclusion of the pilot program. The evaluation of the pilot program shall, at a minimum, assess the cost effectiveness, effect on quality of care and/or quality of life, and customer satisfaction, and recommend whether the pilot program should be continued or expanded.

SECTION 4.12
TRANSITION COSTS FOR PLAN TERMINATIONS (JAN 1999)

In the event a Participating Plan's license to use the Blue Cross and/or Blue Shield service marks is terminated, thereby rendering it ineligible to participate in this Contract, the costs of transitioning the terminated Plan's Service Benefit Plan subscribers to a successor Plan shall be subject to advance approval. The Carrier shall submit to OPM a proposed transition plan, together with a detailed estimate of costs, prior to the incurrence of any significant transition costs. OPM and the Carrier shall negotiate an advance agreement pursuant to FAR 31.109 that covers the extent of allowable transition costs.

SECTION 4.13
PAYMENT BY ELECTRONIC FUNDS TRANSFER-CENTRAL CONTRACTOR REGISTRATION (MAY 1999) (FAR 52.232-33)

The references to the Central Contractor Registration in FAR 52.232-33 are not applicable to this contract.

SECTION 4.14
FEDERAL INCOME TAX RELATED TO HEALTH INSURANCE PROVIDERS' FEE (JANUARY 2015)

(a) Notwithstanding FAR 31.205-41(b)(1) and this Contract Section 3.2(b)(1)(ii), a charge for an incremental amount of Federal income tax liability incurred as the result of compliance with the Health Insurance Providers Fee (HIP Fee) provision of the Affordable Care Act section 9010 (hereafter referred to as the "HIP Tax Cost") by a participating local plan (Local Plan) that administers the Service Benefit Plan on behalf of the Blue Cross and Blue Shield Association (Carrier), and that is a covered entity within the meaning of 26 CFR Part 57, is an allowable cost to the Carrier under this contract under the criteria set forth below.

(1) The allowable cost to the Carrier for a year is the sum of the HIP Tax Cost for each Local Plan. The HIP Tax Cost for each Local Plan equals:
the amount reimbursed by OPM to the Carrier for the HIP Fee attributable to the Local Plan (Local Plan HIP Fee) for the year, divided by one minus the tax rate for the Local Plan specified under section (2) below, (Local Plan Tax Rate), less the Local Plan HIP Fee. In mathematical terms, the allowable charge to the Carrier for the HIP Tax Cost is the sum of each Local Plan's application of the formula below:

$$\left[\frac{\text{Local Plan HIP Fee}}{1 - \text{Local Plan Tax Rate}}\right] - \text{Local Plan HIP Fee}$$

(2) The Local Plan Tax Rate for purposes of the formula specified in section (1) is the lowest of the following:
(a) the rate specified at 26 USC §11 (b) (1) (D),

(b) the rate specified at 26 USC § 55(b)(1)(B)(i), for any year in which the Local Plan is entitled to the special deduction under 26 USC § 833(a)(2), or
(c) zero, for any year in which the Local Plan experiences a Net Operating Loss or other circumstance resulting in no tax liability. For a year in which the Local Plan experiences a Net Operating Loss resulting in no tax liability, the Carrier will charge the HIP Tax Cost attributable to the Local Plan in the first subsequent year in which the Local Plan's tax liability is greater than zero. The Local Plan will calculate the HIP Tax Cost in this circumstance by applying the formula using the HIP Fee for the year of the loss and the Local Plan Tax Rate for the year in which the tax liability is greater than zero. This charge by the Carrier is in addition to the charge allowed by the Carrier for the Local Plan Tax Cost for the year in which the tax liability is greater than zero.

(d) If the Local Plan Tax Rate reflected on the Local Plan's tax return actually filed for the contract year (which normally occurs the following year) differs from the Local Plan Tax Rate that was anticipated when the costs were drawn down by the Carrier for the contract year as allowable administrative expenses, the Carrier will make a commensurate adjustment to its current year drawdown of administrative expenses.

(b) The Contracting Officer or an authorized representative of the Contracting Officer shall have the right to examine and audit all books and records, including tax filings, relating to the calculation of the HIP Tax Cost charge for each Local Plan.

Part IV - Attachment I
SECTION 4.14
FEDERAL INCOME TAX RELATED TO HEALTH INSURER'S PROVIDER FEE

Examples of Allowable 9010 Tax Cost:

C is an experience rated FEHB carrier consisting of participating Local Plans F and G who underwrite and administer C in different geographic areas.

In 2015, F reports $900 on IRS Form 8963 and pays $500 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the $500 HIP Fee, F's Form 8963 reflects that $300 is attributable to F's FEHBP business.

Also in 2015, G reports $950 on IRS Form 8963 and pays $550 pursuant to methods described at 26 CFR Part 57, in satisfaction of its Affordable Care Act section 9010 Health Insurance Provider Fee (HIP Fee) expense with respect to calendar year 2014 health risks. Of the $550 HIP Fee, G's Form 8963 reflects that $325 is attributable to G's FEHBP business.

In 2015, C draws down a 2015 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2014 health risks, which is calculated as the sum of F and G's HIP Fee, or $300 +325 = $725, which is an allowable cost, from its FEHB letter of credit account (LOCA). C reimburses F for its HIP Fee of 300 and G for its HIP Fee of 325.

F records income of $300 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by $300. F records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, F pays quarterly payments to the IRS for its' 2015 tax liability. F's 2015 tax rate is 35 percent.

G records income of $325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by $325. G records 2015 income tax expense as an accrued expense as required under Generally Accepted Accounting Principles (GAAP) or Statements of Statutory Accounting Principles (SSAP). In addition, G pays quarterly payments to the IRS for its' 2015 tax liability. Because G claims a special deduction under 26 USC § 833(a)(2), G's 2015 tax rate is 20 percent.

In 2015, C also draws down from its LOCA a 2015 HIP Tax Cost reimbursement for the 2015 income tax expense accrued and paid by F & G in 2015. C's 2015 HIP Tax cost reimbursement is calculated as follows:

Local Plan F HIP Tax Cost: ($300/1-.35)-$300 = $162
Local Plan G HIP Tax Cost: ($325/1-.20)-$325 = $81
Sum which is C's allowable HIP Tax Cost for 2015 = $243

In 2016, F & G report the same HIP Fee expense for 2015 health risks.

In 2016, F experiences the same tax rate as for 2015, but G incurs a net operating loss, resulting in a zero percent tax rate for 2016.

In 2016, C draws down a 2016 HIP Fee Reimbursement of its FEHBP HIP Fee expense for 2015 health risks of 300 + 325 = $725, which is an allowable cost, from C's FEHB letter of credit account (LOCA). C reimburses F for 300 and G for 325.

In 2016, F proceeds as in 2015 and C may charge 162 as an allowable HIP Tax Cost attributable to F in 2016.

In 2016 G records income of $325 for the reimbursement of the allowable HIP fee and does not have any associated income tax deduction increasing taxable income by $325. Because G determines that its 2016 tax liability will be zero as it will have a Net Operating Loss for 2016, C does not incur an allowable 2016 HIP Tax Cost attributable to G. C must refund any such amounts drawn down during 2016.

Local Plan F HIP Tax Cost for 2016 = 162
Local Plan G HIP Tax Cost for 2016 = 0
Reimbursement attributable to G = adjustment for amounts drawn down by C, if any
Sum = C's allowable HIP Tax Cost for 2016 = 162 less adjustment.

In 2017, F proceeds as in 2015. C's allowable 2017 HIP Tax Cost includes $162 attributable to F. In 2017, G has an operating gain and reports the same HIP Fee amount and experiences the same 20% tax rate as in 2015. C's allowable 2017 HIP Tax Cost includes $81 attributable to G.

In addition, in 2017, because G's operating gain results in a tax rate higher than zero, G incurs economic disadvantage. This is because the 2016 HIP Fee reimbursement of $325 has reduced G's otherwise applicable Net Operating Loss carry-forward amount. G calculates the economic disadvantage as the difference between its 2017 tax liability with and without the 2016 HIP Fee reimbursement. This disadvantage is included in the Carrier's 2017 charge as an allowable HIP Tax Cost with respect to 2016. This is calculated as $325 (2016 HIP Fee) divided by 1-20% (application of 2017 Local Plan Tax Rate), less $325.]

Local Plan F HIP Tax Cost for 2017 = 162
Local Plan G HIP Tax Cost for 2017 = 81
Local Plan G HIP Tax Cost for 2017 due to 2016 HIP Fee reimbursement = apply formula using 2016 Fee Reimbursement amount and 2017 tax rate of 20% =81
Sum = C's allowable HIP Tax Cost for 2017 = 162 + 81 + 81 = $324

APPENDIX A

ATTACH
2024 BLUE CROSS AND BLUE SHIELD
SERVICE BENEFIT PLAN BROCHURES
RI 71-005 AND RI 71-017

APPENDIX B

SUBSCRIPTION RATES, CHARGES, ALLOWANCES AND LIMITATIONS

Fee-For-Service Carrier

Blue Cross Blue Shield Association
CONTRACT NO. CS _1039__
Effective January 1, 2024

(a) Biweekly net-to-Carrier rates, with appropriate adjustments for Enrollees paid on other than a biweekly basis, are as follows:

The attached letter contains your final 2024 biweekly rates of:
$353.05 Self, $793.39 Self Plus One, and $873.83 Family BASIC Option
$405.98 Self, $887.83 Self Plus One, and $977.75 Family STANDARD Option
$212.71 Self, $457.25 Self Plus One, and $502.94 Family FOCUS Option

(b) The amount of administrative expenses and charges to be included in the Annual Accounting Statement required by Section 3.2 shall be as set out in the schedule below:

Item	Amount
(i) Administrative Expenses	Actual, but not to exceed the Contractual Expense Limitation for 2024, * plus an amount sufficient to cover the costs needed to pay the Plan's Independent Public Accountant to undertake the audits and agreed upon procedures required in the "FEHBP Experienced-Rated Carrier and Service Organization Audit Guide."
(ii) Taxes	Actual (except that premium taxes as defined are not allowable).
(iii) Service Charge**	$ Redacted

*The Contractual Expense Limitation for 2024 is $Redacted. Notwithstanding Section 3.2(b) of this contract, costs of "activities that improve healthcare quality" as determined in accordance with the medical loss ratio provision of the Affordable Care Act (Section 2718 of the Public Health Service act; 42 U.S.C. 300gg-18 and its implementing regulations), are accounted for as benefits and not counted towards the Contractual Expense Limit.

** The Service Charge for the 2024 contract year is based on the Overall Performance Score calculated in accordance with the 2023 Appendix F. The Service Charge for the 2025 contract year will be based on the Overall Performance Score calculated in accordance with the 2024 Appendix F.

Appendix E

Updates per changes to the FAR.

SMALL BUSINESS SUBCONTRACTING PLAN (SEP 2023) (FAR 52.219-9)

(a) This clause does not apply to small business concerns.

(b) *Definitions*. As used in this clause—

"Alaska Native Corporation (ANC)" means any Regional Corporation, Village Corporation, Urban Corporation, or Group Corporation organized under the laws of the State of Alaska in accordance with the Alaska Native Claims Settlement Act, as amended (43 U.S.C. 1601, et seq.) and which is considered a minority and economically disadvantaged concern under the criteria at 43 U.S.C. 1626(e)(1). This definition also includes ANC direct and indirect subsidiary corporations, joint ventures, and partnerships that meet the requirements of 43 U.S.C. 1626(e)(2).

"Commercial plan" means a subcontracting plan (including goals) that covers the offeror's fiscal year and that applies to the entire production of commercial products and commercial services sold by either the entire company or a portion thereof (*e.g.*, division, plant, or product line).

"Commercial product" means a product that satisfies the definition of "commercial product" in the Federal Acquisition Regulation (FAR) 2.101.

"Commercial service" means a service that satisfies the definition of "commercial service" in FAR 2.101.

"Indian tribe" means any Indian tribe, band, group, pueblo, or community, including native villages and native groups (including corporations organized by Kenai, Juneau, Sitka, and Kodiak) as defined in the Alaska Native Claims Settlement Act (43 U.S.C.A. 1601 et seq.), that is recognized by the Federal Government as eligible for services from the Bureau of Indian Affairs in accordance with 25 U.S.C. 1452(c). This definition also includes Indian-owned economic enterprises that meet the requirements of 25 U.S.C. 1452(e).

"Individual subcontracting plan" means a subcontracting plan that covers the entire contract period (including option periods), applies to a specific contract, and has goals that are based on the offeror's planned subcontracting in support of the specific contract, except that indirect costs incurred for common or joint purposes may be allocated on a prorated basis to the contract.

"Master subcontracting plan" means a subcontracting plan that contains all the required elements of an individual subcontracting plan, except goals, and may be incorporated into individual subcontracting plans, provided the master subcontracting plan has been approved.

"Reduced payment" means a payment that is for less than the amount agreed upon in a subcontract in accordance with its terms and conditions, for supplies and services for which the Government has paid the prime contractor.

"Subcontract" means any agreement (other than one involving an employer-employee relationship) entered into by a Federal Government prime Contractor or subcontractor calling for supplies or services required for performance of the contract or subcontract.

"Total contract dollars" means the final anticipated dollar value, including the dollar value of all options.

"Untimely payment" means a payment to a subcontractor that is more than 90 days past due under the terms and conditions of a subcontract for supplies and services for which the Government has paid the prime contractor.

(c) (1) The Offeror, upon request by the Contracting Officer, shall submit and negotiate a subcontracting plan, where applicable, that separately addresses subcontracting with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns. If the Offeror is submitting an individual subcontracting plan, the plan must separately address subcontracting with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns, with a separate part for the basic contract and separate parts for each option (if any). The subcontracting plan shall be included in and made a part of the resultant contract. The subcontracting plan shall be negotiated within the time specified by the Contracting Officer. Failure to submit and negotiate the subcontracting plan shall make the Offeror ineligible for award of a contract.

(2)(i) The Contractor may accept a subcontractor's written representations of its size and socioeconomic status as a small business, small disadvantaged business, veteran-owned small business, service-disabled veteran-owned small business, or a women-owned small business if the subcontractor represents that the size and socioeconomic status representations with its offer are current, accurate, and complete as of the date of the offer for the subcontract.

(ii) The Contractor may accept a subcontractor's representations of its size and socioeconomic status as a small business, small disadvantaged business, veteran-owned small business, service-disabled veteran-owned small business, or a women-owned small business in the System for Award Management (SAM) if–

(A) The subcontractor is registered in SAM; and

(B) The subcontractor represents that the size and socioeconomic status representations made in SAM are current, accurate and complete as of the date of the offer for the subcontract.

(iii) The Contractor may not require the use of SAM for the purposes of representing size or socioeconomic status in connection with a subcontract.

(iv) In accordance with 13 CFR 121.411,126.900,127.700, and 128.600 a contractor acting in good faith is not liable for misrepresentations made by its subcontractors regarding the subcontractor's size or socioeconomic status.

(d) The offeror's subcontracting plan shall include the following:

(1) Separate goals, expressed in terms of total dollars subcontracted, and as a percentage of total planned subcontracting dollars, for the use of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns as subcontractors. For individual subcontracting plans, and if required by the Contracting Officer, goals shall also be expressed in terms of percentage of total contract dollars, in addition to the goals expressed as a percentage of total subcontract dollars. The Offeror shall include all subcontracts that contribute to contract performance, and may include a proportionate share of products and services that are normally allocated as indirect costs. In accordance with 43 U.S.C. 1626–

(i) Subcontracts awarded to an ANC or Indian tribe shall be counted towards the subcontracting goals for small business and small disadvantaged business concerns, regardless of the size or Small Business Administration certification status of the ANC or Indian tribe; and

(ii) Where one or more subcontractors are in the subcontract tier between the prime Contractor and the ANC or Indian tribe, the ANC or Indian tribe shall designate the appropriate Contractor(s) to count the subcontract towards its small business and small disadvantaged business subcontracting goals.

(A) In most cases, the appropriate Contractor is the Contractor that awarded the subcontract to the ANC or Indian tribe.

(B) If the ANC or Indian tribe designates more than one Contractor to count the subcontract toward its goals, the ANC or Indian tribe shall designate only a portion of the total subcontract award to each Contractor. The sum of the amounts designated to various Contractors cannot exceed the total value of the subcontract.

(C) The ANC or Indian tribe shall give a copy of the written designation to the Contracting Officer, the prime Contractor, and the subcontractors in between the prime Contractor and the ANC or Indian tribe within 30 days of the date of the subcontract award.

(D) If the Contracting Officer does not receive a copy of the ANC's or the Indian tribe's written designation within 30 days of the subcontract award, the Contractor that awarded the subcontract to the ANC or Indian tribe will be considered the designated Contractor.

(2) A statement of—

(i) Total dollars planned to be subcontracted for an individual subcontracting plan; or the Offeror's total projected sales, expressed in dollars, and the total value of projected subcontracts, including all indirect costs except as described in paragraph (g) of this clause, to support the sales for a commercial plan;

(ii) Total dollars planned to be subcontracted to small business concerns (including ANC and Indian tribes); and

(iii) Total dollars planned to be subcontracted to veteran-owned small business concerns;

(iv) Total dollars planned to be subcontracted to service-disabled veteran-owned small business;

(v) Total dollars planned to be subcontracted to HUBZone small business concerns;

(vi) Total dollars planned to be subcontracted to small disadvantaged business concerns (including ANC and Indian tribes); and

(vii) Total dollars planned to be subcontracted to women-owned small business concerns

(3) A description of the principal types of supplies and services to be subcontracted, and an identification of the types planned for subcontracting to—

(i) Small business concerns;

(ii) Veteran-owned small business concerns;

(iii) Service-disabled veteran-owned small business concerns;

(iv) HUBZone small business concerns;

(v) Small disadvantaged business concerns; and

(vi) Women-owned small business concerns.

(4) A description of the method used to develop the subcontracting goals in paragraph (d)(1) of this clause.

(5) A description of the method used to identify potential sources for solicitation purposes (*e.g.,* existing company source lists, SAM, veterans service organizations, the National Minority Purchasing Council Vendor Information Service, the Research and Information Division of the Minority Business Development Agency in the Department of Commerce, or small, HUBZone, small disadvantaged, and women-owned small business trade associations). A firm may rely on the information contained in SAM as an accurate representation of a concern's size and ownership characteristics for the purposes of maintaining a small, veteran-owned small, service-disabled veteran-owned small, HUBZone small, small disadvantaged, and women-owned small business source list. Use of SAM as its source list does not relieve a firm of its responsibilities (*e.g.,* outreach, assistance, counseling, or publicizing subcontracting opportunities) in this clause.

(6) A statement as to whether or not the Offeror included indirect costs in establishing subcontracting goals, and a description of the method used to determine the proportionate share of indirect costs to be incurred with—

(i) Small business concerns (including ANC and Indian tribes);

(ii) Veteran-owned small business concerns;

(iii) Service-disabled veteran-owned small business concerns;

(iv) HUBZone small business concerns;

(v) Small disadvantaged business concerns; and

(vi) Women-owned small business concerns.

(7) The name of the individual employed by the Offeror who will administer the Offeror's subcontracting program, and a description of the duties of the individual.

(8) A description of the efforts the Offeror will make to assure that small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns have an equitable opportunity to compete for subcontracts.

(9) Assurances that the Offeror will include the clause of this contract entitled "Utilization of Small Business Concerns" in all subcontracts that offer further subcontracting opportunities, and that the Offeror will require all subcontractors (except small business concerns) that receive subcontracts in excess of the applicable threshold specified in FAR 19.702(a) on the date of subcontract award, with further subcontracting possibilities to adopt a subcontracting plan that complies with the requirements of this clause.

(10) Assurances that the Offeror will—

(i) Cooperate in any studies or surveys as may be required;

(ii) Submit periodic reports so that the Government can determine the extent of compliance by the Offeror with the subcontracting plan;

(iii) After November 30, 2017, include subcontracting data for each order when reporting subcontracting achievements for indefinite-delivery, indefinite-quantity contracts with individual subcontracting plans where the contract is intended for use by multiple agencies;

(iv) Submit Standard Form (SF) 294 Subcontracting Report for Individual Contract in accordance with paragraph (l) of this clause. Submit the Summary Subcontract Report (SSR), in accordance with paragraph (l) of this clause. The reports shall provide information on subcontract awards to small business concerns (including ANCs and Indian tribes that are not small businesses), veteran-owned small business concerns, service-disabled veteran-owned small business concerns, HUBZone small business concerns, small disadvantaged business concerns (including ANCs and Indian tribes that have not been certified by the Small Business Administration as small disadvantaged businesses), women-owned small business concerns, and for NASA only, Historically Black Colleges and Universities and Minority Institutions. Reporting shall be in accordance with this clause, or as provided in agency regulations;

(v) Ensure that its subcontractors with subcontracting plans agree to submit the SF 294 in accordance with paragraph (l) of this clause. Ensure that its subcontractors with subcontracting plans agree to submit the SSR in accordance with paragraph (l) of this clause

(vi) [RESERVED]; and

(vii) Require that each subcontractor with a subcontracting plan provide the prime contract number, its own unique entity identifier, and the e-mail address of the subcontractor's official responsible for acknowledging receipt of or rejecting the Standard Forms 294, to its subcontractors with subcontracting plans.

(11) A description of the types of records that will be maintained concerning procedures that have been adopted to comply with the requirements and goals in the plan, including establishing source lists; and a description of the offeror's efforts to locate small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns and award subcontracts to them. The records shall include at least the following (on a plant-wide or company-wide basis, unless otherwise indicated):

(i) Source lists (*e.g.,* SAM), guides, and other data that identify small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns.

(ii) Organizations contacted in an attempt to locate sources that are small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, or women-owned small business concerns.

(iii) Records on each subcontract solicitation resulting in an award of more than the simplified acquisition threshold, as defined in FAR 2.101 on the date of subcontract award, indicating—

(A) Whether small business concerns were solicited and, if not, why not;

(B) Whether veteran-owned small business concerns were solicited and, if not, why not;

(C) Whether service-disabled veteran-owned small business concerns were solicited and, if not, why not;

(D) Whether HUBZone small business concerns were solicited and, if not, why not;

(E) Whether small disadvantaged business concerns were solicited and, if not, why not;

(F) Whether women-owned small business concerns were solicited and, if not, why not; and

(G) If applicable, the reason award was not made to a small business concern.

(iv) Records of any outreach efforts to contact—

(A) Trade associations;

(B) Business development organizations;

(C) Conferences and trade fairs to locate small, HUBZone small, small disadvantaged service-disabled veteran-owned, and women-owned small business sources; and

(D) Veterans service organizations.

(v) Records of internal guidance and encouragement provided to buyers through—

(A) Workshops, seminars, training, etc.; and

(B) Monitoring performance to evaluate compliance with the program's requirements.

(vi) On a contract-by-contract basis, records to support award data submitted by the offeror to the Government, including the name, address, and business size of each subcontractor. Contractors having commercial plans need not comply with this requirement.

(12) Assurances that the Offeror will make a good faith effort to acquire articles, equipment, supplies, services, or materials, or obtain the performance of construction work from the small business concerns that it used in preparing the bid or proposal, in the same or greater scope, amount, and quality used in preparing and submitting the bid or proposal. Responding to a request for a quote does not constitute use in preparing a bid or proposal. The Offeror used a small business concern in preparing the bid or proposal if–

(i) The Offeror identifies the small business concern as a subcontractor in the bid or proposal or associated small business subcontracting plan, to furnish certain supplies or perform a portion of the subcontract; or

(ii) The Offeror used the small business concern's pricing or cost information or technical expertise in preparing the bid or proposal, where there is written evidence of an intent or understanding that the small business concern will be awarded a subcontract for the related work if the Offeror is awarded the contract.

(13) Assurances that the Contractor will provide the Contracting Officer with a written explanation if the Contractor fails to acquire articles, equipment, supplies, services or materials or obtain the performance of construction work as described in (d)(12) of this clause. This written explanation must be submitted to the Contracting Officer within 30 days of contract completion.

(14) Assurances that the Contractor will not prohibit a subcontractor from discussing with the Contracting Officer any material matter pertaining to payment to or utilization of a subcontractor.

(15) Assurances that the Offeror will pay its small business subcontractors on time and in accordance with the terms and conditions of the underlying subcontract, and notify the contracting officer when the prime contractor makes either a reduced or an untimely payment to a small business subcontractor (see 52.242-5).

(e) In order to effectively implement this plan to the extent consistent with efficient contract performance, the Contractor shall perform the following functions:

(1) Assist small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns by arranging solicitations, time for the preparation of bids, quantities, specifications, and delivery schedules so as to facilitate the participation by such concerns. Where the Contractor's lists of potential small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business subcontractors are excessively long, reasonable effort shall be made to give all such small business concerns an opportunity to compete over a period of time.

(2) Provide adequate and timely consideration of the potentialities of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns in all "make-or-buy" decisions.

(3) Counsel and discuss subcontracting opportunities with representatives of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business firms.

(4) Confirm that a subcontractor representing itself as a HUBZone small business concern is certified by SBA as a HUBZone small business concern by accessing SAM or by accessing Dynamic Small Business Search (DSBS) at *https://web.sba.gov/pro-net/search/dsp_dsbs.cfm.*

(5) Provide notice to subcontractors concerning penalties and remedies for misrepresentations of business status as small, veteran-owned small business, HUBZone small, small disadvantaged, or women-owned small business for the purpose of obtaining a subcontract that is to be included as part or all of a goal contained in the Contractor's subcontracting plan.

(6) For all competitive subcontracts over the simplified acquisition threshold, as defined in FAR 2.101 on the date of subcontract award, in which a small business concern received a small business preference, upon determination of the successful subcontract Offeror, prior to award of the subcontract the Contractor must inform each unsuccessful small business subcontract Offeror in writing of the name and location of the apparent successful Offeror and if the successful subcontract Offeror is a small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, or women-owned small business concern.

(7) Assign each subcontract the NAICS code and corresponding size standard that best describes the principal purpose of the subcontract.

(f) A master subcontracting plan on a plant or division-wide basis that contains all the elements required by paragraph (d) of this clause, except goals, may be incorporated by reference as a part of the subcontracting plan required of the Offeror by this clause; provided—

(1) The master subcontracting plan has been approved;

(2) The Offeror ensures that the master subcontracting plan is updated as necessary and provides copies of the approved master subcontracting plan, including evidence of its approval, to the Contracting Officer; and

(3) Goals and any deviations from the master subcontracting plan deemed necessary by the Contracting Officer to satisfy the requirements of this contract are set forth in the individual subcontracting plan.

(g) A commercial plan is the preferred type of subcontracting plan for contractors furnishing commercial products and commercial services. The commercial plan shall relate to the offeror's planned subcontracting generally, for both commercial and Government business, rather than solely to the Government contract. Once the Contractor's commercial plan has been approved, the Government will not require another subcontracting plan from the same Contractor while the plan remains in effect, as long as the product or service being provided by the Contractor continues to meet the definition of a commercial product or commercial service. A Contractor with a commercial plan shall comply with the reporting requirements stated in paragraph (d)(10) of this clause by submitting one SSR for all contracts covered by its commercial plan. A Contractor authorized to use a commercial subcontracting plan shall include in its subcontracting goals and in its SSR all indirect costs, with the exception of those such as the following: Employee salaries and benefits; payments for petty cash; depreciation; interest; income taxes; property taxes; lease payments; bank fees; fines, claims, and dues; original equipment manufacturer relationships during warranty periods (negotiated up front with the product); utilities and other services purchased from a municipality or an entity solely authorized by the municipality to provide those services in a particular geographical region; and philanthropic contributions. This report shall be acknowledged or rejected by the Contracting Officer who approved the plan. This report shall be submitted within 30 days after the end of the Government's fiscal year.

(h) Prior compliance of the offeror with other such subcontracting plans under previous contracts will be considered by the Contracting Officer in determining the responsibility of the offeror for award of the contract.

(i) A contract may have no more than one subcontracting plan. When a contract modification exceeds the subcontracting plan threshold in 19.702(a), or an option is exercised, the goals of the existing subcontracting plan shall be amended to reflect any new subcontracting opportunities. When the goals in a subcontracting plan are amended, these goal changes do not apply retroactively.

(j) Subcontracting plans are not required from subcontractors when the prime contract contains the clause at FAR 52.212-5, Contract Terms and Conditions Required to Implement Statutes or Executive Orders—Commercial Products and Commercial Services, or when the subcontractor provides a commercial product or commercial service subject to the clause at FAR 52.244-6, Subcontracts for Commercial Products and Commercial Services, under a prime contract.

(k) The failure of the Contractor or subcontractor to comply in good faith with—

(1) the clause of this contract entitled "Utilization Of Small Business Concerns," or

(2) an approved plan required by this clause, shall be a material breach of the contract and may be considered in any past performance evaluation of the Contractor.

(l) The Contractor shall submit a SF 294. Purchases from a corporation, company, or subdivision that is an affiliate of the Contractor or subcontractor are not included in these reports. Subcontract awards by affiliates shall be treated as subcontract awards by the Contractor. Subcontract award data reported by the Contractor and subcontractors shall be limited to awards made to their immediate next-tier subcontractors. Credit cannot be taken for awards made to lower tier subcontractors, unless the Contractor or subcontractor has been designated to receive a small business or small disadvantaged business credit from an ANC or Indian tribe. Only subcontracts involving performance in the U.S. or its outlying areas should be included in these reports with the exception of subcontracts under a contract awarded by the State Department or any other agency that has statutory or regulatory authority to require subcontracting plans for subcontracts performed outside the United States and its outlying areas.

(1) SF 294. This report is not required for commercial plans. The report is required for each contract containing an individual subcontracting plan.

(i) The report shall be submitted semi-annually during contract performance for the periods ending March 31 and September 30. A report is also required for each contract within 30 days of contract completion. Reports are due 30 days after the close of each reporting period, unless otherwise directed by the Contracting Officer. Reports are required when due, regardless of whether there has been any subcontracting activity since the inception of the contract or the previous reporting period. When a Contracting Officer rejects a report, the Contractor shall submit a revised report within 30 days of receiving the notice of report rejection.

(ii) (A) When a subcontracting plan contains separate goals for the basic contract and each option, as prescribed by FAR 19.704(c), the dollar goal inserted on this report shall be the sum of the base period through the current option; for example, for a report submitted after the second option is exercised, the dollar goal would be the sum of the goals for the basic contract, the first option, and the second option.

(B) If a subcontracting plan has been added to the contract pursuant to 19.702(a)(3) or 19.301-2(e), the Contractor's achievements must be reported in the report on a cumulative basis from the date of incorporation of the subcontracting plan into the contract.

(i) When a subcontracting plan includes indirect costs in the goals, these costs must be included in this report.

(ii) The authority to acknowledge receipt or reject the SF 294 resides–

(A) In the case of the prime Contractor, with the Contracting Officer; and

(B) In the case of a subcontract with a subcontracting plan, with the entity that awarded the subcontract.

(2) SSR. (i) Reports submitted under individual contract plans.

(A) This report encompasses all subcontracting under prime contracts and subcontracts with an executive agency, regardless of the dollar value of the subcontracts. This report also includes indirect costs on a prorated basis when the indirect costs are excluded from the subcontracting goals.

(B) The report may be submitted on a corporate, company or subdivision (e.g., plant or division operating as a separate profit center) basis, unless otherwise directed by the agency.

(C) If the Contractor and/or a subcontractor is performing work for more than one executive agency, a separate report shall be submitted to each executive agency covering only that agency's contracts, provided at least one of that agency's contracts is over the applicable threshold specified in FAR 19.702(a), and the contract contains a subcontracting plan. For DoD, a consolidated report shall be submitted for all contracts awarded by military departments/agencies and/or subcontracts awarded by DoD prime contractors.

(D) The report shall be submitted annually by October 30, for the twelve month period ending September 30. When a Contracting Officer rejects an SSR, the Contractor is required to submit a revised SSR within 30 days of receiving the notice of report rejection.

(E) Subcontract awards that are related to work for more than one executive agency shall be appropriately allocated.

(F) The authority to acknowledge or reject SSRs, including SSRs submitted by subcontractors with subcontracting plans, resides with the Government agency awarding the prime contracts unless stated otherwise in the contract.

(ii) Reports submitted under a commercial plan.

(A) The report shall include all subcontract awards under the commercial plan in effect during the Government's fiscal year and all indirect costs.

(B) The report shall be submitted annually, within 30 days after the end of the Government's fiscal year.

(C) If a Contractor has a commercial plan and is performing work for more than one executive agency, the Contractor shall specify the percentage of dollars attributable to each agency.

(D) The authority to acknowledge or reject SSRs for commercial plans resides with the Contracting Officer who approved the commercial plan.

Appendix F Plan Performance Assessment

Amends Appendix F of the FEHB contract regarding the measures utilized in the Plan Performance Assessment.

Measures and contributions to performance areas and scores for 2024 Performance and 2025 Service Charge.

To be performed in accordance with the 2024 FEHB Plan Performance Assessment Procedure Manual and the FEHB Plan Performance Assessment Methodology Carrier Letter (CL 2020-15). The Service Charge for the 2025 contract year will be based on the Overall Performance Score calculated in accordance with this Appendix F.

1. Performance Area Contributions to Overall Performance Score (OPS)

Performance Area	Contribution to Overall Performance Score
Clinical Quality, Customer Service, and Resource Use	65%
Contract Oversight	35%

2. Clinical Quality, Customer Service, and Resource Use (QCR) Performance Area Measures

Performance Area	Measure	Abbrv	Measure Source	Priority Level	Measure Weight
	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: 18-64 Years	AAB	HEDIS	1	2.50
	Controlling High Blood Pressure	CBP	HEDIS	1	2.50
	Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Control <8.0%	HBD	HEDIS	1	2.50

Clinical Quality	Antidepressant Medication Management: Effective Continuation Phase Treatment	AMM	HEDIS	2	1.25
	Asthma Medication Ratio	AMR	HEDIS	2	1.25
	Breast Cancer Screening	BCS-E	HEDIS	2	1.25
	Cervical Cancer Screening	CCS	HEDIS	2	1.25
	Childhood Immunization Status: Combination 10	CIS	HEDIS	2	1.25
	Colorectal Cancer Screening: 51-75 Years	COL	HEDIS	2	1.25
	Follow-Up After Emergency Department Visit for Substance Use - 30-Day Follow-Up: Total	FUA	HEDIS	2	1.25
	Follow-Up After Emergency Department Visit for Mental Illness-30-Day Follow-Up: Total	FUM	HEDIS	2	1.25
	Prenatal and Postpartum Care: Timeliness of Prenatal Care	PPC	HEDIS	2	1.25
	Statin Therapy for Patients With Cardiovascular Disease-Statin Adherence 80%: Total	SPC	HEDIS	2	1.25

	Use of Opioids From Multiple Providers: Multiple Prescribers	UOP	HEDIS	2	1.25
Customer Service	Coordination of Care	CoC	CAHPS	3	1.00
	Claims Processing	CP	CAHPS	3	1.00
	Getting Care Quickly	GCQ	CAHPS	3	1.00
	Getting Needed Care	GNC	CAHPS	3	1.00
	Overall Health Plan Rating	RHP	CAHPS	3	1.00
	Overall Personal Doctor Rating	RPD	CAHPS	3	1.00
Resource Use	Use of Imaging Studies for Low Back Pain: 18-64 Years	LBP	HEDIS	1	2.50
	Acute Hospital Utilization-Nonoutlier Member Acute Inpatient and Observation Stay Discharges–Total Discharges–Observed-to-Expected (O/E) Ratio–Total	AHU	HEDIS	2	1.25
	Emergency Department Utilization–Nonoutlier Member Number of Emergency Department Visits–(O/E) Ratio–Total: Total	EDU	HEDIS	2	1.25
	Plan All-Cause Readmissions- (O/E) Ratio–18-64 Years	PCR	HEDIS	2	1.25

EXHIBIT I

Blue Cross® and Blue Shield® Service Benefit Plan

www.fepblue.org

2018

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

IMPORTANT:

- Rates: Back Cover
- Changes for 2018: Pages 16-18
- Summary of benefits: Pages 160-163

This Plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See pages 5 and 10 for details. This Plan is accredited. See page 14.

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

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 800-772-1213 (TTY: 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 800-MEDICARE (800-633-4227), (TTY: 877-486-2048).

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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 healthcare 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 are enrolled 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, 2018, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2018, and changes are summarized on pages 16-18. 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. (See page 10)

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 healthcare 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 healthcare provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare 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 800-FEP-8440 (800-337-8440) and explain the situation.
  - If we do not resolve the issue:

CALL – THE HEALTH CARE FRAUD HOTLINE

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 (TCC).
- 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.

Discrimination Is Against the Law

We comply with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557 we do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

We:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator of your Local Plan by contacting your Local Plan at the telephone number appearing on the back of your ID card.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator of your Local Plan. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, your Local Plan's Civil Rights Coordinator is available to help you.

For information about how to file a civil rights complaint, go to www.fepblue.org/en/rights-and-responsibilities/.

Call the customer service number on the back of your Member ID card. For TTY, dial 711.

Español (Spanish)
Para obtener asistencia en Español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

繁體中文 (Chinese)
請撥打您 ID 卡上的客服號碼以尋求中文協助。

Tiếng Việt (Vietnamese)
Gọi số dịch vụ khách hàng trên thẻ ID của quý vị để được hỗ trợ bằng Tiếng Việt.

한국어 (Korean)
한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Tagalog (Tagalog – Filipino)
Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Русский (Russian)
Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

(العربية (Arabic
اتصل برقم خدمة العملاء الموجود على بطاقة هُويتك للحصول على المساعدة باللغة العربية.

Kreyòl Ayisyen (French Creole)
Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Français (French)
Pour une assistance en français du Canada, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

Português (Portuguese)
Ligue para o número de telefone de atendimento ao cliente exibido no seu cartão de identificação para obter ajuda em português.

Polski (Polish)
Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

日本語 (Japanese)
日本語でのサポートは、IDカードに**記載**のカスタマーサービス**番号**までお**電話**でお**問い合**わせください。

Italiano (Italian)
Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Deutsch (German)
Rufen Sie den Kundendienst unter der Nummer auf Ihrer ID-Karte an, um Hilfestellung in deutscher Sprache zu erhalten.

فارسی (Farsi)
برای دریافت راهنمایی به زبان فارسی ، با شماره خدمات مشتری که بر روی کارت شناسایی شما درج شده است تماس بگیرید.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. 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 take notes, 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.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

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

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's SpeakUp™ patient safety program.
- www.ahrq.gov/patients-consumers/. 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 healthcare providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.bemedwise.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 healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("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, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

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. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

You will not be billed for inpatient services when care is related to treatment of specific hospital-acquired conditions if you use Preferred or Member hospitals. This policy helps to protect you from having to pay for the cost of treating these conditions, and it encourages hospitals to improve the quality of care they provide.

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 are married.

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 your spouse, or one other 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.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

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 or children.

If this law applies to you, you must enroll in 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 2018 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 2017 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 family members 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 assistance with enrolling in a conversion policy (non-FEHB individual policy). FEP helps members with Temporary Continuation of Coverage (TCC) and with finding replacement coverage.

- **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 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 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 coverage.

- **Finding replacement coverage**

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. 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 healthcare 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.

OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. The local plans and vendors that support Blue Cross and Blue Shield Service Benefit Plan hold accreditation from National Committee for Quality Assurance (NCQA) and/or URAC. To learn more about this plan's accreditations, please visit the following websites:

- National Committee for Quality Assurance (www.ncqa.org);
- URAC (www.URAC.org).

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 healthcare 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 Preferred 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 healthcare facilities, physicians, and other healthcare 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 151-153). 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.

  Note: We may implement pilot programs in one or more Local Plan areas to test the feasibility and examine the impact of various initiatives. The pilot programs do not affect all Plan areas. Information on specific pilots is not published in this brochure; it is communicated to members and network providers in accordance with our agreement with OPM. Certain pilot programs may incorporate benefits that are different from those described in this brochure. For example, certain pilot programs may revise the Plan Allowance for Non-participating providers described in Section 10 of this brochure.

Your rights and responsibilities

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/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence
- Profit status
- Care management, including medical practice guidelines
- Disease management programs
- How we determine if procedures are experimental or investigational

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, at www.fepblue.org/en/rights-and-responsibilities.

By law, you have the right to access your personal health information (PHI). For more information regarding access to PHI, visit our website at www.fepblue.org/en/terms-and-privacy/notice-of-privacy-practices/ to obtain a Notice of our Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

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 2018

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.

Changes to our Standard Option only

- Your copayment for Tier 1 (generic) anti-hypertensive drugs obtained at Preferred retail pharmacies is now $3 (no deductible). Previously, your cost-share under Preferred retail pharmacies was 20% of the plan allowance (no deductible). (See page 105.)
- Your copayment for Tier 1 (generic) anti-hypertensive drugs obtained through the Mail Service Prescription Drug Program is now $3 (no deductible). Previously, your copayment for the Mail Service Prescription Drug Program was $15 (no deductible). (See page 105.)
- Your copayment for Tier 2 preferred brand-name asthma drugs obtained at Preferred retail pharmacies is now 20% of the Plan allowance (no deductible). Previously, your copayment was 30% of the Plan allowance (no deductible). (See page 106.)
- Your copayment for Tier 2 preferred brand-name asthma drugs obtained through the Mail Service Prescription Drug Program is now $65 (no deductible). Previously, your copayment was $80 (no deductible). (See page 106.)
- Your cost-share for Tier 3 non-preferred brand-name drugs is 50% (no deductible) of the Plan allowance for Preferred retail pharmacies. Previously, your cost-share was 45% (no deductible) of the Plan allowance. (See page 111.)
- Your copayment for Tier 3 non-preferred brand-name drugs will be $125 copayment (no deductible) for the Mail Service Prescription Drug Program. Previously, your copayment was $105. (See page 112.)
- We now provide benefits for skilled nursing facility admissions for members who do not have Medicare Part A as their primary payor. Previously, benefits were limited to Standard Option members with primary Medicare Part A. (See page 88.)

Changes to our Basic Option only

- We now provide a reimbursement account for Medicare Part B premiums to any member with Medicare Part A and Part B. The account must be used exclusively to pay Medicare Part B premiums. Previously, there was no reimbursement account benefit. (See page 122.)
- Your copayment for Tier 1 (generic) anti-hypertensive drugs obtained at Preferred retail pharmacies is now $5. Previously, your cost-share under Preferred retail pharmacies was $10 copayment for 30-day supply. (See page 105.)
- When Medicare Part B is primary, your copayment for Tier 1 (generic) anti-hypertensive drugs obtained through the Mail Service Prescription Drug Program is now $5. Previously, your copayment for the Mail Service Prescription Drug Program was $20. (See page 106.)
- Your copayment for Tier 2 preferred brand-name asthma drugs obtained at a Preferred retail pharmacy is now $35 for each purchase of up to a 30-day supply ($105 copayment for a 90-day supply). Previously, your copayment was $50 for each purchase of up to a 30-day supply ($150 copayment for 90-day supply). (See page 106.)
- When Medicare Part B is primary, your copayment for Tier 2 preferred brand-name asthma drugs obtained at a Preferred retail pharmacy is now $30 for each purchase of up to a 30-day supply ($90 copayment for a 90-day supply). Previously, your copayment was $45 for each purchase up to a 30-day supply ($135 copayment for 90-day supply). (See page 106.)
- When Medicare Part B is primary, your copayment for Tier 2 preferred brand-name asthma drugs obtained through the Mail Service Prescription Drug Program is now a $75 copayment. Previously, your copayment was $90. (See page 106.)
- Your cost-share for Tier 3 non-preferred brand-name drugs obtained at a Preferred retail pharmacy is 60% of Plan allowance ($75 minimum) for up to a 30-day supply ($210 minimum for a 90-day supply). Previously, your cost-share was 60 % of the Plan allowance ($65 minimum) for a 30-day supply ($195 minimum for a 90-day supply). (See page 111.)
- When Medicare Part B is primary, your cost-share for Tier 3 non-preferred brand-name drugs obtained at a Preferred retail pharmacy is 50% of the Plan allowance ($60 minimum) for up to a 30-day supply ($175 minimum for a 90-day supply). Previously, your cost-share was 50% of the Plan allowance ($55 minimum) for a 30-day supply ($165 minimum for a 90-day supply). (See page 111).
- When Medicare Part B is primary, your cost-share for Tier 3 non-preferred brand-name drugs obtained through the Mail Service Prescription Drug Program is now a $125 copayment. Previously, your copayment was $115. (See page 112.)

Changes to both our Standard and Basic Options

- Your copayment for Tier 1 (generic) asthma drugs is now $5 for Preferred retail pharmacies and Mail Service Prescription Drug Program (with and without Medicare Part B). Previously, your cost-share was 20% of the Plan allowance (no deductible) for Standard Option and $10 copayment for each purchase of up to a 30-day supply and a $30 copayment for 90-day supply for Basic Option. (See page 106.)
- We now provide preventive care benefits for DNA analysis of stool samples as a technique for colorectal cancer screening, paid in full when billed by a preferred provider. Limited to one per calendar year. Previously, medical benefits were provided with a member cost-share. (See page 42.)
- We now provide preventive care benefits for generic cholesterol-lowering statin drugs. Previously, pharmacy benefits were provided with a member cost-share. (See page 110.)
- We now provide preventive care benefits for aspirin to prevent cardiovascular disease and colorectal cancer for adults ages 50 through 59. (See page 110.)
- We now provide preventive care benefits for the screening of latent tuberculosis infection in adults age 18 and over. Limited to once per calendar year. Previously, no preventive care benefits were available for this screening. (See pages 41 and 47.)
- We now provide benefits for telehealth services delivered via phone or secure online video for the treatment of minor acute conditions (see page 150 for definition), and counseling for behavioral health and substance use disorders. (See pages 38 and 98.)
- We now use the Local Plan Allowance as our Plan allowance for inpatient services performed by Non-member facilities. Previously, our allowance was 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. (See page 151.)
- We now use the allowance equal to the greater of 1) the Medicare participating fee schedule amount or the Medicare Part B drug average sale price (ASP), or 2) 100% of the Local Plan Allowance for services performed by Non-participating professional providers. Previously, if there was no Medicare participating fee schedule or Local Plan UCR amount, our allowance was 60% of the billed charge. (See page 152.)
- The contract holder and spouse are eligible for the wellness incentive rewards for the Blue Health Assessment, Diabetes Management Incentive Program, Hypertension Management Program, Pregnancy Care Incentive Program, and Smoking and Tobacco Cessation Program. Previously, eligible members for the wellness incentive rewards were limited to two adults per contract, age 18 or over. (See pages 120, 121 and 122.)
- You are now entitled to receive the pregnancy care incentive of $75 toward your health account and the MyBlue Pregnancy Box when you complete the Blue Health Assessment (BHA) indicating that you are pregnant and submit a copy of the provider's medical record documenting the first trimester prenatal care visit. Previously, you had to complete the BHA and enroll in My Pregnancy Care Assistant. (See page 122.)
- If you choose to get the brand-name drug and your provider's prescription allows for generic substitution, your applicable cost-share for a brand-name drug will be the drug tier cost-share plus the difference in the costs of the brand-name and generic drugs. Your expenses for "dispense as written" prescriptions do not count toward your catastrophic protection out-of-pocket maximum. Previously, if the provider's prescription allowed for generic substitution and you chose to get the brand-name drug, you were responsible only for the drug tier cost-share. (See page 101.)
- We now require precertification for overseas admission to a residential treatment center. Benefits are not available if precertification is not obtained. Previously, precertification was not required. (See page 125.)
- We now provide 100% coverage for inpatient services performed at a Preferred facility for overseas members when AXA Assistance has arranged direct billing or acceptance of a guarantee of benefits with the facility, and for services billed by a Department of Defense (DoD) facility. Previously, member cost-share was not waived for services billed by a DoD facility. (See page 32.)
- We now provide family planning benefits for vasectomy and related covered professional services, e.g., anesthesia, with no member cost-share. Previously, this was a surgical benefit with member cost-share. (See page 50.)
- We now provide benefits for oral medical foods under the pharmacy benefit only. Prior approval is required. Previously, medical benefits were provided for oral medical foods. (See page 107.)

- We may implement pilot programs in one or more Local Plan areas to test the feasibility and examine the impact of various initiatives. The pilot programs do not affect all Plan areas. Information on specific pilots is not published in this brochure; it is communicated to members and network providers in accordance with our agreement with OPM. Certain pilot programs may incorporate benefits that are different from those described in this brochure. Previously, we did not provide pilot language in the brochure. Pilot oversight was conducted with the affected Plans. (See page 15.)
- We now apply facility-billed claims for osteopathic and chiropractic manipulative treatment services to a member's annual manipulative treatment visit maximum. Previously, only professional claims applied to a member's annual visit maximum. (See page 60.)
- We now provide benefits for gonadotropin-releasing hormone (GnRH) antagonists and testosterones regardless of age. Previously, benefits were limited to members age 16 and over. (See page 108.)
- We now limit the coverage of blood and marrow stem cell transplants for autoimmune diagnoses to those listed on page 75. Previously, the listed diagnoses were presented as examples of covered diagnoses. Now those listed diagnoses serve as the complete list of covered diagnoses. Benefits are not available for diagnoses not on the list.
- We now limit the coverage of allogeneic blood or marrow stem cells to the following inherited metabolic disorders: Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy, Hurler's syndrome and Maroteaux-Lamy syndrome variants. Previously, we also covered Hunter's syndrome and Sanfilippo's syndrome. (See page 72.)
- We now provide coverage limited to the following diagnoses for autologous blood or marrow stem cell transplants, only when performed as part of a clinical trial: chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL), chronic myelogenous leukemia, glial tumors, retinoblastoma, rhabdomyosarcoma, Wilm's tumor and other childhood kidney cancers. Previously, we also covered breast cancer and epithelial ovarian cancer under the autologous blood or marrow stem cell clinical trial transplant benefit. (See page 74.)

Section 3. How you get care

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 14 for more information about Preferred providers.

Under both Standard and Basic Option, you can also get care for the treatment of minor acute conditions (see page 150 for definition), counseling for behavioral health and substance use disorder using teleconsultation services delivered via phone by calling 855-636-1579 (TTY: 855-636-1578) or via secure online video at fepblue.org/telehealth. Please see pages 38 and 98 for more information.

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 healthcare 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 healthcare 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 are physicians and other healthcare providers, 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.**

If you have questions about covered providers or would like the names of PPO (Preferred) providers, please contact the Local Plan where services will be performed.

• 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 surgicenter, 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 use. Accredited healthcare 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 use 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 87 and 99. 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® Specialty Care

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 29-31 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 71).

Skilled Nursing Facility (SNF)

A SNF is a freestanding institution or a distinct part of a hospital which customarily bills insurance as a skilled nursing facility and meets the following criteria:

- Is Medicare-certified as a skilled nursing facility;
- Is licensed in accordance with state or local law or is approved by the state or local licensing agency as meeting the licensing standards (where state or local law provides for the licensing of such facilities);
- Has a transfer agreement in effect with one or more Preferred hospitals; and
- Is primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care; or rehabilitation services for the rehabilitation of injured, disabled or sick persons.

To be covered, skilled nursing facility care cannot be maintenance or custodial care. The term skilled nursing facility does not include any institution that is primarily for the care and treatment of mental diseases.

Note: Additional criteria apply when you do not have Medicare Part A (see page 88).

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 may require precertification and prior approval. If you do not obtain precertification, there may be a reduction or denial of benefits. Be sure to read all of the precertification and prior approval information below and on pages 23-27.

- **Inpatient hospital admission, inpatient residential treatment center admission, or skilled nursing facility admission**

Precertification is the process by which – prior to your inpatient 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, inpatient residential treatment center, or skilled nursing facility whether they have contacted us and provided all necessary information. You are also responsible for enrolling in case management and working with your case manager if you care involves residential treatment or a skilled nursing facility. For information about precertification of an emergency inpatient hospital admission, please see page 26.

Warning: We will reduce our benefits for the inpatient hospital stay by $500, even if you have obtained prior approval for the service or procedure being performed during the stay, 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: If precertification was not obtained prior to admission, inpatient benefits (such as room and board) are not available for inpatient care at a residential treatment center, or if you do not have Medicare Part A, at a skilled nursing facility. 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; with the exception of admissions for gender reassignment surgery and admissions to residential treatment centers, and skilled nursing facilities.
- You have another group health insurance policy that is the primary payor for the hospital stay; with the exception of admissions for gender reassignment surgery. (See page 77 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)
- Medicare Part A is the primary payor for the hospital or skilled nursing facility stay; with the exception of admissions for gender reassignment surgery. (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 page 67 in order for benefits to be provided for the admission and surgical procedure.

• Other services

You must obtain prior approval **for these services under both Standard and Basic Option. Precertification is also required if the service or procedure requires an inpatient hospital admission. All gender reassignment surgeries require prior approval; if inpatient admission is necessary, precertification is also required. Contact us using the custome**r 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:

- **Outpatient sleep studies performed outside the home** – Prior approval is required for sleep studies performed in a provider's office, sleep center, clinic, outpatient center, hospital, skilled nursing facility, residential treatment center and any other location that is not your home.
- **Applied behavior analysis (ABA)** – Prior approval is required for ABA and all related services, including assessments, evaluations, and treatments.
- **Gender reassignment surgery –** Prior to surgical treatment of gender dysphoria, your provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and your provider later modifies the plan.
- **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 43.
- **Surgical services** – The surgical services on the following list 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 page 67.)

- Outpatient surgical correction of congenital anomalies (see definition on page 147);
- Outpatient surgery needed to correct accidental injuries (see definition on page 147) to jaws, cheeks, lips, tongue, roof and floor of mouth; and
- Gender reassignment surgery.

- **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 89 for information about the exception to this requirement.
- **Organ/tissue transplants** – See pages 72-75 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/CertificationandComplianc/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 21 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 74) 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 800-624-5060 (TTY: 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 104 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.

Note: The Specialty Drug Pharmacy Program will not fill your prescription until you have obtained prior approval. AllianceRx Walgreens Prime, 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.

- **Medical foods covered under the pharmacy benefit require prior approval.**

- **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 pages 22-25 or is one of the transplant procedures listed on pages 71-75) – 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 87 and 99 for additional information.

Note: If we approve the request for prior approval or precertification, you will be provided with a notice that identifies the approved services and the authorization period. You must contact us with a request for a new approval five (5) business days prior to a change to the approved original request, and for requests for an extension beyond the approved authorization period in the notice you received. We will advise you of the information needed to review the request for change and/or extension.

- **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 27.) 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 27.

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.

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. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **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 147 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 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 share/ Cost-sharing

Cost share or 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 82). 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 84).

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 151-153). 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 and on the next page 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 37; see page 82 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 63). 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 inpatient facility care you receive overseas, we provide benefits in full for admissions to a Department of Defense (DoD) facility, or when the Worldwide Assistance Center, (provided by AXA Assistance) has arranged direct billing or acceptance of a guarantee of benefits with the facility. If a direct billing arrangement or guarantee of benefits is not accepted by the facility, you are responsible for the applicable copayment or coinsurance. For outpatient 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 healthcare 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 29-31;
- 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.

If your provider's prescription allows for generic substitution and you select a brand-name drug, your expenses for the difference in cost-share do not count toward your catastrophic protection out-of-pocket maximum (see page 101 for additional information).

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 above) 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 page 16 for how our benefits changed this year. Pages 160-163 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.

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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 healthcare 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 get care*, for information on covered professional providers and other healthcare 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 healthcare 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 healthcare 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.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 111 for information about Tier 4 and Tier 5 specialty drug fills from a Preferred pharmacy. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731. Basic Option members must use a preferred pharmacy.
- **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 healthcare 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 39-40 for our coverage of laboratory, X-ray, and other diagnostic tests billed for by a healthcare professional, and to pages 83-84 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 healthcare 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 healthcare 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 147 for more information about "agents.") Participating/Non-participating: You pay all charges
Telehealth professional services for: • Minor acute conditions (see page 150 for definition) Note: Refer to Section 5(h) Wellness and other special Features for information on telehealth services and how to access a provider.	Preferred Telehealth Provider: $10 (no deductible) Participating/Non-participating: You pay all charges	Preferred Telehealth Provider: $15 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 *(continued on next page)*	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**
Inpatient professional services *(continued)* • 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	See page 38	See page 38
Not covered: • *Routine services except for those Preventive care services described on pages 41-47* • *Telephone consultations and online medical evaluation and management services except as shown in Section 5(a) page 39 and Section 5(e) page 98* • *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 147 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 147 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 23). 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 43-44). Note: See page 43 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: Prior approval is required for sleep studies performed in a location other than the home. 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 for bone density tests, CT scans/MRIs/PET scans, angiographies, genetic testing, nuclear medicine, and sleep studies performed outside the home Preferred: $40 copayment for sleep studies performed at home Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 147 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). Covered services include: • Visits/exams for preventive care Note: See the definition of Preventive care, Adult on page 154 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 use Note: See pages 62 and 113 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 • Screening for latent tuberculosis 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 65 for our payment levels for diagnostic colonoscopies) – Sigmoidoscopy – Double contrast barium enema – DNA analysis of stool samples • Prostate cancer tests – Prostate Specific Antigen (PSA) test • Cervical cancer tests (including Pap tests) • Screening mammograms, including mammography using digital technology 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 ages 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 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 *(continued on next page)*	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)* 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 pancreatic or prostate cancer diagnosed in a first- or second-degree relative; 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 A history of pancreatic or prostate cancer diagnosed in a first- or second-degree relative; 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 43. 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 40 for our coverage of diagnostic BRCA testing). Note: Preventive care benefits are not available for surgical removal of breasts, ovaries, or prostate.	See page 43	See page 43

Preventive care, adult – continued on next page

Preventive care, adult *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Immunizations limited to the following vaccines (as licensed by the U.S. Food and Drug Administration (FDA)): • 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 years) • 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 110 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 41-45 do not apply to children up to age 22. (See benefits under *Preventive care, children*, this Section.) Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: www.healthcare.gov/preventive-care-benefits A complete list of women's preventive services can be found at www.healthcare.gov/preventive-care-women/ For additional information: healthfinder.gov/myhealthfinder/default.aspx	See above and pages 41-45	See above and pages 41-45

Preventive care, adult – continued on next page

Preventive care, adult *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Not covered: • *Genetic testing related to family history of cancer or other disease, except as described on pages 43-44* *Note: See page 40 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* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure. Medical benefits may be available for these services.*	*All charges*	*All charges*
Preventive care, children		
Benefits are provided for preventive care services for children up to age 22, including services recommended under the Affordable Care Act (ACA) and as described in the Bright Future Guidelines provided by the American Academy of Pediatrics (AAP). 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) • Immunizations as licensed by the U.S. Food and Drug Administration (FDA) limited to the following vaccines: – Diphtheria, tetanus, pertussis – Hemophilus influenza type b (Hib) – Hepatitis (types A and B) *(continued on next page)*	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.

Preventive care, children – continued on next page

Preventive care, children *(continued)*	You Pay	
	Standard Option	Basic Option
Immunizations *(continued)* – 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 vaccines to specific age ranges, frequencies, and/or other patient-specific indications, including gender. • Nutritional counseling services (see page 42) 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 • Screening for latent tuberculosis infection for children ages 18 through 21 Note: See page 110 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. Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ A complete list of women's preventive services can be found at www.healthcare.gov/preventive-care-women/ HHS: www.healthcare.gov/preventive-care-benefits For additional information: healthfinder.gov/myhealthfinder/default.aspx Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines, go to https://brightfutures.aap.org/Pages/default.aspx	See page 48	See page 48

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 healthcare 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 42 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 60. Note: Maternity care benefits are not provided for prescription drugs required during pregnancy, except as recommended under the Affordable Care Act. See page 110 for more information. See Section 5(f) for other prescription drug coverage. Note: Here are some things to keep in mind: • You do not need to precertify your delivery; see page 27 for other circumstances, such as extended stays for you or your baby. *(continued on next page)*	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 the notes on pages 82-85. 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**
• You may remain in the hospital up to 48 hours after a vaginal 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. • Hospital services are listed in Section 5(c) and Surgical benefits are in Section 5(b). 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 65 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 800-262-7890.	Nothing (no deductible)	Nothing
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 40 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	You Pay	
	Standard Option	Basic Option
A range of voluntary family planning services for women, limited to: • Contraceptive counseling • Diaphragms and contraceptive rings • Injectable contraceptives • Intrauterine devices (IUDs) • Implantable contraceptives • Tubal ligation or tubal occlusion/tubal blocking procedures only Family planning services for men, limited to: • Vasectomy Note: We also provide benefits for professional services associated with tubal ligation/occlusion/blocking procedures, vasectomy, 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
• 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 108 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	You Pay	
	Standard Option	Basic Option
Diagnosis and treatment of infertility, except for the Reproductive services listed as not covered on page 49 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 healthcare 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 147 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.
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) and 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 38 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 healthcare 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 147 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 38 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 38 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 healthcare 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 23-25). • 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 24 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 60. • Outpatient cardiac rehabilitation • Pulmonary rehabilitation therapy • Applied behavior analysis (ABA) for the treatment of an autism spectrum disorder (see prior approval requirements on page 23) Note: See Section 5(c) for our payment levels for treatment therapies billed for by the outpatient department of a hospital. Note: See page 60 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 healthcare 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 147 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 23-25). • 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.) • Applied behavior analysis (ABA) for the treatment of an autism spectrum disorder (see prior approval requirements on page 23)	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 rehabilitation 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 healthcare 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 healthcare 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 147 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*	*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 57.	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 healthcare 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 147 for more information about "agents.") Participating/Non-participating: You pay all charges
Not covered: • *Routine hearing tests (except as indicated on page 46)* • *Hearing aids (except as described on page 57)*	*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 21 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
• Eye examinations related to a specific medical condition • Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 21 Note: See page 55 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 39-40 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 55.	Preferred primary care provider or other healthcare 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 healthcare 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 147 for more information about "agents.") 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**
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 55* • *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 55*	*All charges*	*All charges*
Foot care		
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 healthcare 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 healthcare 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 147 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 limited to treatment of erectile dysfunction or as part of an approved plan for gender reassignment surgery • Surgical implants 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
• 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)*	*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 58)* • *Equipment for cosmetic purposes* • *Topical Hyperbaric Oxygen Therapy (THBO)*	*All charges*	*All charges*
Medical supplies		
• Medical foods and nutritional supplements when administered by catheter or nasogastric tubes 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* • *Medical foods administered orally, except as described in Section 5(f)*	*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 147 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 88* • *Private duty nursing*	*All charges*	*All charges*
Manipulative treatment		
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. 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: $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	You Pay	
	Standard Option	Basic Option
Acupuncture Note: Acupuncture must be performed and billed by a healthcare 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 19 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 healthcare 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 42 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 healthcare 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, or applied behavior analysis (ABA), 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 42), 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*	*All charges*	*All charges*

Section 5(b). Surgical and anesthesia services provided by physicians and other healthcare 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 healthcare 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 healthcare 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 24 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.**
- **YOU MUST GET PRIOR APPROVAL for gender reassignment surgery. Prior to any gender reassignment surgery, your provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and your provider later modifies the plan (including changes to the procedures to be performed or the anticipated dates for the procedures). See page 23 and page 65 for additional information. If your surgical procedure requires an inpatient admission, YOU MUST ALSO GET PRECERTIFICATION of the inpatient care.**
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drugs when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 111 for information about Tier 4 and Tier 5 specialty drug fills from a Preferred pharmacy. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731. Basic Option members must use a preferred pharmacy.
- **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 25 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** 29 **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 • Assistant surgeons/surgical assistance if required because of the complexity of the surgical 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 42). 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. • Gender reassignment surgical benefits are limited to the following: – For female to male surgery: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty, and placement of testicular and erectile prosthesis – For male to female surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, labiaplasty **Note: Prior approval is required for gender reassignment surgery.** For more information about prior approval, please refer to page 23. *(continued on next page)*	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 25 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 147 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
Gender reassignment surgical benefits *(continued)* Note: Benefits for gender reassignment surgery are limited to once per covered procedure, per lifetime. Benefits are not available for repeat or revision procedures when benefits were provided for the initial procedure. Benefits are not available for gender reassignment surgery for any condition other than gender dysphoria. • Gender reassignment surgery on an inpatient or outpatient basis is subject to the pre-surgical requirements listed below. **The member must meet all requirements**. – **Prior approval is obtained** – **Member must be at least 18 years of age at the time prior approval is requested and the treatment plan is submitted** – Diagnosis of gender dysphoria by a qualified healthcare professional o New gender identity has been present for at least 24 continuous months o Member has a strong desire to be rid of primary and/or secondary sex characteristics because of a marked incongruence with the member's identified gender o Member's gender dysphoria is not a symptom of another mental disorder or chromosomal abnormality o Gender dysphoria causes clinical distress or impairment in social, occupational, or other important areas of functioning – Member must meet the following criteria: o Living 12 months of continuous, full time, real life experience in the desired gender (including place of employment, family, social and community activities) o 12 months of continuous hormone therapy appropriate to the member's gender identity o Two referral letters from qualified mental health professionals – one must be from the psychotherapist who has treated the member for at least 12 continuous months. Letters must document: diagnosis of persistent and chronic gender dysphoria; any existing co-morbid conditions are stable; member is prepared to undergo surgery and understands all practical aspects of the planned surgery o If medical or mental health concerns are present, they are being optimally managed and are reasonably well-controlled	See page 65	See page 65

Surgical procedures – continued on next page

Surgical procedures *(continued)*	You Pay	
	Standard Option	Basic Option
• 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. Benefits are available only for the following procedures: – Roux-en-Y – Gastric bypass – Laparoscopic adjustable gastric banding – Sleeve gastrectomy – Biliopancreatic bypass with duodenal switch **Note: Benefits for the surgical treatment of morbid obesity are subject to the requirements listed on pages 63-64.** 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 86 for information. Note: **Prior approval is required for outpatient surgery for morbid obesity.** For more information about prior approval, please refer to page 23. • 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 67) 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 42 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 98 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 use for 1 year prior to surgery and there is no evidence of substance use during the 1-year period prior to surgery	See page 65	See page 65

Surgical procedures – continued on next page

Surgical procedures *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
• 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, except when the subsequent surgery is necessary to treat a complication from the prior morbid obesity surgery. – 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	See page 65	See page 65
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 sexual inadequacy (except surgical placement of penile prostheses to treat erectile dysfunction and gender reassignment surgeries specifically listed as covered)* • *Reversal of gender reassignment surgery*	*All charges*	*All charges*

Reconstructive surgery	You Pay	
	Standard Option	Basic Option
• Surgery to correct a functional defect • Surgery to correct a congenital anomaly (See Section 10, p. 147 for definition) • 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 25 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 147 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 sexual dysfunction or sexual inadequacy (except surgical placement of penile prostheses to treat erectile dysfunction and gender reassignment surgeries specifically listed as covered)* • *Reversal of gender reassignment surgery*	*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 24 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 25 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 147 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 24-24) 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 74-75 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 22-27 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 74** must be performed at a FACT-accredited facility. See page 21 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 140 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 25 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 for the diagnoses as indicated below: • 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, Hurler's syndrome and 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 for the diagnoses as indicated below: • 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) *(continued on next page)*	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**
Autologous blood or marrow stem cell transplants *(continued)* 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**.	See page 73	See page 73
Blood or marrow stem cell transplants for the diagnoses as indicated below, **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: – Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) – Chronic myelogenous leukemia – 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 for the diagnoses as indicated below, **only** when performed at a FACT-accredited facility (see page 21) 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 (limited to: multiple sclerosis, scleroderma, systemic lupus erythematosus and 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 140 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 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 73-74 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 73-74 • 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 155 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 24).		
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 72-75 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 AND SKILLED NURSING FACILITY 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 80. See page 151 for more information about these types of services.
- **YOU MUST GET PRIOR APPROVAL for the following services if they are to be performed on an outpatient basis: sleep studies performed outside the home, 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 gender reassignment surgery. See page 23 for prior approval and page 65 for the surgical benefit.**
- 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 healthcare 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 151 for more information. See pages 87 and 99 for inpatient residential treatment center. 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 80. See page 151 for more information about these types of services. Note: Here are some things to keep in mind: • You do not need to precertify your delivery; see page 27 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. *(continued on next page)*	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 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 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.

Inpatient hospital – continued on next page

Inpatient hospital *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Other hospital services and supplies *(continued)* • 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 59 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 86 for information.	See page 80	See page 80
Not covered: • *Admission to noncovered facilities, such as nursing homes, extended care facilities, schools, or residential treatment centers (except as described on pages 87 and 99)* • *Personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services* • *Private duty nursing* • *Facility room and board expenses when, in our judgment, an 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* • *Care that is 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.* – *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 an inpatient 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 19-21).*	*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 42). 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 page 50 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 38. 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 86 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 48-49 for other included maternity services. *(continued on next page)*	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 147 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**
Outpatient surgical and treatment services *(continued)* Note: See page 85 for outpatient drugs, medical devices, and durable medical equipment billed for by a facility. 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.	See page 82	See page 82
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 40 for coverage criteria and limitations. • Nuclear medicine • Sleep studies Note: Prior approval is required for sleep studies performed in a location other than your home.	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 147 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 147 for more information about "agents.")
Outpatient **treatment services** performed and billed by a facility, limited to: • Cardiac rehabilitation • Cognitive rehabilitation therapy • Pulmonary rehabilitation • Physical, occupational, and speech therapy • Applied behavior analysis (ABA) for an autism spectrum disorder (see prior approval requirements on page 23) • Manipulative treatment services Note: We provide benefits for manipulative treatment services as described on page 60.	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, speech and cognitive rehabilitation therapy, as described on page 54, and ABA as described on page 53.	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 147 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 147 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 41-45 • Cancer screenings listed on page 42 and ultrasound screening for abdominal aortic aneurysm Note: See pages 43-44 for our coverage requirements for preventive BRCA testing. Note: See page 48 for our payment levels for covered preventive care services for children billed for by facilities and performed on an outpatient basis.	See pages 41-45 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 • Surgical implants 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. Note: Certain self-injectable drugs are covered only when dispensed by a pharmacy under the pharmacy benefit. These drugs will be covered once per lifetime per therapeutic category of drugs when dispensed by a non-pharmacy-benefit provider. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 111 for information about Tier 4 and Tier 5 specialty drug fills from a Preferred pharmacy.	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 82-84 for specific coverage information. Member/Non-member: You pay all charges

Blue Distinction® Specialty Care	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 Knee and Hip Replacement, Blue Distinction Center for Spine Surgery, or Blue Distinction Center for Comprehensive Bariatric Surgery. • Bariatric surgeries covered are: – Roux-en-Y – Gastric bypass – Laparoscopic adjustable gastric banding – Sleeve gastrectomy – Biliopancreatic bypass with duodenal switch • 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 79-81 for regular inpatient hospital benefits and pages 82-85 for outpatient facility benefit levels. Note: See page 21 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

Blue Distinction® Specialty Care – continued on next page

Blue Distinction® Specialty Care *(continued)*	You Pay	
	Standard Option	**Basic Option**
Outpatient facility services related to specific covered bariatric surgical procedures, when the surgery is performed at a designated Blue Distinction Center for Bariatric Surgery Note: You must meet the pre-surgical requirements listed on page 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). Note: These benefits do not apply to other types of outpatient surgical services, even when performed at a Blue Distinction Center. See page 82 for the benefits we provide. Note: See page 21 for more information about Blue Distinction Centers.	Blue Distinction Center: $100 per day per facility (no deductible)	Blue Distinction Center: $25 per day per facility
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 use 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 38 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
When you do not have Medicare Part A: For Members who do not have Medicare Part A, we cover skilled nursing facility (SNF) inpatient care for a maximum of 30 days annually, when the Member can be expected to benefit from short-term SNF services with a goal of returning home. The following criteria must also be met: • Member is enrolled in case management prior to admission to the SNF (signed consent required), and actively participates in case management both prior to and during admission to the SNF. • Precertification is obtained prior to admission (including overseas care). • We approve the preliminary treatment plan prior to admission (plan must include proposed therapies and document the need for inpatient care). • Member participates in all treatment and care planning activities, including discharge planning/transition to home. Benefits are not available for inpatient SNF care solely for management of tube feedings, for home level dialysis treatment, as an interim transition to long term care placement, or for any other non-covered services. Note: No inpatient benefits (such as room and board) will be provided if precertification is not obtained prior to admission (see page 23). Members are responsible for enrolling in case management (see page 22)	Preferred: $175 (no deductible) per admission Participating/Member: $275 plus 35% of the Plan allowance (no deductible) per admission Non-participating/Non-member: $275 plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment per admission	All charges
When you have Medicare Part A: When Medicare Part A is the primary payor (meaning it pays first) and has made a 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. Note: See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c03.pdf for complete Medicare benefit period definition. 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 54 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 have Medicare Part A, we will only provide benefits if Medicare provided benefits for the admission.***	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

Extended care benefits/Skilled nursing care facility benefits – continued on next page

Extended care benefits/Skilled nursing care facility benefits *(continued)*	You Pay	
	Standard Option	Basic Option
Not covered: *Telephone, television, personal comfort items, such as guest meals and beds, beauty and barber services, recreational outings/trips, stretcher or wheelchair transportation, non-emergent 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, custodial or long term care (see Definitions), and domiciliary care provided because care in the home is not available or is unsuitable.*	*All charges*	*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 90	See below and page 90
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
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 page 24 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. *(continued on next page)*		

Hospice care – continued on next page

Hospice Care *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Hospice care prior approval *(continued)* 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 90. **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 next page	See next page
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

Hospice care – continued on next page

Hospice Care *(continued)*	You Pay	
	Standard Option	**Basic Option**
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 804-673-1678. See page 125 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 $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 day per facility Member emergency room: $125 copayment per day per facility Non-member emergency room: $125 copayment per day per facility, 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 and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider	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

Medical emergency – continued on next page

Medical emergency *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
• 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 day per facility Member: $125 copayment per day per facility Non-member: $125 copayment per day per facility, 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.
• Urgent care center services and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider	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		
See page 92 for complete ambulance benefit and coverage information.		

Section 5(e). Mental health and substance use disorder 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 page 123. 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 healthcare 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.
- Every year, we conduct an analysis of the financial requirements and treatment limitations which apply to this Plan's mental health and substance use disorder benefits in compliance with the federal Mental Health Parity and Addiction Equity Act (the Act), and the Act's implementing regulations. Based on the results of this analysis, we may suggest changes to program benefits to OPM. More information on the Act is available on the following Federal Government websites:
  https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html
  https://www.dol.gov/ebsa/mentalhealthparity/
  www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act
- **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 use disorder 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 use disorder 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 use disorder 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 use phone number on the back of your ID card. Note: See pages 62 and 113 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
Telehealth professional services for: • Behavioral health counseling • Substance use disorder counseling Note: Refer to Section 5(h) Wellness and other special features for information on telehealth services and how to access a provider.	Preferred Telehealth provider : $10 (no deductible) Participating/Non-participating: You pay all charges	Preferred Telehealth provider: $15 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 use disorder-includes room and board and ancillary charges for confinements in a hospital/treatment facility for rehabilitative treatment of alcoholism or substance use. 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 use 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 98 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; biofeedback; 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* • *Inpatient services performed or billed by residential treatment centers, except as described on pages 87 and 99* • *Services performed or billed by schools, halfway houses, or members of their staffs* *Note: We cover professional services as described on page 98 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 105.
- If there is no generic drug available, you must still pay the brand-name cost-sharing amount when you receive a brand-name drug.
- If you select a brand-name drug over an available generic drug, you will be responsible for the applicable tier cost-share plus the difference in the costs of the brand-name and generic drugs. If the provider's prescription is for the brand-name drug and indicates "dispense as written," you are responsible only for the applicable tier cost-share.
- 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.
- Benefits for certain self-injectable (self-administered) drugs are provided only when they are dispensed by a pharmacy under the pharmacy benefit. Medical benefits will be provided for a once-per-lifetime dose per therapeutic category of drugs dispensed by your provider or any non-pharmacy-benefit provider. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 111 for Tier 4 and Tier 5 specialty drug fills from a Preferred pharmacy.
- 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.
- Medication prices vary among different retail pharmacies, the Mail Service Prescription Drug Program, and the Specialty Drug Pharmacy Program. **Review purchasing options for your prescriptions to get the best price.** A drug cost tool is available at www.fepblue.org or call:
  - **Retail Pharmacy Program: 800-624-5060 (TTY: 800-624-5077)**
  - **Mail Service Prescription Drug Program: 800-262-7890 (TTY: 800-216-5343)**
  - **Specialty Drug Pharmacy Program: 888-346-3731 (TTY: 877-853-9549)**
- **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 104 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 or biosimilar becomes available or if new safety concerns arise. If your drug is moved to a higher tier, your cost-share will increase. See pages 111, 112 and 113 for the amounts Members pay for Preferred retail, mail service, and specialty drug purchases. Tier reassignments during the year are not considered benefit changes.
- A pharmacy restriction may be applied for clinically inappropriate use of prescription drugs and supplies.

- **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.
  - The Standard Option formulary contains a comprehensive list of drugs under all therapeutic categories with two exceptions: some drugs, nutritional supplements and supplies are not covered (see page 115); we may also exclude certain FDA-approved drugs when multiple generic equivalents/alternative medications are available. See pages 103 and 104 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.
  - The Basic Option formulary contains a comprehensive list of drugs under all therapeutic categories with two exceptions: some drugs, nutritional supplements and supplies are not covered (see page 115); we may also exclude certain FDA-approved drugs when multiple generic equivalents/ alternative medications are available. See pages 103 and 104 for details.
  - We use a managed formulary for certain drug classes.
  - 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 154 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 154 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.

  Note: The Specialty Drug Pharmacy Program will not fill your prescription until you have obtained prior approval. AllianceRx Walgreens Prime, 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 112.

  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 111 for information about your cost-share for specialty drugs purchased at a Preferred retail pharmacy that are affected by these restrictions.

Standard Option Only

- **Under Standard Option**, some drugs, nutritional supplements and supplies are not covered (see page 115); we may also exclude certain FDA-approved drugs when multiple generic equivalents/alternative medications are available. If you purchase a drug, nutritional supplement, or supply that is not covered or a drug specifically excluded from coverage on the formulary, you will be responsible for the full cost of the item.
- The Standard Option formulary includes a list of preferred drugs that are safe, effective and appropriate for our Members, and are available at lower costs than those of non-preferred drugs. If your physician prescribed a more expensive non-preferred drug for you, we may ask that he or she prescribe a preferred drug instead; we encourage you to do the same. If you purchase a drug that is not on our preferred drug list, your cost will be higher. 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.** 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.
- The Basic Option formulary includes a list of preferred drugs that are safe, effective and appropriate for our Members, and are available at lower costs than those of non-preferred drugs. If your physician prescribed a more expensive non-preferred drug for you, we may ask that he or she prescribe a preferred drug instead; we encourage you to do the same. If you purchase a drug that is not on our preferred drug list, your cost will be higher. Your cooperation with our cost-savings efforts helps keep your premium affordable.
- **Under Basic Option**, some drugs, nutritional supplements, and supplies are not covered (see page 115); we may also exclude certain FDA-approved drugs when multiple generic equivalents/alternative medications are available. If you purchase a drug, nutritional supplement, or supply that is not covered or a drug specifically excluded from coverage, you will be responsible for the full cost of the item.

  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 800-624-5060 (TTY: 800-624-5077). If you do not find your drug on the formulary or the preferred drug list, please call 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. Please note the list of drugs excluded from coverage may change during the year. For the most up-to-date excluded drug list, please visit www.fepblue.org/formulary.

- **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.** 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 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: 800-624-5060 (TTY: 800-624-5077)

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

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

Patient Safety and Quality Monitoring (PSQM)

We have a special program to promote patient safety and monitor healthcare 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 800-624-5060 (TTY: 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 800-624-5060 (TTY: 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 on the Generic Incentive Program List 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 Program

- 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.

Please note the list of eligible generic drug replacements may change. For the most up-to-date information, please visit www.fepblue.org/en/benefit-plans/coverage/pharmacy/generic-incentive-program or call:

Retail Pharmacy Program: 800-624-5060 (TTY: 800-624-5077)

Mail Service Prescription Drug Program: 800-262-7890 (TTY: 800-216-5343)

Specialty Drug Pharmacy Program: 888-346-3731 (TTY: 877-853-9549)

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**
Asthma Medications		
Preferred Retail Pharmacies:	Tier 1 (generic drug): $5 copayment (no deductible) Tier 2 (preferred brand-name drug): 20% of the Plan allowance (no deductible)	Tier 1 (generic drug): $5 copayment Tier 2 (preferred brand-name drug): $35 copayment for each purchase of up to a 30-day supply ($105 copayment for 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment Tier 2 (preferred brand-name drug): $30 copayment for each purchase of up to a 30-day supply ($90 copayment for 90-day supply)
Mail Service Prescription Drug Program: Note: See pages 111-113 for Tier 3, 4 and 5 prescription drug benefits.	Tier 1 (generic drug): $5 copayment (no deductible) Tier 2 (preferred brand-name drug): $65 copayment (no deductible)	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment Tier 2 (preferred brand-name drug): $75 copayment Note: See page 26 for information about drugs and supplies that require prior approval. You must obtain prior approval before Mail Service will fill your prescription. See pages 26 and 139.
Anti-hypertensive Medications		
Preferred Retail Pharmacies:	Tier 1 (generic drug): $3 copayment (no deductible)	Tier 1 (generic drug): $5 copayment
Mail Service Prescription Drug Program: Note: See pages 111-113 for Tier 2, 3, 4, and 5 prescription drug benefits.	Tier 1 (generic drug): $3 copayment (no deductible)	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment Note: See page 26 for information about drugs and supplies that require prior approval. You must obtain prior approval before Mail Service will fill your prescription. See pages 26 and 139.

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	You Pay	
	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 110 for our coverage of medicines to promote better health as recommended under the Affordable Care Act. • Specialized nutritional formulas for children up to age 22 to treat inborn errors of amino acid metabolism – Must meet the definition of medical food (See definition on page 150 – Must be intended for use solely under medical supervision in the dietary management of an inborn error of amino acid metabolism – Must be receiving active, regular and ongoing medical supervision and must be unable to manage your condition by modification of diet alone • 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) in formula form only Note: Prior approval is required for medical foods provided under the pharmacy benefit. Note: See Section 5(a), page 59, 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 58 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 113. Note: You may be eligible to receive smoking and tobacco cessation medications at no charge. See page 113 for more information.	See page 105 and pages 108-113	See page 105 and pages 108-113

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	You Pay	
	Standard Option	**Basic Option**
• Drugs for the diagnosis and treatment of infertility, except as described on page 115 • Drugs to treat gender dysphoria (gonadotropin-releasing hormone (GnRH) antagonists and testosterones • 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 111 and 112 for details.	See page 105 and pages 108-113	See page 105 and pages 108-113
• 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
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 the following vaccines: • Herpes zoster (shingles) vaccines • Human papillomavirus (HPV) vaccines • Influenza (flu) vaccines • Pneumococcal vaccines • Meningococcal vaccines	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.

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	You Pay	
	Standard Option	Basic Option
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 Preferred Retail Pharmacy Program at 800-624-5060 (TTY: 800-624-5077) to see which vaccines your pharmacy can provide.		
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 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 111 and 112 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 for the primary prevention of cardiovascular disease and colorectal cancer • Aspirin for adults age 50 through 59 for the primary prevention of cardiovascular disease and colorectal cancer • Generic cholesterol-lowering statin drugs 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 104 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/preventive-care-benefits. See pages 41-48 in Section 5(a) for information about other covered preventive care services. Note: See page 113 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 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 Preferred Retail Pharmacy Program at 800-624-5060 (TTY: 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 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 113 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 Preferred 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 112.** Note: For a list of the Preferred Network Long Term Care pharmacies, call 800-624-5060 (TTY: 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 Preferred Retail pharmacy Program at 800-624-5060 (TTY: 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 105 for information. Tier 2 (preferred brand-name drug): 30% of the Plan allowance (no deductible) Tier 3 (non-preferred brand-name drug): 50% 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 ($75 minimum) for each purchase of up to a 30-day supply ($210 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 ($60 minimum) for each purchase of up to a 30-day supply ($175 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 113 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 800-262-7890 (TTY: 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 105 for information. Tier 2 (preferred brand-name drug): $80 copayment (no deductible) Tier 3 (non-preferred brand-name drug): $125 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): $125 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 104. 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 111 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 154 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 are most convenient for you, as well as ask you about any side effects you may be experiencing. See page 134 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 888-346-3731 (TTY: 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 the contract holder or spouse, 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 page 121. 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 continuing 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 62 for our coverage of smoking and tobacco cessation treatment, counseling, and classes.	See page 113	See page 113
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 page 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 111 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 foods administered orally are not covered if not obtained at a retail pharmacy or through the Mail Service Prescription Drug Program* • *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 58 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* • *Products and foods other than liquid formulas or powders mixed to become formulas; foods and formulas readily available in a retail environment and marketed for persons without medical conditions; low-protein modified foods (e.g., pastas, breads, rice, sauces and baking mixes); nutritional supplements, energy products; and similar items* *Note: See page 110 for our coverage of medicines recommended under the Affordable Care Act and page 113 for smoking and tobacco cessation medications.* *Note: See Section 5(a), page 59 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 59* • *Drugs and supplies related to sexual dysfunction or sexual inadequacy* • *Drugs and covered-drug-related supplies for the treatment of 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 108* • *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 108* • *Drugs used to terminate pregnancy* • *Sublingual allergy desensitization drugs, except as described on page 52*	*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 page.

Basic Option dental benefits appear on page 119.

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 page. 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**	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).
Periodic oral evaluation *(up to 2 per person per calendar year)*	$12	$8	
Limited oral evaluation	$14	$9	
Comprehensive oral evaluation	$14	$9	
Detailed and extensive oral evaluation	$14	$9	

Dental benefits – continued on next page

Standard Option dental benefits *(continued)*			
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 images	$16	$10	
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 (*up to 2 per person per calendar year*)	$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). Wellness and other 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 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 healthcare 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 healthcare expenses. See page 121 for complete information. • **Tobacco Cessation** Incentive Program – If you are the contract holder or spouse 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 113-114 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 TTY 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.

Wellness and other 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, the contract holder or spouse is 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, 2018**. 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 888-258-3432 toll-free.
Diabetes Management Incentive Program	The **Diabetes Management Incentive Program** is designed to encourage Members to achieve and maintain control of their blood sugar and help manage or slow the progression of complications related to diabetes. Through this program you can earn a maximum of $100 toward a health account to be used for most qualified medical expenses. This incentive is in addition to other incentives described in this brochure and is limited to the contract holder or spouse. To qualify for the Diabetes Management Incentive Program, each eligible Member must complete the following steps: • Complete the Blue Health Assessment (BHA), indicating that you have been diagnosed with Type 1 or Type 2 diabetes. Note: The BHA is available on our website, www.fepblue.org. • Provide us with lab test results for an HbA1c performed in the first six months of the calendar year (January 1 to June 30) to receive a $25 incentive reward. • Provide us with lab test results for an HbA1c performed in the last six months of the calendar year (July 1 to December 31) to receive a $75 incentive reward; the test results must show: – Your HbA1c result is less than 8 percent; or – If your HbA1c is greater than or equal to 8 percent, you will receive the incentive if we provided benefits for three nutritional counseling visits performed during the calendar year. Note: See pages 39 and 42 for information on nutritional counseling. Information on how to submit your HbA1c lab results can be found on our website, www.fepblue.org/diabetes.

Wellness and other special features – continued on next page

Hypertension Management Program	The **Hypertension Management Program** gives Members with hypertension (otherwise known as high blood pressure) 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 the contract holder or spouse 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 healthcare 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. 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 Pregnancy Care Box, you must be female, and the contract holder or spouse, and must complete the Blue Health Assessment (BHA) questionnaire. Information on the program is available on our website, www.fepblue.org. Also see page 121 for information on the BHA. To qualify for the $75 incentive, you must meet the criteria above for the Pregnancy Care Box and send us a copy of your healthcare provider's medical record that confirms you had a prenatal care visit during the first trimester of your pregnancy. Information that must be included when submitting your medical record can be found on our website, www.fepblue.org/maternity. To receive 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 are limited to two pregnancies per calendar year.
Reimbursement Account for Basic Option Members enrolled in Medicare Part A and Part B	Basic Option Members enrolled in Medicare Part A and Part B are eligible for up to a $600 reimbursement account. The account is used exclusively to pay for Medicare Part B premiums. For more information on how to obtain reimbursement, please visit www.fepblue.org/mra or call 888-706-2583.

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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 healthcare 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 healthcare needs with the services of a registered nurse, licensed social worker, or other licensed healthcare professional practicing within the scope of their license and certified as a case manager by a nationally recognized board certified in case management to assess, coordinate, evaluate, support and monitor the Member's treatment plan and healthcare needs. Enrollment in case management requires your consent. Members in case management are asked to provide verbal consent prior to enrollment in case management and must provide written consent for case management. Note: Benefits for care provided by residential treatment centers and for inpatient care provided by skilled nursing facilities for Members enrolled in Standard Option who do not have Medicare Part A require written consent and participation in Case Management prior to admission; please see pages 87, 99 and 125 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.

Wellness and other special features – continued on next page

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 will review the Member's healthcare needs and may at our sole discretion, identify a less costly alternative treatment plan for the Member. The Member (or their healthcare proxy) and provider(s) must cooperate in the process. Case Management Program enrollment is required for eligibility. Prior to the starting date of the alternative treatment plan, members who are eligible to receive services through the flexible benefits option are required to sign and return a written consent for case management and 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. **We must receive the consent for case management and the alternative benefits agreement signed by the Member/healthcare proxy before you receive any services included in the alternative benefits agreement.** • Alternative benefits will be made available for a limited period of time and are subject to our ongoing review. You must cooperate with and participate in the review process. Your provider(s) must submit the information necessary for our reviews. You and/or your healthcare proxy must participate in care conferences and caregiver training as requested by your provider(s) or by us. • We may revoke the alternative benefits agreement immediately at any time, if we discover we were misled by the information given to us by you, your provider, or anyone else involved in your care, or that you are not meeting the terms of the agreement. • If we approve alternative benefits, we do not guarantee that they will be extended beyond the limited time period and/or scope of the alternative benefits agreement 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 at our sole discretion, 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 alternative benefits for the stated time period, unless we are misled by the information given to us or circumstances change. Benefits as stated in this brochure will apply to all services and dates of care not included in the alternative benefits agreement. You or your provider may request an extension of the time period initially approved for alternative benefits, no later than five business days prior to the end of the alternative benefits agreement. We will review the request, including the services proposed as an alternative and the cost of those services, but benefits as stated in this brochure will apply if we do not approve your request. Note: If we deny a request for precertification or prior approval of regular contract benefits, as stated in this brochure, 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).
Telehealth Services	Go to fepblue.org/telehealth or call 855-636-1579 (TTY: 855-636-1578) toll free to access on-demand, affordable, high-quality care for adults and children experiencing non-emergency medical issues, including treatment of minor acute conditions (see page 150 for definition), and counseling for behavioral health and substance use disorder. Note: This benefit is available only through the contracted telehealth provider network.

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 125-126 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 healthcare 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, with the exception of admissions for gender reassignment surgery (see pages 23 and 65 for information) and admissions to residential treatment centers and skilled nursing facilities.

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 804-673-1678. Members in the United States, Puerto Rico, or the U.S. Virgin Islands should call 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.
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 **inpatient facility care** you receive overseas, we provide benefits at the Preferred level **under both Standard and Basic Options, without Member cost-share,** for admissions to a DoD facility, or when the Worldwide Assistance Center (provided by AXA Assistance) has arranged direct billing or acceptance of a guarantee of benefits with the facility. For **outpatient 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 82-85.

	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 114 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.
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 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 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 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

These benefits are not part of the FEHB contract or premium, and you cannot file an FEHB dispute regarding these benefits. Fees paid 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®

The Service Benefit Plan presents Blue365®, a program that offers exclusive health and wellness deals that will assist in your efforts to be 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.

Each week, Blue365 Members receive great health and wellness deals via email. With Blue365, there is no paperwork to fill out. Just 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

Fitness Your Way™ by Tivity Health can help you meet your health and fitness goals, on your budget, and on your own time. Fitness Your Way by Tivity Health offers access to more than 9,500 different fitness locations for just $29 a month and a low $29 enrollment fee, with a 3-month commitment.* The over 9,500 locations include Anytime Fitness®, Curves®, and Planet Fitness®. A limited number of Gold's Gyms and YMCAs in certain areas are also participating. You'll have access to well-being support, health articles, and online health coaching, as well as exercise tracking and nutrition goals, social networking, rewards, and the Daily Challenge 24 hours a day, 7 days a week. For more information or to enroll, visit www.fepblue.org/healthclub or call customer service at 888-242-2060, Monday through Friday, 8 a.m. – 8 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 Members 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 several drugs related to dental care, weight loss, hair removal and hair growth, and other miscellaneous health conditions.

Please refer to fepblue.org/ddp for a full list of discounted drugs, including those that 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 fepblue.org/ddp or call 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 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 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 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 150).
- Experimental or investigational procedures, treatments, drugs, or devices (see Section 5(b) 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 and gender reassignment surgeries specifically listed as covered).
- Travel expenses except as specifically provided for covered transplants performed in a Blue Distinction Center for Transplant (see page 77).
- 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 145), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge, see page 146), or state premium taxes however applied.
- Prescriptions, 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, diagnostic tests, and procedures and services for the treatment of morbid obesity listed on page 67.
- 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 41-48 and page 85; and certain routine services associated with covered clinical trials (see page 140).
- Recreational or educational therapy, and any related diagnostic testing, except as provided by a hospital during a covered inpatient stay.
- Applied behavior analysis (ABA) and related services for any condition other than an autism spectrum disorder.
- Applied behavior analysis (ABA) services and related services performed as part of an educational program; or provided in or by a school/educational setting; or provided as a replacement for services that are the responsibility of the educational system.
- 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 115), meditation techniques, relaxation techniques, movement therapies, and energy therapies.
- Membership or concierge service fees charged by a healthcare provider.
- Fees associated with copies, forwarding or mailing of records except as specifically described in Section 8.
- 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, speech, or cognitive rehabilitation 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 133-134 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 retail 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 retail 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 800-624-5060 to request a retail prescription drug claim form to claim benefits. Hearing-impaired Members with TTY equipment may call 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 800-262-7890 (TTY: 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 134 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 888-346-3731 (TTY: 877-853-9549), or you may send your prescription to: Specialty Drug Pharmacy Program, AllianceRx Walgreens Prime, P.O. Box 692169, Orlando, FL 32869. 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 888-346-3731 (TTY: 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 125-126 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 healthcare 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 healthcare 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 healthcare 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;
- Your daytime phone number and the best time to call; and
- 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 healthcare 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 healthcare 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 healthcare 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 on NAIC rules regarding the coordinating of benefits, visit our website at www.fepblue.org/coordinationofbenefits.

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 146). 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 healthcare 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 healthcare 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 877-888-3337, (TTY: 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 800-MEDICARE (800-633-4227), (TTY: 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 143.
- 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 800-772-1213, (TTY: 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 800-772-1213, (TTY: 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 healthcare. 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 145 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 23 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 healthcare 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**

If you are enrolled in Medicare Part B, 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 healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227), (TTY: 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.
Does not participate with Medicare and is not a member of our PPO network		your out-of-network deductibles, coinsurance, and any balance up to 115% of the Medicare approved amount
Opts-out of Medicare via private contract		your deductibles, coinsurance, copayments, and any balance your physician 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.

Physicians Who Opt-Out of Medicare

A physician may have opted-out of Medicare and may or may not ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. This is different than a Non-participating doctor, and we recommend you ask your physician if he or she has opted-out of Medicare. Should you visit an opt-out physician, the physician will not be limited to 115% of the Medicare approved amount. You may be responsible for paying the difference between the billed amount and our regular in-network/out-of-network benefits.

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.
Biologic drug	A complex drug or product that is manufactured in a living organism, or its components, that is used as a diagnostic, preventive or therapeutic agent.
Biosimilar drug	An FDA-approved biologic drug, which is considered highly similar to an original brand-name biologic drug, with no clinically meaningful differences from the original biologic drug in terms of safety, purity and potency.
Biosimilar, interchangeable drug	An FDA-approved biosimilar drug that may be automatically substituted for the original brand-name biologic drug.
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.
Clinical trials	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 29.
Concurrent care claims	A claim for continuing care or an ongoing course of treatment that is subject to prior approval. See page 26 in Section 3.
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; ambiguous genitalia; and webbed fingers and toes. Note: Congenital anomalies do not include conditions related to the teeth or intra-oral structures supporting the teeth.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 28.

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 healthcare 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.

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 healthcare 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 healthcare 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 healthcare 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

Healthcare 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).

Healthcare professional

A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law. See page 19 for information about how we determine which healthcare 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 healthcare provider. For more information, visit our website, www.fepblue.org.

Inpatient

You are an inpatient when you are formally admitted to a hospital with a doctor's order.

Note: Inpatient care requires precertification. For some services and procedures prior approval must also be obtained. See pages 22-27.

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 use 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 healthcare 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 healthcare 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, able to be provided safely only in the inpatient 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.

Minor acute conditions

Common, non-emergent conditions. Examples of common conditions include sinus problems, rashes, allergies, cold and flu symptoms, etc.

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.

Outpatient

You are an outpatient if you are getting emergency department services, observation services, outpatient surgery, lab tests, X-rays, or any other hospital services, and the doctor has not written an order to admit you to a hospital as an inpatient. In these cases, you are an outpatient even if you are admitted to a room in the hospital for observation and spend the night at the hospital.

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 healthcare 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 117 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 healthcare 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 Local Plan Allowance. The Local Plan Allowance varies by region and is determined by that Plan. 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 to 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 healthcare 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 Local Plan Allowance. In the absence of a Medicare participating fee schedule amount or ASP for any service, drug, or supply, our allowance is the Local Plan Allowance. 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 healthcare 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 the Worldwide Assistance Center (provided by 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, D.C., 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 pages 32 and 125.

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, healthcare institutions, and other covered healthcare 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 healthcare 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, and latent tuberculosis; screening for alcohol/substance use; 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 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 23-25.

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 page 140).

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.

Telehealth Services

Non-emergency services provided by telephone or secure online video for minor acute conditions (see page 150 for definition) and behavioral health and substance use disorder counseling. Go to fepblue.org/telehealth or call 855-636-1579 (TTY: 855-636-1578) toll free to access this benefit. After your telehealth visit, please follow-up with your primary care provider.

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 four 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 healthcare 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.

Fourth, the **Federal Employees' Group Life Insurance Program (FEGLI)** can help protect your family from burdensome funeral costs and the unexpected loss of your income.

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 healthcare flexible spending account (HCFSA) or a limited expense healthcare spending account (LEX HCFSA) is $2,600 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 healthcare 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 877-FSAFEDS, 877-372-3337 (TTY: 866-353-8058), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time.

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 877-888-3337 (TTY: 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. Long term care can be received in your home, in a nursing home, in an assisted living facility, or in adult day care. You must apply and pass a medical screening (called underwriting), and be approved for enrollment. Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Your qualified relatives can apply even if you do not. 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 800-LTC-FEDS (800-582-3337), (TTY: 800-843-3557), or visit www.ltcfeds.com.

The Federal Employees Group Life Insurance Program – *FEGLI*

The Federal Employees' Group Life Insurance Program (FEGLI) can help protect your family from burdensome funeral costs and the unexpected loss of your income. You can get life insurance coverage starting at one year's salary to more than six times your salary and many options in between. You can also get coverage on the lives of your spouse and unmarried dependent children under age 22. You can continue your coverage into retirement if you meet certain requirements. For more information, visit www.opm.gov/life.

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Do not rely only 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. Page numbers in **bold** type are main entries.

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Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2018

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 healthcare 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 healthcare professionals $35 per office visit for specialists Non-PPO: 35%* of our allowance	38-40 41-48
Telehealth services	PPO: $10 Non-PPO: You pay all charges	39, 98
Services provided by a hospital:		
• Inpatient	PPO: $350 per admission Non-PPO: $450 per admission, plus 35% of our allowance	79-81
• Outpatient	PPO: 15%* of our allowance Non-PPO: 35%* of our allowance	82-85
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	94-95
• 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)	95-96, 92
Mental health and substance use 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	97-100

Standard Option Summary – continued on next page

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2018 *(continued)*

Prescription drugs	Retail Pharmacy Program: • PPO: 20% of our allowance generic (15% if you have Medicare)/30% of our allowance Preferred brand-name/50% 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/ $125 non-preferred brand-name per prescription; up to a 90-day supply Specialty Drug Pharmacy Program: • See inside for details	111-113
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, 116-118
Wellness and other special features: Health Tools; Blue Health Assessment; MyBlue® Customer eService; Diabetes Management Incentive Program; National Doctor & Hospital Finder℠; Healthy Families; travel benefit/services overseas; Care Management Programs; and Flexible benefits option		120-124
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

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2018

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 healthcare professionals; $40 per office visit for specialists Non-PPO: You pay all charges	38-40 41-48
Telehealth services	PPO: $15 Non-PPO: You pay all charges	39, 98
Services provided by a hospital:		
• Inpatient	PPO: $175 per day up to $875 per admission Non-PPO: You pay all charges	80-81
• Outpatient	PPO: $100 per day per facility Non-PPO: You pay all charges	82-85
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	94-95
• Medical emergency	Same as for accidental injury	93, 95-96
Mental health and substance use 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	97-100

Basic Option Summary – continued on next page

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2018 *(continued)*

Prescription drugs	Retail Pharmacy Program: • PPO: $10 generic/$50 Preferred brand-name per prescription ($45 if you have primary Medicare Part B)/60% coinsurance ($75 minimum) for non-preferred brand-name drugs (50% ($60 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/$125 non-preferred brand-name per prescription; up to a 90-day supply	111-113
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, 116, 119
Wellness and other special features: Health Tools; Blue Health Assessment; MyBlue® Customer eService; Diabetes Management Incentive Program; National Doctor & Hospital Finder℠; Healthy Families; travel benefit/services overseas; Care Management Programs; and Flexible benefits option		120-124
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

2018 Rate Information for the Blue Cross and Blue Shield Service Benefit Plan

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

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 United States Postal Service employees.

Postal Category 1 rates apply to career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NALC, NPMHU, NPPN, and NRLCA.

Postal Category 2 rates apply to career bargaining unit employees who are represented by the following agreement: PPOA.

Non-Postal rates apply to all career non-bargaining unit Postal Service employees.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center: 877-477-3273, option 5, TTY: 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.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Enrollment Code	Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Standard Option Self Only	104	$229.25	$113.16	$496.71	$245.18	$106.79	$100.43
Standard Option Self Plus One	106	$491.00	$257.81	$1,063.83	$558.59	$244.17	$230.53
Standard Option Self and Family	105	$521.58	$271.95	$1,130.09	$589.23	$257.46	$242.97
Basic Option Self Only	111	$221.18	$73.72	$479.21	$159.74	$67.09	$61.19
Basic Option Self Plus One	113	$491.00	$171.84	$1,063.83	$372.32	$158.20	$144.56
Basic Option Self and Family	112	$521.58	$180.98	$1,130.09	$392.12	$166.49	$152.00

EXHIBIT J

Blue Cross® and Blue Shield® Service Benefit Plan

www.fepblue.org

2019

A Fee-For-Service Plan (Standard and Basic Option) with a Preferred Provider Organization

This Plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See pages 4 and 9 for details. This Plan is accredited. See page 13.

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

IMPORTANT
- Rates: Back Cover
- Changes for 2019: Page 15
- Summary of benefits: Page 170

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

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:
United States Office of Personnel Management
Healthcare and Insurance
http://www.opm.gov/insure

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

The Office of Personnel Management (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 800-772-1213, TTY 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 800-MEDICARE 800-633-4227, TTY 877-486-2048.

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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 healthcare benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2019, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2019, 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. (See page 9.)

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 healthcare 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 healthcare provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare 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 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 800-FEP-8440 (800-337-8440) and explain the situation.
  - If we do not resolve the issue:

CALL – THE HEALTH CARE FRAUD HOTLINE

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)
  - 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 (TCC).
- 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.

Discrimination is Against the Law

The Blue Cross and Blue Shield Service Benefit Plan complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, we do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

We:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator of your Local Plan by contacting your Local Plan at the telephone number appearing on the back of your ID card.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator of your Local Plan. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, your Local Plan's Civil Rights Coordinator is available to help you.

Members may file a complaint with the HHS Office of Civil Rights, OPM, or FEHB Program Carriers.

You can also file a civil rights complaint with the Office of Personnel Management by mail at:

Office of Personnel Management
Healthcare and Insurance
Federal Employee Insurance Operations
Attention: Assistant Director, FEIO
1900 E Street NW, Suite 3400-S
Washington, D.C. 20415-3610

For further information about how to file a civil rights complaint, go to www.fepblue.org/en/rights-and-responsibilities/, or call the customer service telephone number on the back of your member ID card. For TTY, dial 711.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. 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 take notes, ask questions and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medications or give your doctor and pharmacist a list of all the medications and dosages that you take, including non-prescription (over-the-counter) medications 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 medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by telephone, mail, through the Plan or Provider's portal?
- Do not assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

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

For more information on patient safety, please visit:

- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. 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 healthcare providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- 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 healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not 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, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

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. When such an event occurs, neither you nor your FEHB Plan will incur costs to correct the medical error.

You will not be billed for inpatient services when care is related to treatment of specific hospital-acquired conditions if you use Preferred or Member hospitals. This policy helps to protect you from having to pay for the cost of treating these conditions, and it encourages hospitals to improve the quality of care they provide.

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 and one eligible family member, or 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 Plus One or Self and Family 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 are married.

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, you or they cannot be enrolled in or covered as a family member by another enrollee in 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 your spouse, or one other 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.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

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 or children.

If this law applies to you, you must enroll in 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 lowest-cost nationwide Plan option as determined by OPM.

- 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 lowest-cost nationwide Plan option as determined by OPM.

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 does not 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 does not 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 2019 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 2018 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 family members 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 assistance with enrolling in a conversion policy (non-FEHB individual policy). FEP helps members with Temporary Continuation of Coverage (TCC) and with finding replacement coverage.

- **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 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 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 coverage.

  We also want to inform you that the Patient Protection and ACA did not eliminate TCC or change the TCC rules.

- **Finding replacement coverage**

  If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please refer to the next section of this brochure. 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 ACA's Health Insurance Marketplace. These rules are established by the Federal Government agencies that have responsibility for implementing the ACA and by the Marketplace.

- **Health Insurance Marketplace**

  If you would like to purchase health insurance through the ACA'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 healthcare 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.

OPM requires that FEHB plans be accredited to validate that Plan operations and/or care management meet nationally recognized standards. The local plans and vendors that support the Blue Cross and Blue Shield Service Benefit Plan hold accreditation from National Committee for Quality Assurance (NCQA) and/or URAC. To learn more about this plan's accreditations, please visit the following websites:

- National Committee for Quality Assurance (www.ncqa.org);
- URAC (www.URAC.org).

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 healthcare 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 Preferred 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. 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 telephone 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 healthcare facilities, physicians, and other healthcare 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 161-163). 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.

  Note: We may implement pilot programs in one or more Local Plan areas and overseas to test the feasibility and examine the impact of various initiatives. The pilot programs do not affect all Plan areas. Information on specific pilots is not published in this brochure; it is communicated to members and network providers in accordance with our agreement with OPM. Certain pilot programs may incorporate benefits that are different from those described in this brochure. For example, certain pilot programs may revise the Plan Allowance for Non-participating providers described in Section 10 of this brochure.

Your rights and responsibilities

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/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence
- Profit status
- Care management, including case management and disease management programs
- How we determine if procedures are experimental or investigational

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, at www.fepblue.org/en/rights-and-responsibilities.

By law, you have the right to access your personal health information (PHI). For more information regarding access to PHI, visit our website at www.fepblue.org/en/terms-and-privacy/notice-of-privacy-practices/ to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

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 2019

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.

Changes to our Standard Option only

- Your cost-share for Tier 1 (generic drugs) without Medicare Part B is now a $7.50 copayment for each purchase of up to a 30-day supply ($22.50 for a 31 to 90-day supply) obtained through a Preferred retail pharmacy. Previously, your cost-share was 20% of the Plan allowance. (See page 119.)
- Your cost-share for Tier 1 (generic drugs) with Medicare Part B primary is now a $5 copayment for each purchase of up to a 30-day supply ($15.00 for a 31 to 90-day supply) obtained through a Preferred retail pharmacy. Previously, your cost-share was 15% of the Plan allowance. (See page 119.)
- Your copayment for the Tier 1 generic drug metformin (with and without Medicare Part B) is now a $1 copayment for each purchase of up to a 90-day supply obtained through a Preferred retail pharmacy. Previously, your coinsurance was 20% (without Medicare Part B) and 15% (with Medicare Part B primary). (See page 116.)
- Your copayment for the Tier 1 generic drug metformin (with and without Medicare Part B) is now a $1 copayment for each purchase of up to a 90-day supply obtained through the Mail Service Prescription Drug Program. Previously, your copayment was $15 (without Medicare Part B) and $10 (with Medicare Part B primary). (See page 116).
- Your copayment for Tier 2 (preferred brand-name drugs) is now $90 for each purchase of up to a 90-day supply for the Mail Service Prescription Drug Program with Medicare Part B. Previously, your member copayment was $80. (See page 120.)
- Your copayment for Tier 2 preferred diabetic medications, preferred test strips, and preferred supplies is now a 20% coinsurance obtained through a Preferred retail pharmacy. Previously, your coinsurance was 30%. (See page 117.)
- Your copayment for Tier 2 preferred diabetic medications, preferred test strips, and preferred supplies is now a $40 copayment for each purchase of up to a 90-day supply obtained through the Mail Service Prescription Drug Program. Previously, your copayment was $80. (See page 117.)
- Your copayment for Tier 4 (preferred specialty drugs) is now a $50 copayment for each purchase of up to a 30-day supply ($140 for a 31 to 90-day supply) obtained through the Specialty Drug Pharmacy Program. Previously, your copayment was $35 for each purchase of up to a 30-day supply ($95 for a 31 to 90-day supply). (See page 121.)
- Your copayment for Tier 5 (non-preferred specialty drugs) is now a $70 copayment for each purchase of up to a 30-day supply ($200 for a 31 to 90-day supply) obtained through the Specialty Drug Pharmacy Program. Previously, your copayment was $55 for each purchase of up to a 30-day supply ($155 for a 31 to 90-day supply). (See page 121.)

Changes to our Basic Option only

- Your copayment for Tier 1 generic drug metformin (with and without Medicare Part B) is now $1 for each purchase of up to a 90-day supply obtained through a Preferred retail pharmacy. Previously, your copayment was $10 for each purchase of up to a 30-day supply ($30 for a 31 to 90-day supply). (See page 116.)
- Your copayment for Tier 1 generic drug metformin (with Medicare Part B primary) is now $1 for each purchase of up to a 90-day supply obtained through the Mail Service Prescription Drug Program. Previously, your copayment was $20. (See page 116.)
- Your copayment for Tier 2 (preferred brand-name drugs) without Medicare Part B is now $55 for each purchase of up to a 30-day supply ($165 for a 31 to 90-day supply) obtained through a Preferred retail pharmacy. Previously, your copayment was $50 for each purchase of up to a 30-day supply ($150 for a 31 to 90-day supply). (See page 119.)
- Your copayment for Tier 2 (preferred brand-name drugs) with Medicare Part B primary is now $50 for each purchase of up to a 30-day supply ($150 for a 31 to 90-day supply) obtained through a Preferred retail pharmacy. Previously, your copayment was $45 for each purchase of up to a 30-day supply ($135 for a 31 to 90-day supply). (See page 119.)
- Your copayment for Tier 2 (preferred brand-name drugs) with Medicare Part B primary is now $100 for each purchase of up to a 90-day supply obtained through the Mail Service Prescription Drug Program. Previously, your copayment was $90. (See page 120.)

- Your copayment for Tier 2 preferred diabetic medications, preferred test strips, and preferred supplies (without Medicare Part B) is now $35 for each purchase of up to a 30-day supply ($65 for a 31 to 90-day supply) obtained through a Preferred retail pharmacy. Previously, your copayment was $50 for each purchase of up to a 30-day supply ($150 for a 31 to 90-day supply). (See page 117.)
- Your copayment for Tier 2 preferred diabetic medications, preferred test strips, and preferred supplies (with Medicare Part B primary) is now $30 for each purchase of up to a 30-day supply ($60 for a 31 to 90-day supply) obtained through a Preferred retail pharmacy. Previously, your copayment was $45 for each purchase of up to a 30-day supply ($135 for a 31 to 90-day supply. (See page 117.)
- Your copayment for Tier 2 preferred diabetic medications, preferred test strips, and preferred supplies (with Medicare Part B primary) is now $50 for each purchase of up to a 90-day supply obtained through the Mail Service Prescription Drug Program. Previously, your copayment was $90. (See page 117.)
- Your copayment for Tier 4 (preferred specialty drug) without Medicare Part B is now $70 for each purchase of up to a 30-day supply ($210 for a 31 to 90-day supply) obtained though the Specialty Drug Pharmacy Program. Previously, your copayment was $55 for each purchase of up to a 30-day supply ($165 for a 31 to 90-day supply). (See page 121.)
- Your copayment for Tier 4 (preferred specialty drug) with Medicare Part B primary is now $65 for each purchase of up to a 30-day supply ($185 for a 31 to 90-day supply). Previously, your copayment was $50 for each purchase of up to a 30-day supply ($140 for a 31 to 90-day supply). (See page 121.)
- Your copayment for Tier 5 (non-preferred specialty drug) without Medicare Part B is now $95 for each purchase of up to a 30-day supply ($285 for a 31 to 90-day supply) obtained though the Specialty Drug Pharmacy Program. Previously, your copayment was $80 for each purchase of up to a 30-day supply ($240 for a 31 to 90-day supply). (See page 121.)
- Your copayment for Tier 5 (non-preferred specialty drug) with Medicare Part B primary is now $85 for each purchase of up to a 30-day supply ($240 for a 31 to 90-day supply) obtained through the Specialty Drug Pharmacy Program. Previously, your copayment was $70 for each purchase of up to a 30-day supply ($195 for a 31 to 90-day supply). (See page 121.)

Changes to both our Standard and Basic Options

- We now provide preventive care benefits for adults for tetanus, diphtheria, and pertussis booster with no limit. Previously, the tetanus, diphtheria, and pertussis booster benefit was limited to every 10 years. (See page 47.)
- We now limit the dental diagnostic imaging benefit to intraoral complete series. Previously, Standard Option dental benefits also included coverage for individual bitewing images, two bitewing images, four bitewing images, vertical bitewings, posterior-anterior or lateral skull and facial bone survey images, and panoramic images. Previously, Basic Option dental benefits included coverage for individual bitewing images, two bitewing images and four bitewing images. (See pages 128-129.)
- We provide benefits for inpatient admissions to Non-member hospitals or other facilities for emergency (maternity) deliveries and base our payment on the billed amount. We provide benefits for inpatient admissions to Non-member hospitals or other facilities for non-emergency (routine maternity) deliveries and base our payment on the Local Plan Allowance. Previously, our allowance for routine maternity deliveries was based on the billed amount. (See page 161.)
- We now use the Local Plan Allowance to reimburse outpatient Non-member facilities for non-emergency services. Previously, our allowance for Non-member facility claims for non-emergency surgical services was the average paid nationally to Preferred Member and Non-member facilities. (See page 161.)
- The Non-participating provider calculation process for emergency medical services performed in the emergency department of a Non-member facility will reference Local Plan Allowance instead of the Usual, Customary, and Reasonable (UCR) amount. (See page 161.)
- We now provide a benefit for electrolysis (hair removal) as part of the preparation for gender reassignment surgery. Previously, there was no benefit. (See page 68.)
- We now allow gender reassignment surgery candidates to be under the care of a mental health professional for a minimum of 12 months prior to treatment. Previously, members were required to be under the care of a mental health professional for at least 12 continuous months. (See page 69.)
- We will now accumulate facility-billed claims for acupuncture services to your annual visit maximum, except when performed as an anesthesia service. Previously, only professional providers' claims for acupuncture services accumulated to your annual visit maximum. (See page 64.)

- We now exclusively provide medical benefits for the infusion medication Remicade and its two biosimilars, Renflexis and Inflectra. Previously, Tier 5 (non-preferred specialty drug) pharmacy benefits were provided for these drugs. (See pages 56 and 123.)
- We now provide preventive care benefits for pathology services associated with preventive colonoscopies and sigmoidoscopies. Previously, these services were covered as diagnostic tests with a member cost-share. (See page 163.)
- We now provide telehealth benefits for dermatology care – diagnosis, treatment, and prevention of diseases of the skin, hair, nails, and body. Previously, there was no telehealth benefit. (See page 40.)
- We now provide bariatric surgery benefits for members who have a diagnosis of morbid obesity for a period of 1 year prior to surgery. Previously, the requirement was a diagnosis of morbid obesity 2 years prior to surgery. (See page 69.)
- Your copayment for Narcan nasal spray/naloxone generic injectable is now $0 for each purchase of up to a 90-day supply obtained through a Preferred retail pharmacy and the Mail Service Prescription Drug Program. Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost share. Previously, the Standard Option coinsurance was 20% of the Plan Allowance (without Medicare Part B) and 15% of the Plan Allowance (with Medicare Part B primary) obtained through a Preferred retail pharmacy. The Basic Option copayment was $10 for each purchase of up to a 30-day supply obtained through a Preferred retail pharmacy. (See page 118.)
- We now require prior approval for all non-emergent air ambulance transport. Previously, prior approval was not required. (See pages 23 and 97.)

Section 3. How You Get Care

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.

Under both Standard and Basic Option, you can also get care for the treatment of minor acute conditions (see page 160 for definition), dermatology care, and counseling for behavioral health and substance use disorder using teleconsultation services delivered via telephone by calling 855-636-1579 (TTY: 855-636-1578) or via secure online video at www.fepblue.org/telehealth. Please see pages 40 and 104 for more information.

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 healthcare 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 healthcare 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 are physicians and other healthcare providers, 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.**

If you have questions about covered providers or would like the names of PPO (Preferred) providers, please contact the Local Plan where services will be performed.

- **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 surgicenter, 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 use disorder. Accredited healthcare 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 use disorder 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 92-93 and 105-106. If you have questions about treatment at an RTC, please contact us at the customer service telephone number listed on the back of your ID card.

Blue Distinction® Specialty Care

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 91 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 is important to always request Preferred providers for your care. For more information, see pages 30-32 in Section 4, *Your Costs for Covered Services*, or call your Local Plan at the telephone 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 telephone 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 80.

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 telephone 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 74).

Skilled Nursing Facility (SNF)

A SNF is a freestanding institution or a distinct part of a hospital which customarily bills insurance as a skilled nursing facility and meets the following criteria:

- Is Medicare-certified as a skilled nursing facility;

- Is licensed in accordance with state or local law or is approved by the state or local licensing agency as meeting the licensing standards (where state or local law provides for the licensing of such facilities);
- Has a transfer agreement in effect with one or more Preferred hospitals; and
- Is primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care; or rehabilitation services for the rehabilitation of injured, disabled or sick persons.

To be covered, skilled nursing facility care cannot be maintenance or custodial care. The term skilled nursing facility does not include any institution that is primarily for the care and treatment of mental diseases.

Note: Additional criteria apply when Medicare Part A is not the primary payor (see page 93).

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.

Exceptions:

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 telephone 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 may require precertification and prior approval. If you do not obtain precertification, there may be a reduction or denial of benefits. Be sure to read all of the precertification and prior approval information below and on pages 23-27.

- **Inpatient hospital admission, inpatient residential treatment center admission, or skilled nursing facility admission**

Precertification is the process by which – prior to your inpatient 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, inpatient residential treatment center, or skilled nursing facility whether or not they have contacted us and provided all necessary information. You are also responsible for enrolling in case management and working with your case manager if your care involves residential treatment or a skilled nursing facility. For information about precertification of an emergency inpatient hospital admission, please see page 27.

Warning: We will reduce our benefits for the inpatient hospital stay by $500, even if you have obtained prior approval for the service or procedure being performed during the stay, 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: If precertification was not obtained prior to admission, inpatient benefits (such as room and board) are not available for inpatient care at a residential treatment center, or, when Medicare Part A is not the primary payor, at a skilled nursing facility. 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; with the exception of admissions for gender reassignment surgery and admissions to residential treatment centers, and skilled nursing facilities.
- You have another group health insurance policy that is the primary payor for the hospital stay; with the exception of admissions for gender reassignment surgery. (See page 80 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)

- Medicare Part A is the primary payor for the hospital or skilled nursing facility stay; with the exception of admissions for gender reassignment surgery. (See page 80 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 69-70 in order for benefits to be provided for the admission and surgical procedure.

- **Other services**

You must obtain prior approval for these services under both Standard and Basic Option. Precertification is also required if the service or procedure requires an inpatient hospital admission. All gender reassignment surgeries require prior approval; if inpatient admission is necessary, precertification is also required. Contact us using the customer service telephone 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:

- **Gene therapy and cellular immunotherapy, for example CAR-T and T-Cell receptor therapy**
- **Air Ambulance Transport (non-emergent)** – Air ambulance transport related to immediate care of a medical emergency or accidental injury does not require prior approval; see Section 5 (c), page 97, for more information.
- **Outpatient sleep studies performed outside the home** – Prior approval is required for sleep studies performed in a provider's office, sleep center, clinic, outpatient center, hospital, skilled nursing facility, residential treatment center and any other location that is not your home.
- **Applied behavior analysis (ABA)** – Prior approval is required for ABA and all related services, including assessments, evaluations, and treatments.
- **Gender reassignment surgery –** Prior to surgical treatment of gender dysphoria, your provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and your provider later modifies the plan.
- **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 telephone 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 45.
- **Surgical services** – The surgical services on the following list 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 page 69-70.)
  - Outpatient surgical correction of congenital anomalies (see definition on page 157);
  - Outpatient surgery needed to correct accidental injuries (see definition on page 157) to jaws, cheeks, lips, tongue, roof and floor of mouth; and
  - Gender reassignment surgery.

- **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 95 for information about the exception to this requirement.
- **Organ/tissue transplants** – See pages 73-77 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 81). Contact us at the customer service telephone 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 pages 74-75 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/CertificationandComplianc/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 telephone number listed on the back of your ID card.

  The blood or marrow stem cell transplants listed on pages 75-77 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 77** 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 telephone number listed 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 76-80 for the list of conditions covered **only** in clinical trials. Contact us at the customer service telephone 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 78) 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 800-624-5060 (TTY: 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 pages 111-112 for more information 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.

  Note: The Specialty Drug Pharmacy Program will not fill your prescription until you have obtained prior approval. AllianceRx Walgreens Prime, 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.
- **Medical foods covered under the pharmacy benefit require prior approval.** See Section 5(f), page 114, for more information.

- **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 telephone 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 23 or is one of the transplant procedures listed on pages 74-79) – 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 telephone number;
  - Reason for inpatient admission, proposed treatment, or surgery;
  - Name and telephone 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 92-93 and 105-106 for additional information.

Note: If we approve the request for prior approval or precertification, you will be provided with a notice that identifies the approved services and the authorization period. You must contact us with a request for a new approval five (5) business days prior to a change to the approved original request, and for requests for an extension beyond the approved authorization period in the notice you received. We will advise you of the information needed to review the request for change and/or extension.

- **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 27.) If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not 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 FEHB 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, 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* below.

  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, 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.

  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. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **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, 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 157 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 verbal 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 share/Cost-sharing

Cost share or 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 86). 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 88).

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 or not 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 telephone 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**

  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 telephone 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 161-163). 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 following tables 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 40; see page 86 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 66). 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 inpatient facility care you receive overseas, we provide benefits in full for admissions to a Department of Defense (DoD) facility, or when the Overseas Assistance Center (provided by GMMI, Inc.) has arranged direct billing or acceptance of a guarantee of benefits with the facility. If a direct billing arrangement or guarantee of benefits is not accepted by the facility, you are responsible for the applicable copayment or coinsurance. For outpatient 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 healthcare 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 30-31;
- 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.

If your provider's prescription allows for generic substitution and you select a brand-name drug, your expenses for the difference in cost-share do not count toward your catastrophic protection out-of-pocket maximum (see page 108 for additional information).

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 33 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 above) 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. Benefits

See page 15 for how our benefits changed this year. Pages 169-172 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.

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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 Retail Pharmacy Program, a Mail Service Prescription Drug Program, and a 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 Retail Pharmacy Program and a 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 Healthcare 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 Get Care*, for information on covered professional providers and other healthcare 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 healthcare 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 or facility bills for the service.
- The services listed in this Section are for the charges billed by a physician or other healthcare 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.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 119 for information about Tier 4 and Tier 5 specialty drug fills from Preferred providers and Preferred pharmacies. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731. Basic Option members must use Preferred providers and Preferred pharmacies (see page 121).
- **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 healthcare 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 41-43 for our coverage of laboratory, X-ray, and other diagnostic tests billed for by a healthcare professional, and to page 88 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 healthcare 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 healthcare 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 157 for more information about "agents.") Participating/Non-participating: You pay all charges
Telehealth professional services for: • Minor acute conditions (see page 160 for definition) • Dermatology care (see page 164 for definition) Note: Refer to Section 5(h), *Wellness and Other Special Features*, for information on telehealth services and how to access a provider.	**Preferred Telehealth Provider: $10 (no deductible)** Participating/Non-participating: You pay all charges	**Preferred Telehealth Provider: $15** 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	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

Benefit Description	You Pay	
Diagnostic and Treatment Services (cont.)	**Standard Option**	**Basic Option**
• 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	See previous page	See previous page
Not covered: • *Routine services except for those Preventive care services described on pages 43-50* • *Telephone consultations and online medical evaluation and management services except as shown in Section 5(a) page 40 and Section 5(e) page 104* • *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	**Standard Option**	**Basic Option**
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 157 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

Benefit Description	You Pay	
Lab, X-ray and Other Diagnostic Tests (cont.)	**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 157 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 23). 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 45-46). Note: See page 45 in this Section for coverage of genetic counseling and testing services related to family history of cancer or other disease.	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 for bone density tests, CT scans/MRIs/PET scans, angiographies, genetic testing, nuclear medicine, and sleep studies performed outside the home Preferred: $40 copayment for sleep studies performed at home Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 157 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.

Lab, X-ray and Other Diagnostic Tests - continued on next page

Benefit Description	You Pay	
Lab, X-ray and Other Diagnostic Tests (cont.)	**Standard Option**	**Basic Option**
• Nuclear medicine • Sleep studies Note: Prior approval is required for sleep studies performed in a location other than the home. Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.	See previous page	See previous page
Preventive Care, Adult	**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). Covered services include: • Visits/exams for preventive care Note: See the definition of Preventive Care, Adult, on page 163 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 use disorder Note: See pages 64 and 115 for our coverage of smoking and tobacco cessation treatment. • Screening for chlamydial infection • Screening for gonorrhea infection • Screening for human immunodeficiency virus (HIV) infection • Screening for syphilis infection	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

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
• Screening for latent tuberculosis 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.	See previous page	See previous page
• Colorectal cancer tests, including: - Fecal occult blood test - Colonoscopy, with or without biopsy (see page 67 for our payment levels for diagnostic colonoscopies) - Sigmoidoscopy - Double contrast barium enema - DNA analysis of stool samples • Prostate cancer tests – Prostate Specific Antigen (PSA) test • Cervical cancer screening tests - Pap tests of the cervix - Human papillomavirus (HPV) tests of the cervix • Screening mammograms, including mammography using digital technology 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 ages 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.	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

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
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.	See previous page	See previous page
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 23 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): • Individual from a family with a known harmful mutation in BRCA1 and/or BRCA2 gene; or • Two first-degree female relatives with breast cancer, one of whom was diagnosed at age 50 or younger; or • A combination of three or more first- or second-degree female relatives with breast cancer regardless of age at diagnosis; or • 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

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
• 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 • A first-degree female relative with bilateral breast cancer; or • A combination of two or more first- or second-degree female relatives with ovarian cancer regardless of age at diagnosis; or • A history of pancreatic or prostate cancer diagnosed in a first- or second-degree relative; or • 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: • Individual from a family with a known harmful mutation in BRCA1 and/or BRCA2 gene; or • Any first-degree relative with breast or ovarian cancer; or • A history of pancreatic or prostate cancer diagnosed in a first- or second-degree relative; or • 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 45. 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 42 for our coverage of diagnostic BRCA testing). Note: Preventive care benefits are not available for surgical removal of breasts, ovaries, or prostate.	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

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
Immunizations limited to the following vaccines (as licensed by the U.S. Food and Drug Administration (U.S. FDA)): • 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 • Varicella *Many Preferred retail pharmacies participate in our vaccine network. See page 116 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 117 for our payment levels for medications to promote better health as recommended under the Affordable Care Act. Note: The benefits listed above and on pages 43-46 do not apply to children up to age 22. (See benefits under *Preventive Care, Child*, this Section.) Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/	See above and pages 43-46	See above and pages 43-46

Preventive Care, Adult - continued on next page

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
HHS: www.healthcare.gov/preventive-care-benefits A complete list of women's preventive services can be found at www.healthcare.gov/preventive-care-women/ For additional information: www.healthfinder.gov/myhealthfinder/default.aspx	See above and pages 43-46	See above and pages 43-46
Not covered: • *Genetic testing related to family history of cancer or other disease, except as described on pages 45-46* *Note: See page 42 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* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure. Medical benefits may be available for these services.*	*All charges*	*All charges*
Preventive Care, Child	**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 as described in the Bright Future Guidelines provided by the American Academy of Pediatrics (AAP). 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)	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.	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.

Preventive Care, Child - continued on next page

Benefit Description	You Pay	
Preventive Care, Child (cont.)	**Standard Option**	**Basic Option**
• Immunizations as licensed by the U.S. Food and Drug Administration (U.S. FDA) limited to the following vaccines: - 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 vaccines to specific age ranges, frequencies, and/or other patient-specific indications, including gender. • Nutritional counseling services 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 • Cervical cancer screening tests - Pap tests of the cervix - Human papillomavirus (HPV) tests of the cervix • Screening for human immunodeficiency virus (HIV) infection • Screening for syphilis infection • Screening for latent tuberculosis infection for children ages 18 through 21 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. Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Continued from previous page: 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.	Continued from previous page: 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.

Preventive Care, Child - continued on next page

Benefit Description	You Pay	
Preventive Care, Child (cont.)	**Standard Option**	**Basic Option**
Note: See page 117 for our payment levels for medications to promote better health as recommended under the Affordable Care Act. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ A complete list of women's preventive services can be found at www.healthcare.gov/preventive-care-women/ HHS: www.healthcare.gov/preventive-care-benefits For additional information: www.healthfinder.gov/myhealthfinder/default.aspx Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines, go to www.brightfutures.aap.org/Pages/default.aspx	See previous page	See previous page
Maternity Care	**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 healthcare providers such as physicians, physician assistants, midwives, nurse practitioners/clinical specialists, and lactation consultants Note: See page 52 for our coverage of breast pump kits.	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	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 the notes on pages 86-90. 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

Benefit Description	You Pay	
Maternity Care (cont.)	**Standard Option**	**Basic Option**
• 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 41 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 63. Note: Maternity care benefits are not provided for prescription drugs required during pregnancy, except as recommended under the Affordable Care Act. See page 117 for more information. See Section 5(f) for other prescription drug coverage. Note: Here are some things to keep in mind: • You do not need to precertify your delivery; see page 27 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal 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 apply to circumcision when billed by a professional provider for a male newborn. • Hospital services are listed in Section 5(c) and Surgical benefits are in Section 5(b). Note: See page 161 for our payment for inpatient stays resulting from an emergency delivery at a hospital or other facility not contracted with your Local Plan. 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 67 for our payment levels for circumcision.	Continued from previous page: 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 telephone number on the back of your ID card to obtain information about your coverage and the Plan allowance for the services.	See previous page

Maternity Care - continued on next page

Benefit Description	You Pay	
Maternity Care (cont.)	**Standard Option**	**Basic Option**
• Breast pump kit, limited to one of the two kits listed below, per calendar year, for members 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 800-262-7890.	Nothing (no deductible)	Nothing
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 42 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 above on this page* • *Breastfeeding supplies other than those contained in the breast pump kit described above on this page 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 members not enrolled in the Service Benefit Plan*	*All charges*	*All charges*
Family Planning	**Standard Option**	**Basic Option**
A range of voluntary family planning services for women, limited to: • Contraceptive counseling • Diaphragms and contraceptive rings • Injectable contraceptives • Intrauterine devices (IUDs) • Implantable contraceptives • Tubal ligation or tubal occlusion/tubal blocking procedures only	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

Benefit Description	You Pay	
Family Planning (cont.)	**Standard Option**	**Basic Option**
Family planning services for men, limited to: • Vasectomy Note: We also provide benefits for professional services associated with tubal ligation/occlusion/blocking procedures, vasectomy, 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.	See previous page	See previous page
• 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 115 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	**Standard Option**	**Basic Option**
Diagnosis and treatment of infertility including covered: • Diagnostic and treatment services • Laboratory tests • Diagnostic tests • Surgical procedures • Prescription drugs Note: See Section 5(a) for covered labs, diagnostic tests, and X-rays. Note: See Section 5(b) for covered surgical services. Note: See Section 5(f) for covered prescription drugs. Note: See page 54 for a list of services not covered as treatments for infertility or as alternatives to conventional conception.	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 healthcare 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 157 for more information about “agents.”) Participating/Non-participating: You pay all charges (except as noted on the next page)

Reproductive Services - continued on next page

Benefit Description	You Pay	
Reproductive Services (cont.)	**Standard Option**	**Basic Option**
		Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.
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) and 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	**Standard Option**	**Basic Option**
• Allergy testing • Allergy treatment • Sublingual allergy desensitization drugs as licensed by the U.S. FDA, limited to Grastek, Oralair, and Ragwitek Note: See page 40 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 healthcare 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 157 for more information about “agents.”) Participating/Non-participating: You pay all charges (except as noted on the next page)

Allergy Care - continued on next page

Benefit Description	You Pay	
Allergy Care (cont.)	**Standard Option**	**Basic Option**
		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 40 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 40 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 healthcare 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	**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 22-25).	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 healthcare 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 157 for more information about “agents.”) Participating/Non-participating: You pay all charges

Treatment Therapies - continued on next page

Benefit Description	You Pay	
Treatment Therapies (cont.)	**Standard Option**	**Basic Option**
• 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 24 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 63. • Outpatient cardiac rehabilitation • Pulmonary rehabilitation therapy • Applied behavior analysis (ABA) for the treatment of an autism spectrum disorder (see prior approval requirements on page 23) Note: See Section 5(c) for our payment levels for treatment therapies billed for by the outpatient department of a hospital. Note: See pages 63-64 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 healthcare 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 157 for more information about "agents.") Participating/Non-participating: You pay all charges
• Auto-immune infusion medications: Remicade, Renflexis or Inflectra Note: See above for your costs for intravenous (IV)/ infusion therapy - Home IV or infusion therapy.	Preferred: 10% 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 billed amount	Preferred: 15% of the Plan allowance Member or Non-member: 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 22-25). • Renal dialysis – Hemodialysis and peritoneal dialysis	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

Treatment Therapies - continued on next page

Benefit Description	You Pay	
Treatment Therapies (cont.)	**Standard Option**	**Basic Option**
• Pharmacotherapy (medication management) (See Section 5(c) for our coverage of drugs administered in connection with these treatment therapies.) • Applied behavior analysis (ABA) for the treatment of an autism spectrum disorder (see prior approval requirements on page 23)	See previous page	See previous page
Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Rehabilitation Therapy	**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 healthcare 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 healthcare 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 157 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* • *Equine therapy and hippotherapy (exercise on horseback)* • *Massage therapy*	*All charges*	*All charges*

Benefit Description	You Pay	
Hearing Services (Testing, Treatment, and Supplies)	**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 60.	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 healthcare 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 157 for more information about "agents.") Participating/Non-participating: You pay all charges
Not covered: • *Routine hearing tests (except as indicated on page 48)* • *Hearing aids (except as described on page 60)*	*All charges*	*All charges*
Vision Services (Testing, Treatment, and Supplies)	**Standard Option**	**Basic Option**
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 21 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

Benefit Description	You Pay	
Vision Services (Testing, Treatment, and Supplies) (cont.)	**Standard Option**	**Basic Option**
• Eye examinations related to a specific medical condition • Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 21 Note: See page 58 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 41-43 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 58.	Preferred primary care provider or other healthcare 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 healthcare 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 157 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 58* • *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* 58	*All charges*	*All charges*
Foot Care	**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 healthcare 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)	Preferred primary care provider or other healthcare 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 157 for more information about "agents.") Participating/Non-participating: You pay all charges

Foot Care - continued on next page

Benefit Description	You Pay	
Foot Care (cont.)	**Standard Option**	**Basic Option**
	Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	
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	**Standard Option**	**Basic Option**
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 limited to treatment of erectile dysfunction or as part of an approved plan for gender reassignment surgery • Surgical implants 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
• 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

Orthopedic and Prosthetic Devices - continued on next page

Benefit Description	You Pay	
Orthopedic and Prosthetic Devices (cont.)	**Standard Option**	**Basic Option**
• 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)*	*All charges*	*All charges*
Durable Medical Equipment (DME)	**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	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.

Durable Medical Equipment (DME) - continued on next page

Benefit Description	You Pay	
Durable Medical Equipment (DME) (cont.)	**Standard Option**	**Basic Option**
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.	See previous page	See previous page
• 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
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 52* • *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 above)* • *Equipment for cosmetic purposes* • *Topical Hyperbaric Oxygen Therapy (THBO)*	*All charges*	*All charges*
Medical Supplies	**Standard Option**	**Basic Option**
• Medical foods and nutritional supplements when administered by catheter or nasogastric tubes 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

Medical Supplies - continued on next page

Benefit Description	You Pay	
Medical Supplies (cont.)	**Standard Option**	**Basic Option**
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* • *Medical foods administered orally, except as described in Section 5(f)*	*All charges*	*All charges*
Home Health Services	**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 157 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 pages 93-94.* • *Private duty nursing*	*All charges*	*All charges*
Manipulative Treatment	**Standard Option**	**Basic Option**
Manipulative treatment performed by a professional provider, 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)	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.

Manipulative Treatment - continued on next page

Benefit Description	You Pay	
Manipulative Treatment (cont.)	**Standard Option**	**Basic Option**
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.	Continued from previous page: 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.	Continued from previous page: Participating/Non-participating: You pay all charges
Alternative Treatments	**Standard Option**	**Basic Option**
Acupuncture Note: Acupuncture must be performed and billed by a healthcare 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: When billed by a facility such as the outpatient department of a hospital, you are limited to the number of visits per calendar year listed on this page. See Section 5(c) for your cost share. Note: See page 82 for our coverage of acupuncture when provided as anesthesia for covered surgery. Note: See page 50 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 healthcare 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	**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.	Preferred: Nothing (no deductible) Participating: 35% of the Plan allowance (deductible applies)	Preferred: Nothing Participating/Non-participating: You pay all charges

Educational Classes and Programs - continued on next page

Benefit Description	You Pay	
Educational Classes and Programs (cont.)	**Standard Option**	**Basic Option**
• Smoking and tobacco cessation classes Note: See Section 5(f) for our coverage of smoking and tobacco cessation drugs.	Continued from previous page: Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	See previous page
• Diabetic education Note: See pages 41 and 44 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 healthcare 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, or applied behavior analysis (ABA), when performed as part of an educational class or program* • *Premenstrual syndrome (PMS), lactation (except as described on page 50), headache, eating disorder (except as described on pages 41 and 44), 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*	*All charges*	*All charges*

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare 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 healthcare 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 healthcare 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*, page 157) to jaws, cheeks, lips, tongue, roof and floor of mouth. Please refer to page 23 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.**
- **YOU MUST GET PRIOR APPROVAL for gender reassignment surgery. Prior to any gender reassignment surgery, your provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and your provider later modifies the plan (including changes to the procedures to be performed or the anticipated dates for the procedures). See page 23 and page 68 for additional information. If your surgical procedure requires an inpatient admission, YOU MUST ALSO GET PRECERTIFICATION of the inpatient care.**
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 119 for information about Tier 4 and Tier 5 specialty drug fills from Preferred providers and Preferred pharmacies. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731. Basic Option members must use Preferred providers and Preferred pharmacies (see page 121).
- **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 25 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 • Assistant surgeons/surgical assistance if required because of the complexity of the surgical 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 44). 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 71) • 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.	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 25 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 157 for more information about "agents.") Participating/Non-participating: You pay all charges

Surgical Procedures - continued on next page

Benefit Description	You Pay	
Surgical Procedures (cont.)	**Standard Option**	**Basic Option**
• Gender reassignment surgical benefits are limited to the following: - For female to male surgery: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty, electrolysis (hair removal at the covered operative site), and placement of testicular and erectile prosthesis - For male to female surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, labiaplasty, and electrolysis (hair removal at the covered operative site) **Note: Prior approval is required for gender reassignment surgery.** For more information about prior approval, please refer to page 23. Note: Benefits for gender reassignment surgery are limited to once per covered procedure, per lifetime. Benefits are not available for repeat or revision procedures when benefits were provided for the initial procedure. Benefits are not available for gender reassignment surgery for any condition other than gender dysphoria. • Gender reassignment surgery on an inpatient or outpatient basis is subject to the pre-surgical requirements listed below. **The member must meet all requirements**. - **Prior approval is obtained** - **Member must be at least 18 years of age at the time prior approval is requested and the treatment plan is submitted** - Diagnosis of gender dysphoria by a qualified healthcare professional • New gender identity has been present for at least 24 continuous months • Member has a strong desire to be rid of primary and/or secondary sex characteristics because of a marked incongruence with the member's identified gender • Member's gender dysphoria is not a symptom of another mental disorder or chromosomal abnormality • Gender dysphoria causes clinical distress or impairment in social, occupational, or other important areas of functioning - Member must meet the following criteria: • Living 12 months of continuous, full-time, real-life experience in the desired gender (including place of employment, family, social and community activities) • 12 months of continuous hormone therapy appropriate to the member's gender identity	See page 67	See page 67

Surgical Procedures - continued on next page

Benefit Description	You Pay	
Surgical Procedures (cont.)	**Standard Option**	**Basic Option**
• Two referral letters from qualified mental health professionals – one must be from a psychotherapist who has treated the member for a minimum of 12 months. Letters must document: diagnosis of persistent and chronic gender dysphoria; any existing co-morbid conditions are stable; member is prepared to undergo surgery and understands all practical aspects of the planned surgery • If medical or mental health concerns are present, they are being optimally managed and are reasonably well-controlled • 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. Benefits are available only for the following procedures: - Roux-en-Y - Gastric bypass - Laparoscopic adjustable gastric banding - Sleeve gastrectomy - Biliopancreatic bypass with duodenal switch **Note: Benefits for the surgical treatment of morbid obesity are subject to the requirements listed on pages 66-67.** 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 page 91 for information. Note: **Prior approval is required for outpatient surgery for morbid obesity.** For more information about prior approval, please refer to page 23. • 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 above) for a period of 1 year 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 41 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	See page 67	See page 67

Surgical Procedures - continued on next page

Benefit Description	You Pay	
Surgical Procedures (cont.)	**Standard Option**	**Basic Option**
- 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 104 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 use disorder for 1 year prior to surgery and there is no evidence of substance use disorder 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, except when the subsequent surgery is necessary to treat a complication from the prior morbid obesity surgery. - 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	See page 67	See page 67
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*	*All charges*	*All charges*

Surgical Procedures - continued on next page

Benefit Description	You Pay	
Surgical Procedures (cont.)	**Standard Option**	**Basic Option**
• *LASIK, INTACS, radial keratotomy, and other refractive surgery* • *Surgeries related to sexual inadequacy (except surgical placement of penile prostheses to treat erectile dysfunction and gender reassignment surgeries specifically listed as covered)* • *Reversal of gender reassignment surgery*	*All charges*	*All charges*
Reconstructive Surgery	**Standard Option**	**Basic Option**
• Surgery to correct a functional defect • Surgery to correct a congenital anomaly (See Section 10, page 157, for definition.) • 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 25 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 157 for more information about "agents.") Participating/Non-participating: You pay all charges

Reconstructive Surgery - continued on next page

Benefit Description	You Pay	
Reconstructive Surgery (cont.)	**Standard Option**	**Basic Option**
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 sexual dysfunction or sexual inadequacy (except surgical placement of penile prostheses to treat erectile dysfunction and gender reassignment surgeries specifically listed as covered)* • *Reversal of gender reassignment surgery*	*All charges*	*All charges*
Oral and Maxillofacial Surgery	**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 23 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 telephone 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 25 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 157 for more information about "agents.") Participating/Non-participating: You pay all charges

Oral and Maxillofacial Surgery - continued on next page

Benefit Description	You Pay	
Oral and Maxillofacial Surgery (cont.)	**Standard Option**	**Basic Option**
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 24) 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 77-80 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 pages 74-75. 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 telephone number on the back of your ID card.

Blood or marrow stem cell transplants are covered as shown on pages 75-80. 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 75-76, the medical necessity limitation is considered satisfied if the patient meets the staging description.

The blood or marrow stem cell transplants listed on pages 77-80 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 pages 77-80** 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 telephone number listed 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 77-80 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 77-80 for information about **blood or marrow stem cell transplants covered only in clinical trials** and the **additional requirements** that apply.

Note: See pages 149-150 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 pages 80-81 for more information).

Benefit Description	You Pay	
Organ/Tissue Transplants	**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	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 25 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.

Organ/Tissue Transplants - continued on next page

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
• 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 73 for the prior approval and facility requirements that apply to **organ/tissue transplants**.	See previous page	Continued from previous page: 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 for the diagnoses as indicated below: • 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, Hurler's syndrome and Maroteaux-Lamy syndrome variants) • 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)	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

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
• 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 73 for the prior approval and facility requirements that apply to **blood or marrow stem cell transplants**. Note: Refer to pages 77-80 for information about **blood or marrow stem cell transplants covered only in clinical trials**.	See previous page	See previous page
Autologous blood or marrow stem cell transplants for the diagnoses as indicated below: • 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 73 for the prior approval and facility requirements that apply to **blood or marrow stem cell transplants.** Note: Refer to pages 77-80 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
Blood or marrow stem cell transplants for the diagnoses as indicated below, **only** when performed as part of a clinical trial that meets the facility criteria described on page 73 and the **requirements** listed on page 78: • Allogeneic blood or marrow stem cell transplants for: - Breast cancer - Colon cancer	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

Organ/Tissue Transplants - continued on next page

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
• Allogeneic blood or marrow stem cell transplants for *(continued)*: - 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: - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - 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 78 is not available, we will arrange for the transplant to be provided at an approved transplant facility, if available.	See previous page	Continued from previous page: 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
Blood or marrow stem cell transplants for the diagnoses as indicated below, **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 (limited to: multiple sclerosis, scleroderma, systemic lupus erythematosus and chronic inflammatory demyelinating polyneuropathy)	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

Organ/Tissue Transplants - continued on next page

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
Requirements for **blood or marrow stem cell transplants** covered **only** under **clinical trials**: • You must contact us at the customer service telephone number listed on the back of your ID card to obtain prior approval (see page 24); 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 76, 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 pages 149-150 for our coverage of other costs associated with clinical trials.	See previous page	Continued from previous page: 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

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
Blood or marrow stem cell transplants for the diagnoses as indicated below, **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 (limited to: multiple sclerosis, scleroderma, systemic lupus erythematosus and 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 telephone number listed on the back of your ID card to obtain prior approval (see page 24); 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 76, 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.	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

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
Note: See pages 149-150 for our coverage of other costs associated with clinical trials.		
Related transplant services: • Extraction or reinfusion of blood or marrow stem cells as part of a covered allogeneic or autologous 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 76-77 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 75-77 • 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 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 164 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 telephone 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 77-80
- Related transplant services listed on page 80

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 24).

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 74 for benefit information for these transplants.

Note: See Section 5(c) for our benefits for facility care.

Note: See pages 74-80 for requirements related to blood or marrow stem cell transplant coverage.

Benefit Description	You Pay	
Organ/Tissue Transplants	**Standard Option**	**Basic Option**
Not covered: • *Any transplant not listed as covered and transplants for any diagnosis not listed as covered* • *Donor screening tests and donor search expenses, including associated travel expenses, except as defined on page 80* • *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 pages 74-75* • *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*

Benefit Description	You Pay	
Anesthesia	**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: Anesthesia acupuncture services do not accumulate toward the member's annual maximum. 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 AND SKILLED NURSING FACILITY 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 87. See page 160 for more information about these types of services.
- **YOU MUST GET PRIOR APPROVAL for the following services if they are to be performed on an outpatient basis: sleep studies performed outside the home, surgery for morbid obesity; surgical correction of congenital anomalies; and outpatient surgery needed to correct accidental injuries (see *Definitions*, page 157) to jaws, cheeks, lips, tongue, roof and floor of mouth. Please refer to page 23 for more information.**
- **YOU MUST GET PRIOR APPROVAL for gender reassignment surgery. See page 23 for prior approval and pages 68-69 for the surgical benefit.**
- 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 healthcare 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 or facility bills for the service.
- 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.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 119 for information about Tier 4 and Tier 5 specialty drug fills from Preferred providers and Preferred pharmacies. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731. Basic Option members must use Preferred providers and Preferred pharmacies (see page 121).
- **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 pages 160-161 for more information. See pages 92-93 and 105-106 for inpatient residential treatment center. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • 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 86. See page 160 for more information about these types of services.	Preferred facilities: $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 facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: $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 facilities: $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 facilities: You pay all charges

Inpatient Hospital - continued on next page

Benefit Description	You Pay	
Inpatient Hospital (cont.)	**Standard Option**	**Basic Option**
Note: Here are some things to keep in mind: • You do not need to precertify your delivery; see page 27 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 page 27 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 50-52 for other covered maternity services. Note: See page 62 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 91 for information.	See previous page	See previous page
Not covered: • *Admission to non-covered facilities, such as nursing homes, extended care facilities, schools, or residential treatment centers (except as described on pages 92-93 and 105-106)* • *Personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services* • *Private duty nursing* • *Facility room and board expenses when, in our judgment, an 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* • *Care that is 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.*	*All charges*	*All charges*

Inpatient Hospital - continued on next page

Benefit Description	You Pay	
Inpatient Hospital (cont.)	**Standard Option**	**Basic Option**
- *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 an inpatient 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 19-21).*	*All charges*	*All charges*
Outpatient Hospital or Ambulatory Surgical Center	**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 • Acupuncture • 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 pages 44-45). 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	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 facilities: $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 157 for more information about "agents.") Member/Non-member facilities: You pay all charges

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**Standard Option**	**Basic Option**
• Other medical supplies, including oxygen • Surgical implants Note: See pages 100-102 for our payment levels for care related to a medical emergency or accidental injury. Note: See pages 52-53 for our coverage of family planning services. Note: For our coverage of hospital-based clinic visits, please refer to the professional benefits described on pages 40-41. 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 91-92 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 50-52 for other included maternity services. Note: See page 90 for outpatient drugs, medical devices, and durable medical equipment billed for by a facility. 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.	See previous page	See previous page
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 84-86 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 facilities: $350 copayment for the duration of services (no deductible) Member facilities: $450 copayment for the duration of services, plus 35% of the Plan allowance (no deductible) Non-member facilities: $450 copayment for the duration of services, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred facilities: $175 per day copayment up to $875 Member/Non-member facilities: You pay all charges

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**Standard Option**	**Basic Option**
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 42 for coverage criteria and limitations. • Nuclear medicine • Sleep studies Note: Prior approval is required for sleep studies performed in a location other than your home.	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 facilities: $150 copayment per day per facility Member facilities: $150 copayment per day per facility Non-member facilities: $150 copayment per day per facility, plus any difference between our allowance and the billed amount Note: For unattended sleep studies and for sleep studies performed in the home, you pay a $40 cost share. Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 157 for more information about “agents.”)
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 facilities: $40 copayment per day per facility Member facilities: $40 copayment per day per facility Non-member facilities: $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 157 for more information about “agents.”)

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**Standard Option**	**Basic Option**
Outpatient **therapy services** performed and billed by a facility, limited to: • Cognitive rehabilitation therapy • Physical, occupational, and speech therapy - Standard Option benefits are limited to a combined total of 75 visits per person per calendar year - Basic Option benefits are limited to a combined total of 50 visits per person per calendar year • Manipulative treatment services - Standard Option benefits are limited to a combined total of 12 visits per person per calendar year - Basic Option benefits are limited to a combined total of 20 visits per person per calendar year	Preferred facilities: $25 copayment per day per facility (no deductible) 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 facilities: $30 copayment per day per facility Member/Non-member facilities: You pay all charges Note: You pay 30% of the Plan allowance for supplies or drugs administered or obtained in connection with your care.
Outpatient **treatment services** performed and billed by a facility, limited to: • Cardiac rehabilitation • Pulmonary rehabilitation • Applied behavior analysis (ABA) for an autism spectrum disorder (see prior approval requirements on page 23)	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 facilities: $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 157 for more information about “agents.”) Member/Non-member facilities: You pay all charges

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**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 facilities: Nothing Member facilities: Nothing Non-member facilities: 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 157 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 43-47 • Cancer screenings listed on page 44 and ultrasound screening for abdominal aortic aneurysm Note: See pages 45-46 for our coverage requirements for preventive BRCA testing. Note: See pages 48-49 for our payment levels for covered preventive care services for children billed for by facilities and performed on an outpatient basis.	See pages 43-47 for our payment levels for covered preventive care services for adults	Preferred facilities: Nothing Member/Non-member facilities: 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 • Surgical implants 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. Note: Certain self-injectable drugs are covered only when dispensed by a pharmacy under the pharmacy benefit. These drugs will be covered once per lifetime per therapeutic category of drugs when dispensed by a non-pharmacy-benefit provider. This benefit limitation does not apply if you have primary Medicare Part B coverage.	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 facilities: 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 86-89 for specific coverage information. Member/Non-member facilities: You pay all charges

Benefit Description	You Pay	
Blue Distinction® Specialty Care	**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 Knee and Hip Replacement, Blue Distinction Center for Spine Surgery, or Blue Distinction Center for Comprehensive Bariatric Surgery. • Bariatric surgeries covered are: - Roux-en-Y - Gastric bypass - Laparoscopic adjustable gastric banding - Sleeve gastrectomy - Biliopancreatic bypass with duodenal switch • 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 telephone 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 83-85 for regular inpatient hospital benefits and pages 86-90 for outpatient facility benefit levels. Note: See pages 19-20 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

Blue Distinction® Specialty Care - continued on next page

Benefit Description	You Pay	
Blue Distinction® Specialty Care (cont.)	**Standard Option**	**Basic Option**
Outpatient facility services related to specific covered bariatric surgical procedures, when the surgery is performed at a designated Blue Distinction Center for Bariatric Surgery Note: You must meet the pre-surgical requirements listed on pages 69-70. 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 telephone 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 benefits do not apply to other types of outpatient surgical services, even when performed at a Blue Distinction Center. See pages 86-87 for the benefits we provide. Note: See pages 19-20 for more information about Blue Distinction Centers.	Blue Distinction Center: $100 per day per facility (no deductible)	Blue Distinction Center: $25 per day per facility
Residential Treatment Center	**Standard Option**	**Basic Option**
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 use disorder: • 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 40 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.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: $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 facilities: $175 per day copayment up to $875 per admission for unlimited days Member/Non-member facilities: You pay all charges

Residential Treatment Center - continued on next page

Benefit Description	You Pay	
Residential Treatment Center (cont.)	**Standard Option**	**Basic Option**
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; biofeedback; Outward Bound programs; equine/hippotherapy 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. Note: For outpatient residential treatment center services, see page 106.	See previous page	See previous page
Extended Care Benefits/Skilled Nursing Care Facility Benefits	**Standard Option**	**Basic Option**
When Medicare Part A is not your primary payor: For members who do not have Medicare Part A, we cover skilled nursing facility (SNF) inpatient care for a maximum of 30 days annually, when the member can be expected to benefit from short-term SNF services with a goal of returning home. The following criteria must also be met: • Member is enrolled in case management prior to admission to the SNF (signed consent required), and actively participates in case management both prior to and during admission to the SNF. • Precertification is obtained prior to admission (including overseas care). • We approve the preliminary treatment plan prior to admission (plan must include proposed therapies and document the need for inpatient care). • Member participates in all treatment and care planning activities, including discharge planning/transition to home. Benefits are not available for inpatient SNF care solely for management of tube feedings, for home level dialysis treatment, as an interim transition to long term care placement, or for any other non-covered services. Note: No inpatient benefits (such as room and board) will be provided if precertification is not obtained prior to admission (see page 22). Members are responsible for enrolling in case management (see page 22).	Preferred facilities: $175 (no deductible) per admission Member facilities: $275 plus 35% of the Plan allowance (no deductible) per admission Non-member facilities: $275 plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment, per admission	All charges

Extended Care Benefits/Skilled Nursing Care Facility Benefits - continued on next page

Benefit Description	You Pay	
Extended Care Benefits/Skilled Nursing Care Facility Benefits (cont.)	**Standard Option**	**Basic Option**
When Medicare Part A is your primary payor: When Medicare Part A is the primary payor (meaning it pays first) and has made a 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. Note: See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c03.pdf for complete Medicare benefit period definition. 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 89 for benefits provided for outpatient physical, occupational, speech, and cognitive rehabilitation therapy, and manipulative treatment services when billed by a skilled nursing facility. See Section 5(f) for benefits for prescription drugs. ***Note: If Medicare Part A is your primary payor, we will only provide benefits if Medicare provided benefits for the admission.***	Preferred facilities: Nothing (no deductible) Member facilities: Nothing (no deductible) Non-member facilities: Nothing (no deductible) Note: You pay all charges not paid by Medicare after the 30th day.	All charges
Not covered: *Telephone, television, personal comfort items, such as guest meals and beds, beauty and barber services, recreational outings/trips, stretcher or wheelchair transportation, non-emergent 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, custodial or long term care (see* Definitions*), and domiciliary care provided because care in the home is not available or is unsuitable*	*All charges*	*All charges*
Hospice Care	**Standard Option**	**Basic Option**
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 pages 95-97	See pages 95-97

Hospice Care - continued on next page

Benefit Description	You Pay	
Hospice Care (cont.)	**Standard Option**	**Basic Option**
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
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 page 24 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 on this page and on pages 96-97. **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: • Advanced care planning (see Section 10, page 157) • Dietary counseling • Durable medical equipment rental • Medical social services • Medical supplies • Nursing care	See next page	See next page

Hospice Care - continued on next page

Benefit Description	You Pay	
Hospice Care (cont.)	**Standard Option**	**Basic Option**
• Oxygen therapy • Periodic physician visits • Physical therapy, occupational therapy, and speech therapy related to the terminal medical condition • Prescription drugs and medications • Services of home health aides (certified or licensed, if the state requires it, and provided by the home hospice agency)	See below and next page	See below and next page
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 95 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 95). 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	Preferred facilities: Nothing (no deductible) Member facilities: $450 per admission copayment, plus 35% of the Plan allowance (no deductible) Non-member facilities: $450 per admission copayment, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred facilities: Nothing Member/Non-member facilities: You pay all charges

Hospice Care - continued on next page

Benefit Description	You Pay	
Hospice Care (cont.)	**Standard Option**	**Basic Option**
Note: Benefits are provided for up to 30 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.		
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	**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. Note: Prior approval is required for all non-emergent air ambulance transport.	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 the Overseas Assistance Center (provided by GMMI, Inc.) by calling the center collect at 804-673-1678. See page 135 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 $150 copayment per day for air or sea ambulance transport services

Ambulance - continued on next page

Benefit Description	You Pay	
Ambulance (cont.)	**Standard Option**	**Basic Option**
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 member, the health of the member and their 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 day per facility Member emergency room: $125 copayment per day per facility Non-member emergency room: $125 copayment per day per facility, 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 and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider	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

Benefit Description	You pay	
Accidental Injury (cont.)	**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	**Standard Option**	**Basic Option**
• **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) 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: 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 emergency room: $125 copayment per day per facility Member emergency room: $125 copayment per day per facility Non-member emergency room: $125 copayment per day per facility, 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.

Medical Emergency - continued on next page

Benefit Description	You pay	
Medical Emergency (cont.)	**Standard Option**	**Basic Option**
		Note: All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.
• Urgent care center services and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider	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 100-101 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	**Standard Option**	**Basic Option**
See pages 97-98 for complete ambulance benefit and coverage information.		

Section 5(e). Mental Health and Substance Use Disorder 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 page 133. 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 healthcare 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.
- Every year, we conduct an analysis of the financial requirements and treatment limitations which apply to this Plan's mental health and substance use disorder benefits in compliance with the federal Mental Health Parity and Addiction Equity Act (the Act), and the Act's implementing regulations. Based on the results of this analysis, we may suggest changes to program benefits to OPM. More information on the Act is available on the following Federal Government websites:
  https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html
  https://www.dol.gov/ebsa/mentalhealthparity/
  www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act
- **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 use disorder 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.**
- You should be aware that some PPO inpatient facilities may have non-PPO professional providers on staff; see exceptions on page 21.

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 use disorder 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 use disorder 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 use disorder telephone number on the back of your ID card. Note: See pages 64-65 and 122 for our coverage of smoking and tobacco cessation treatment. Note: See page 51 for our coverage of mental health visits to treat postpartum depression and depression during pregnancy. Note: We cover outpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers at the levels shown here.	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
Telehealth professional services for: • Behavioral health counseling • Substance use disorder counseling Note: Refer to Section 5(h), *Wellness and Other Special Features*, for information on telehealth services and how to access our telehealth provider network.	Preferred Telehealth provider: $10 (no deductible) Participating/Non-participating: You pay all charges	Preferred Telehealth provider: $15 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 Services - continued on next page

Benefit Description	You Pay	
Professional Services (cont.)	**Standard Option**	**Basic Option**
• 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	**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 use disorder includes room and board and ancillary charges for confinements in a hospital/treatment facility for rehabilitative treatment of alcoholism or substance use disorder. Note: You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: 35% of the Plan allowance for unlimited days (no deductible), and any remaining balance after our payment	Preferred facilities: $175 per day copayment up to $875 per admission for unlimited days Member/Non-member facilities: You pay all charges
Residential Treatment Center	**Standard Option**	**Basic Option**
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 use disorder: • 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 104 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.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: $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 facilities: $175 per day copayment up to $875 per admission for unlimited days Member/Non-member facilities: You pay all charges

Residential Treatment Center - continued on next page

Benefit Description	You Pay	
Residential Treatment Center (cont.)	**Standard Option**	**Basic Option**
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; biofeedback; Outward Bound programs; hippotherapy/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*, page 158); and domiciliary care provided because care in the home is not available or is unsuitable. Note: For outpatient residential treatment center services, see the next section.	See previous page	See previous page
Outpatient Hospital or Other Covered Facility	**Standard Option**	**Basic Option**
Outpatient services provided and billed by a covered facility Note: We cover outpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers at the levels shown here. • 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 Note: A residential treatment center is a covered facility for outpatient care (see Section 10, Definitions, for more information). We cover inpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers, other than room and board and inpatient physician care, at the levels shown here.	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)	**Standard Option**	**Basic Option**
• *Marital, family, educational, or other counseling or training services* • *Services performed by a non-covered provider* • *Testing for and treatment of learning disabilities and intellectual disability* • *Inpatient services performed or billed by residential treatment centers, except as described on pages 92-93 and 105-106*	*All charges*	*All charges*

Not Covered (Inpatient or Outpatient) - continued on next page

Benefit Description	You Pay	
Not Covered (Inpatient or Outpatient) (cont.)	**Standard Option**	**Basic Option**
• *Services performed or billed by schools, halfway houses, group homes or members of their staffs* *Note: We cover professional services as described on page 104 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.)* • *Hippotherapy/equine therapy (exercise on horseback)* • *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 113.
- If there is no generic drug available, you must pay the brand-name cost-sharing amount when you receive a brand-name drug.
- If you select a brand-name drug over an available generic drug, you will be responsible for the applicable tier cost-share plus the difference in the cost of the brand-name and generic drug. If the provider's prescription is for the brand-name drug and indicates "dispense as written," you are responsible only for the applicable tier cost-share.
- 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.
- Benefits for certain self-injectable (self-administered) drugs are provided only when they are dispensed by a pharmacy under the pharmacy benefit. See pages 119-120 for Tier 4 and Tier 5 specialty drug fills from a Preferred pharmacy.
- Benefits for certain auto-immune infusion medications (limited to Remicade, Renflexis and Inflectra) are covered only when they are obtained by a non-pharmacy provider, such as a physician or facility (hospital or ambulatory surgical center). See *Drugs From Other Sources* in this section, pages 124-125, for more 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.
- Medication prices vary among different retail pharmacies, the Mail Service Prescription Drug Program, and the Specialty Drug Pharmacy Program. **Review purchasing options for your prescriptions to get the best price.** A drug cost tool is available at www.fepblue.org or call:
  - **Retail Pharmacy Program: 800-624-5060 TTY: 800-624-5077**
  - **Mail Service Prescription Drug Program: 800-262-7890 TTY: 800-216-5343**
  - **Specialty Drug Pharmacy Program: 888-346-3731 TTY: 877-853-9549**
- **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 pages 111-112 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 or biosimilar becomes available or if new safety concerns arise. If your drug is moved to a higher tier, your cost-share will increase. See pages 119-121 for the amounts members pay for Preferred retail, mail service, and specialty drug purchases. Tier reassignments during the year are not considered benefit changes.
- A pharmacy restriction may be applied for clinically inappropriate use of prescription drugs and supplies.
- The Standard Option and Basic Option formularies both contain a comprehensive list of drugs under all therapeutic categories with two exceptions: some drugs, nutritional supplements and supplies are not covered (see pages 123-124); we may also exclude certain U.S. FDA-approved drugs when multiple generic equivalents/alternative medications are available. See pages 109 and 110 for details.

- **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.
  - There is no calendar year deductible for 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 retail pharmacies or the Specialty Drug Pharmacy Program in order to receive benefits.** Our specialty drug pharmacy is a Preferred pharmacy.
  - The Mail Service Prescription Drug Program is available only to members with primary Medicare Part B coverage.
  - There is **no calendar year deductible.**
  - We use a managed formulary for certain drug classes.

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 pre-addressed reply envelope.

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

- **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 164 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 164 for the definition of “specialty drugs.”

Under Standard Option and Basic Option

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.

Note: The Specialty Drug Pharmacy Program will not fill your prescription until you have obtained prior approval. AllianceRx Walgreens Prime, 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.

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 pages 120-121.

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 pages 119-120 for information about your cost-share for specialty drugs purchased at a Preferred retail pharmacy that are affected by these restrictions.

- **What is covered.**

Under Basic Option, we use a managed formulary for certain drug classes. 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.

Under Standard Option and Basic Option

Note: Both formularies include lists of preferred drugs that are safe, effective and appropriate for our members, and are available at lower costs than non-preferred drugs. If your physician prescribed a more expensive non-preferred drug for you, we may ask that he or she prescribe a preferred drug instead; we encourage you to do the same. If you purchase a drug that is not on our preferred drug list, your cost will be higher. Your cooperation with our cost-savings efforts helps keep your premium affordable.

Note: Some drugs, nutritional supplements, and supplies are not covered (see pages 123-124); we may also exclude certain U.S. FDA-approved drugs when multiple generic equivalents/alternative medications are available. If you purchase a drug, nutritional supplement, or supply that is not covered or a drug specifically excluded from coverage on the formulary, you will be responsible for the full cost of the item.

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 800-624-5060, TTY: 800-624-5077, for assistance. Please note the list of drugs on the website formulary is not comprehensive. If you do not find your drug on the formulary, or the preferred drug list, please call 800-624-5060, TTY: 800-624-5077. Please note the list of drugs excluded from coverage may change during the year. Changes to the formulary are not considered benefit changes. For the most up-to-date excluded drug list, please visit www.fepblue.org/formulary or call 800-624-5060, TTY: 800-624-5077. 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 requests a brand-name drug and indicates "dispense as written." Keep in mind that **Basic Option members must use Preferred providers in order to receive benefits.** See Section 10, *Definitions*, page 159, 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. 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 unless otherwise noted. 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.

  Under Standard Option and Basic Option

  Benefits for Tier 4 and Tier 5 specialty drugs purchased at a 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. 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 of the specialty drug. See page 121 for more information.

  Note: Certain drugs such as narcotics may have additional limits or requirements as established by the U.S. FDA or by national scientific or medical practice guidelines (such as Centers for Disease Control and Prevention, American Medical Association, etc.) 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 22, 30, and 90-day supplies of those medications. **In most cases, refills cannot be obtained until 75% of the prescription has been used. Controlled substances cannot be refilled until 80% of the prescription has been used.** Controlled substances are medications that can cause physical and mental dependence, and have restrictions on how they can be filled and refilled. They are regulated and classified by the DEA (Drug Enforcement Administration) based on how likely they are to cause dependence. 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.

  Note: Benefits for certain self-injectable (self-administered) drugs are provided only when they are dispensed by a pharmacy under the pharmacy benefit. Medical benefits will be provided for a once-per-lifetime dose per therapeutic category of drugs dispensed by your provider or any non-pharmacy-benefit provider. This benefit limitation does not apply if you have primary Medicare Part B coverage. See pages 119-120 for Tier 4 and Tier 5 specialty drug fills from a Preferred pharmacy.

  Note: Benefits for certain auto-immune infusion medications (Remicade, Renflexis and Inflectra) are provided only when obtained by a non-pharmacy provider, such as a physician or facility (hospital or ambulatory surgical center). See *Drugs From Other Sources* in this section, page 125, for more information.

- **Important contact information**

  Retail Pharmacy Program: 800-624-5060, TTY: 800-624-5077;
  Mail Service Prescription Drug Program: 800-262-7890, TTY: 800-216-5343;
  Specialty Drug Pharmacy Program: 888-346-3731, TTY: 877-853-9549; or www.fepblue.org.

Patient Safety and Quality Monitoring (PSQM)

We have a special program to promote patient safety and monitor healthcare 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 U.S. FDA-approved recommendations, national scientific and generally accepted standards of medical practice guidelines (such as Centers for Disease Control, American Medical Association, etc.), 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 800-624-5060, TTY: 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 generally accepted standards of medical, dental, or psychiatric practice in the United States (see Quantity allowances above). **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 800-624-5060, TTY: 800-624-5077. You can also obtain the list and forms 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.

Note: It is your responsibility to know the prior approval authorization expiration date for your medication. We encourage you to work with your physician to obtain prior approval renewal in advance of the expiration date.

Standard Option Generic Incentive Program

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

Retail Pharmacy Program

- Your $7.50 copayment for each purchase of up to a 30-day supply ($5.00 when Medicare Part B is primary) is waived for the first 4 generic drug replacements filled (and/or refills ordered) per drug. You may receive up to 4 copayment waivers per drug change.
- If you switch from one generic drug to another, you will be responsible for your copayment.

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.

Please note the list of eligible generic drug replacements may change and is not considered a benefit change. For the most up-to-date information, please visit www.fepblue.org/en/benefit-plans/coverage/pharmacy/generic-incentive-program or call:

Retail Pharmacy Program: 800-624-5060 TTY: 800-624-5077
Mail Service Prescription Drug Program: 800-262-7890 TTY: 800-216-5343
Specialty Drug Pharmacy Program: 888-346-3731 TTY: 877-853-9549

Benefits 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	**Standard Option**	**Basic Option**
Asthma Medications **Preferred Retail Pharmacies:** Note: See page 25 for information about drugs and supplies that require prior approval.	Tier 1 (generic drug): $5 copayment (no deductible) Tier 2 (preferred brand-name drug): 20% of the Plan allowance (no deductible)	Tier 1 (generic drug): $5 copayment for each purchase of up to a 90-day supply Tier 2 (preferred brand-name drug): $35 copayment for each purchase of up to a 30-day supply ($105 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment Tier 2 (preferred brand-name drug): $30 copayment for each purchase of up to a 30-day supply ($90 copayment for a 31 to 90-day supply)
Mail Service Prescription Drug Program: Note: See page 25 for information about drugs and supplies that require prior approval. You must obtain prior approval before Mail Service will fill your prescription. See pages 25 and 112. Note: See pages 119-121 for Tier 3, 4 and 5 prescription drug benefits.	Tier 1 (generic drug): $5 copayment (no deductible) Tier 2 (preferred brand-name drug): $65 copayment (no deductible)	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment Tier 2 (preferred brand-name drug): $75 copayment
Anti-hypertensive Medications **Preferred Retail Pharmacies:** Note: See page 25 for information about drugs and supplies that require prior approval.	Tier 1 (generic drug): $3 copayment (no deductible)	Tier 1 (generic drug): $5 copayment for each purchase of up to a 90-day supply
Mail Service Prescription Drug Program: Note: See page 25 for information about drugs and supplies that require prior approval. You must obtain prior approval before Mail Service will fill your prescription. See pages 25 and 112. Note: See pages 119-121 for Tier 2, 3, 4, and 5 prescription drug benefits.	Tier 1 (generic drug): $3 copayment (no deductible)	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**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 pages 117-118 for our coverage of medications to promote better health as recommended under the Affordable Care Act. • Specialized nutritional formulas for children up to age 22 to treat inborn errors of amino acid metabolism • Must meet the definition of medical food (see definition on page 160) • Must be intended for use solely under medical supervision in the dietary management of an inborn error of amino acid metabolism • Must be receiving active, regular and ongoing medical supervision and must be unable to manage your condition by modification of diet alone • 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) in formula form only Note: Prior approval is required for medical foods provided under the pharmacy benefit. Note: See Section 5(a), page 62, 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 61 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	See page 113 and pages 115-121	See page 113 and pages 115-121

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
• 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 122. Note: You may be eligible to receive smoking and tobacco cessation medications at no charge. See page 122 for more information. • Drugs for the diagnosis and treatment of infertility, except as described on pages 123-124 • Drugs to treat gender dysphoria (gonadotropin-releasing hormone (GnRH) antagonists and testosterones) • 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 120 and 121 for details.	See below and pages 116-122	See below and pages 116-122
• 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 U.S. FDA standards for OTC products. To receive benefits, you must use a 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

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
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 the following vaccines: • 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 800-624-5060, TTY: 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 every 365 days 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 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. See page 117 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
Metformin and metformin extended release (excluding osmotic and modified release generic drugs) **Preferred Retail Pharmacies:** **Mail Service Prescription Drug Program:**	Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply (no deductible) Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply (no deductible)	Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Other Preferred Diabetic Medications, Test Strips, and Supplies **Preferred Retail Pharmacies:** **Mail Service Prescription Drug Program:** **Note: See pages 120-121 for Tier 2, 3, 4, and 5 prescription drug benefits.** Benefits will be provided for the test strips at Tier 2 (diabetic medications and supplies) for Standard Option members, and Basic Option members with primary Medicare Part B, through the Mail Service Prescription Drug Program. See pages 120-121 for more information.	Tier 2 (preferred diabetic medications and supplies): 20% of the Plan allowance for each purchase of up to a 90-day supply (no deductible) Non-preferred retail pharmacies: You pay all charges Tier 2 (preferred brand-name drug): $40 copayment for each purchase of up to a 90-day supply (no deductible)	Tier 2 (preferred diabetic medications and supplies): $35 copayment for each purchase of up to a 30-day supply ($65 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 2 (preferred brand-name drugs): $30 copayment for each purchase of up to a 30-day supply ($60 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 2 (preferred brand-name drugs) $50 copayment for each purchase of up to a 90-day supply
Medications 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 members at risk for preeclampsia • Aspirin for men age 45 through 79 and women age 55 through 79 • Aspirin for adults age 50 through 59 for the primary prevention of cardiovascular disease and colorectal cancer	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

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
• Generic cholesterol-lowering statin drugs Note: Benefits are not available for acetaminophen, ibuprofen, naproxen, etc. Note: Benefits for the medications listed above and on the previous page are subject to the dispensing limitations described on page 111 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/preventive-care-benefits. See pages 43-50 in Section 5(a) for information about other covered preventive care services. Note: See page 122 for our coverage of smoking and tobacco cessation medications.	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 medications (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 800-624-5060, TTY: 800-624-5077, to request this form. You can also obtain the Coverage Request Form through our website at www.fepblue.org.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges Mail Service Prescription Drug Program: Nothing (no deductible)	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
Opioid Reversal Agents: Tier 1 medications limited to Narcan nasal spray and naloxone generic injectable		
Preferred Retail Pharmacies	Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost share.	Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost share.
Non-preferred Retail Pharmacies	You pay all charges	You pay all charges

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Mail Service Prescription Drug Program	Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost share.	**When Medicare Part B is primary, you pay the following:** Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost share.
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 retail pharmacy to request your prescriptions online and delivery, if available. • For a listing of Preferred retail pharmacies, call the Retail Pharmacy Program at 800-624-5060, TTY: 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 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 121 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 Preferred 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 120.**	Tier 1 (generic drug): $7.50 copayment for each purchase of up to a 30-day supply ($22.50 copayment for a 31 to 90-day supply) (no deductible) Note: You pay a $5 copayment for each purchase of up to a 30-day supply ($15 copayment for a 31 to 90-day supply) 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 108 for information. Tier 2 (preferred brand-name drug): 30% of the Plan allowance for each purchase of up to a 90-day supply (no deductible) Tier 3 (non-preferred brand-name drug): 50% of the Plan allowance for each purchase of up to a 90-day supply (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 a 31 to 90-day supply) Tier 2 (preferred brand-name drug): $55 copayment for each purchase of up to a 30-day supply ($165 copayment for a 90-day supply) Tier 3 (non-preferred brand-name drug): 60% of the Plan allowance ($75 minimum) for each purchase of up to a 30-day supply ($210 minimum for a 31 to 90-day supply) Tier 4 (preferred specialty drug): $65 copayment limited to one purchase of up to a 30-day supply Tier 5 (non-preferred specialty drug): $90 copayment limited to one purchase of up to a 30-day supply **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): see above Tier 2 (preferred brand-name drug): $50 copayment for each purchase of up to a 30-day supply ($150 copayment for a 31 to 90-day supply) Tier 3 (non-preferred brand-name drug): 50% of the Plan allowance ($60 minimum) for each purchase of up to a 30-day supply ($175 minimum for a 31 to 90-day supply) Tier 4 (preferred specialty drug): $60 copayment limited to one purchase of up to a 30-day supply

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Note: For a list of the Preferred Network Long Term Care pharmacies, call 800-624-5060, TTY: 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 800-624-5060, TTY: 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.	See previous page	Continued from previous page: Tier 5 (non-preferred specialty drug): $80 copayment limited to one purchase of up to a 30-day supply
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 For Standard Option and Basic Option members when Medicare Part B is Primary, 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: See page 25 for information about drugs and supplies that require prior approval. You must obtain prior approval before Mail Service will fill your prescription. See pages 25 and 112. 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 121 for information about the Specialty Drug Pharmacy Program.	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 112 for information. Tier 2 (preferred brand-name drug): $90 copayment (no deductible) Tier 3 (non-preferred brand-name drug): $125 copayment (no deductible)	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $20 copayment Tier 2 (preferred brand-name drug): $100 copayment Tier 3 (non-preferred brand-name drug): $125 copayment **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 113 of this Section for our payment levels for drugs obtained through Preferred retail pharmacies.

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
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 800-262-7890, TTY: 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.	Continued from previous page: 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.	See previous page
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 164 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 are most convenient for you, as well as ask you about any side effects you may be experiencing. See page 143 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 31 to 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 888-346-3731, TTY: 877-853-9549.	Specialty Drug Pharmacy Program: Tier 4 (preferred specialty drug): $50 copayment for each purchase of up to a 30-day supply ($140 copayment for a 31 to 90-day supply) (no deductible) Tier 5 (non-preferred specialty drug): $70 copayment for each purchase of up to a 30-day supply ($200 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): $70 copayment for each purchase of up to a 30-day supply ($210 copayment for a 31 to 90-day supply) Tier 5 (non-preferred specialty drug): $95 copayment for each purchase of up to a 30-day supply ($285 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 4 (preferred specialty drug): $65 copayment for each purchase of up to a 30-day supply ($185 copayment for a 31 to 90-day supply) Tier 5 (non-preferred specialty drug): $85 copayment for each purchase of up to a 30-day supply ($240 copayment for a 31 to 90-day supply)

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Smoking and Tobacco Cessation Medications If you are the contract holder or spouse, 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 130-131. 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 continuing monthly pack - 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 pages 64-65 for our coverage of smoking and tobacco cessation treatment, counseling, and classes.	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

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Remicade, Renflexis, and Inflectra are not covered for prescriptions obtained from a retail pharmacy, Mail Service Prescription or through the Specialty Drug Program* • *Medical foods administered orally are not covered if not obtained at a retail pharmacy or through the Mail Service Prescription Drug Program* • *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 62 and 114)* • *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* • *Products and foods other than liquid formulas or powders mixed to become formulas; foods and formulas readily available in a retail environment and marketed for persons without medical conditions; low-protein modified foods (e.g., pastas, breads, rice, sauces and baking mixes); nutritional supplements, energy products; and similar items* *Note: See page 117 for our coverage of medications recommended under the Affordable Care Act and page 122 for smoking and tobacco cessation medications.* *Note: See Section 5(a), page 62 for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube.* • *Infant formula other than described on pages 62 and 114* • *Drugs for which prior approval has been denied or not obtained*	*All charges*	*All charges*

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
• *Drugs and supplies related to sexual dysfunction or sexual inadequacy* • *Drugs and covered-drug-related supplies for the treatment of 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 115* • *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 115* • *Drugs used to terminate pregnancy* • *Sublingual allergy desensitization drugs, except as described on page 54*	*All charges*	*All charges*
Drugs From Other Sources	**Standard Option**	**Basic Option**
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. This includes drugs and supplies covered only under the medical benefit. 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 page 136 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 related to drugs obtained from other sources: - Physician's office – Section 5(a) - Facility (inpatient or outpatient) – Section 5(c) - Hospice agency – Section 5(c)	Preferred: 15% of the Plan allowance (deductible applies) Participating professional provider: 35% of the Plan allowance (deductible applies) Non-participating professional provider: 35% of the Plan allowance (deductible applies) Member: 35% of the Plan allowance (deductible applies) 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 professional provider: You pay all charges Non-participating professional provider: You pay all charges Member or Non-member: You pay all charges

Drugs From Other Sources - continued on next page

Benefits Description	You Pay	
Drugs From Other Sources (cont.)	**Standard Option**	**Basic Option**
• Please refer to page 119 for prescription drugs obtained from a Preferred retail pharmacy, that are billed for by a skilled nursing facility, nursing home, or extended care facility.	See previous page	See previous page
• Auto-immune infusion medications: Remicade, Renflexis and Inflectra Note: Benefits for certain auto-immune infusion medications (limited to Remicade, Renflexis and Inflectra) are covered only when they are obtained by a non-pharmacy provider, such as a physician or facility (hospital or ambulatory surgical center).	Preferred: 10% of the Plan allowance (deductible applies) Participating professional provider: 15% of the Plan allowance (deductible applies) Non-participating professional provider: 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 billed amount.	Preferred: 15% of the Plan allowance Participating professional provider: You pay all charges Non-participating professional provider: You pay all charges Member or Non-member: You pay 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.**

Benefit Description	You Pay	
Accidental Injury Benefit	**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.	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.

Accidental Injury Benefit - continued on next page

Benefit Description	You Pay	
Accidental Injury Benefit (cont.)	**Standard Option**	**Basic Option**
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.	See previous page	See previous page

Dental Benefits

What is Covered

Standard Option dental benefits are presented in the chart on the following page.

Basic Option dental benefits appear on page 129.

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 telephone 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 telephone 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 page. 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 to Age 13**	**We Pay Age 13 and Over**	**You Pay**
Clinical oral evaluations			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).
Periodic oral evaluation *(up to 2 per person per calendar year)*	$12	$8	
Limited oral evaluation	$14	$9	
Comprehensive oral evaluation	$14	$9	
Detailed and extensive oral evaluation	$14	$9	
Diagnostic imaging			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	
Palliative treatment			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).
Palliative treatment of dental pain – minor procedure	$24	$15	
Protective restoration	$24	$15	
Preventive			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).
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 (*up to 2 per person per calendar year*)	$13	$8	
Not covered: Any service not specifically listed above	*Nothing*	*Nothing*	*All charges*

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 telephone 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*)	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
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)*	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
Not covered: Any service not specifically listed above	*Nothing*	*All charges*

Section 5(h). Wellness and Other 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 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 healthcare 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 healthcare expenses. See page 130 for complete information. • **Tobacco Cessation Incentive Program** – If you are the contract holder or spouse 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 page 122 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.
Services for the Deaf and Hearing Impaired	All Blue Cross and Blue Shield Plans provide TTY 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 well-being. For more information, go to www.fepblue.org.
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, both the contract holder and spouse 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, 2019**. 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 888-258-3432 toll-free.
Diabetes Management Incentive Program	The **Diabetes Management Incentive Program** is designed to encourage members to achieve and maintain control of their blood sugar and help manage or slow the progression of complications related to diabetes. Through this program you can earn a maximum of $100 toward a health account to be used for most qualified medical expenses. This incentive is in addition to other incentives described in this brochure and is limited to the contract holder and spouse. To qualify for the Diabetes Management Incentive Program, each eligible member must complete the following steps: • Complete the Blue Health Assessment (BHA), indicating that you have been diagnosed with Type 1 or Type 2 diabetes. Note: The BHA is available on our website, www.fepblue.org. • Provide us with lab test results for an HbA1c performed in the first 6 months of the calendar year (January 1 to June 30) to receive a $25 incentive reward. • Provide us with lab test results for an HbA1c performed in the last 6 months of the calendar year (July 1 to December 31) to receive a $75 incentive reward; the test results must show: - Your HbA1c result is less than 8 percent; or - If your HbA1c is greater than or equal to 8 percent, you will receive the incentive if we provided benefits for three nutritional counseling visits performed during the calendar year. Note: See pages 41 and 44 for information on nutritional counseling. Information on how to submit your HbA1c lab results can be found on our website, www.fepblue.org/diabetes. See page 116 for information about the Diabetic Meter Program.
Hypertension Management Program	The **Hypertension Management Program** gives members with hypertension (otherwise known as high blood pressure) 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 the contract holder and spouse who meet the criteria. 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 healthcare 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. See page 113 for information on preferred generic anti-hypertensive medications.
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. 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 Pregnancy Care Box, you must be pregnant, the contract holder or spouse, and must complete the Blue Health Assessment (BHA) questionnaire. Information on the program is available on our website, www.fepblue.org. Also see page 130 for information on the BHA. To qualify for the $75 incentive, you must meet the criteria above for the Pregnancy Care Box and send us a copy of your healthcare provider's medical record that confirms you had a prenatal care visit during the first trimester of your pregnancy. Information that must be included when submitting your medical record can be found on our website, www.fepblue.org/maternity. To receive 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 are limited to two pregnancies per calendar year.
Annual Incentive Limitation	Financial incentives earned through participation in the Blue Health Assessment, personalized goals through the Online Health Coach, the Diabetes Management Incentive Program, and the Pregnancy Care Incentive Program are limited to a total of $250 per person per calendar year for the contract holder and spouse.
Reimbursement Account for Basic Option Members Enrolled in Medicare Part A and Part B	Basic Option members enrolled in Medicare Part A and Part B are eligible to be reimbursed up to $600 per calendar year for their Medicare Part B premium payments. The account is used to reimburse member-paid Medicare Part B premiums. For more information on how to obtain reimbursement, please visit www.fepblue.org/mra or call 888-706-2583.
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 and 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.

	• **Financial Dashboard** – Log in to MyBlue to access important information in real time, including deductibles, out-of-pocket costs, remaining covered provider visits, medical claims, and pharmacy claims. You also can review your year-to-date summary of completed claims, MyBlue Wellness Card balance, and pharmacy spending throughout the year.
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 healthcare 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 healthcare needs with the services of a registered nurse, licensed social worker, or other licensed healthcare professional practicing within the scope of their license and certified as a case manager by a nationally recognized board certified in case management to assess, coordinate, evaluate, support and monitor the member's treatment plan and healthcare needs. Enrollment in case management requires your consent. Members in case management are asked to provide verbal consent prior to enrollment in case management and must provide written consent for case management. Note: Benefits for care provided by residential treatment centers and for inpatient care provided by skilled nursing facilities for members enrolled in Standard Option who do not have Medicare Part A require written consent and participation in Case Management prior to admission; please see pages 92, 105 and 135 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 telephone 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 will review the member's healthcare needs and may at our sole discretion, identify a less costly alternative treatment plan for the member. The member (or their healthcare proxy) and provider(s) must cooperate in the process. Case Management Program enrollment is required for eligibility. Prior to the starting date of the alternative treatment plan, members who are eligible to receive services through the flexible benefits option are required to sign and return a written consent for case management and 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. **We must receive the consent for case management and the alternative benefits agreement signed by the member/healthcare proxy before you receive any services included in the alternative benefits agreement.** • Alternative benefits will be made available for a limited period of time and are subject to our ongoing review. You must cooperate with and participate in the review process. Your provider(s) must submit the information necessary for our reviews. You and/or your healthcare proxy must participate in care conferences and caregiver training as requested by your provider(s) or by us. • We may revoke the alternative benefits agreement immediately at any time, if we discover we were misled by the information given to us by you, your provider, or anyone else involved in your care, or that you are not meeting the terms of the agreement.

	• If we approve alternative benefits, we do not guarantee that they will be extended beyond the limited time period and/or scope of the alternative benefits agreement 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 at our sole discretion, 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 alternative benefits for the stated time period, unless we are misled by the information given to us or circumstances change. Benefits as stated in this brochure will apply to all services and dates of care not included in the alternative benefits agreement. You or your provider may request an extension of the time period initially approved for alternative benefits, no later than five business days prior to the end of the alternative benefits agreement. We will review the request, including the services proposed as an alternative and the cost of those services, but benefits as stated in this brochure will apply if we do not approve your request. Note: If we deny a request for precertification or prior approval of regular contract benefits, as stated in this brochure, 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).
Telehealth Services	Go to www.fepblue.org/telehealth or call 855-636-1579 (TTY: 855-636-1578) toll free to access on-demand, affordable, high-quality care for adults and children experiencing non-emergency medical issues, including treatment of minor acute conditions (see page 160 for definition), dermatology care, and counseling for behavioral health and substance use disorder. Note: This benefit is available only through the contracted telehealth provider network.
The fepblue Mobile Application	Blue Cross and Blue Shield's new fepblue mobile application is available for download for both iOS and Android mobile telephones. The application provides members with 24/7 access to helpful features, tools and information related to Blue Cross and Blue Shield Service Benefit Plan benefits. Members can log in with their MyBlue® username and password to access personal healthcare information such as benefits, out-of-pocket costs, deductibles (if applicable) and physician visit limits. They can also view claims and approval status, view/share Explanations of Benefits (EOBs), view/share Member ID cards, locate in-network providers, and connect with our telehealth services.

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 136-137 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 healthcare 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, with the exception of admissions for gender reassignment surgery (see pages 23 and 68-69 for information) and admissions to residential treatment centers and skilled nursing facilities. Prior approval is required for all non-emergent air ambulance transport services for overseas members (refer to page 97 for more information).

Overseas 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 Overseas 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 Overseas 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 Overseas Assistance Center (provided by GMMI, Inc.), by calling the center collect at 804-673-1678. Members in the United States, Puerto Rico, or the U.S. Virgin Islands should call 800-699-4337 or email the Overseas Assistance Center at fepoverseas@gmmi.com. GMMI, Inc., 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.

Hospital and professional provider benefits

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 **inpatient facility care** you receive overseas, we provide benefits at the Preferred level **under both Standard and Basic Options, without member cost-share,** for admissions to a DoD facility, or when the Overseas Assistance Center (provided by GMMI, Inc.) has arranged direct billing or acceptance of a guarantee of benefits with the facility.

For **outpatient 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 86-90.

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.

Pharmacy benefits

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 124 in Section 5(f) for more information.

Overseas claims payment

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.

Filing overseas claims

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 260070, Pembroke Pines, FL 33026.
2. Fax: 001-954-308-3957. 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 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@gmmi.com, or from your Local Plan.

Filing a claim for 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 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

These benefits are not part of the FEHB contract or premium, and you cannot file an FEHB dispute regarding these benefits. Fees paid 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 telephone number on the back of your ID card or visit our website at www.fepblue.org.

Blue365® – The Blue Cross and Blue Shield Service Benefit Plan presents Blue365, a program that offers exclusive health and wellness deals that will assist in your efforts to be 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. Each week, Blue365 members receive great health and wellness deals via email. With Blue365, there is no paperwork to fill out. Just 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 – Fitness Your Way by Tivity Health can help you meet your health and fitness goals, on your budget, and on your own time. Fitness Your Way by Tivity Health offers access to more than 10,000 different fitness locations for just $29 a month and a low $29 enrollment fee, with a 3-month commitment.* You'll have access to well-being support, health articles, and online health coaching, as well as exercise tracking and nutrition goals, social networking, rewards, and the Daily Challenge 24 hours a day, 7 days a week. For more information or to enroll, visit www.fepblue.org/healthclub or call customer service at 888-242-2060, Monday through Friday, 8 a.m. – 8 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 members 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 several drugs related to dental care, weight loss, hair removal and hair growth, and other miscellaneous health conditions. Please refer to www.fepblue.org/ddp for a full list of discounted drugs, including those that may be added to this list as they are approved by the U.S. Food and Drug Administration (U.S. FDA). To use the program, simply present a valid prescription and your Service Benefit Plan ID card at a Preferred 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 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 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 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. 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, powers of attorney, bill of sale, contract, residential lease, and much more. **The DIY Docs package includes an easy-to-use 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 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 160).
- Experimental or investigational procedures, treatments, drugs, or devices (see Section 5(b) 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 and gender reassignment surgeries specifically listed as covered).
- Travel expenses except as specifically provided for covered transplants performed in a Blue Distinction Center for Transplant (see page 81).
- 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 155), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge, see page 156), or state premium taxes however applied.
- Prescriptions, 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, diagnostic tests, and procedures and services for the treatment of morbid obesity listed on page 69.
- 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 *Preventive Care, Child* in Sections 5(a) and 5(c), the preventive screenings specifically listed on pages 43-50 and page 90; and certain routine services associated with covered clinical trials (see page 149).
- Recreational or educational therapy, and any related diagnostic testing, except as provided by a hospital during a covered inpatient stay.
- Applied behavior analysis (ABA) and related services for any condition other than an autism spectrum disorder.
- Applied behavior analysis (ABA) services and related services performed as part of an educational program; or provided in or by a school/educational setting; or provided as a replacement for services that are the responsibility of the educational system.
- 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 123), meditation techniques, relaxation techniques, movement therapies, and energy therapies.
- Advanced care planning, except when provided as part of a covered hospice care treatment plan (see page 95).
- Membership or concierge service fees charged by a healthcare provider.
- Fees associated with copies, forwarding or mailing of records except as specifically described in Section 8.
- 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 telephone 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, telephone 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, speech, or cognitive rehabilitation 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 142-143 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 (e.g., medical records) 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 retail 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 retail 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 25).

See the following paragraphs 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 800-624-5060 to request a retail prescription drug claim form to claim benefits. Hearing-impaired members with TTY equipment may call 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 800-262-7890 (TTY: 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 121 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 888-346-3731 (TTY: 877-853-9549), or you may send your prescription to: Specialty Drug Pharmacy Program, AllianceRx Walgreens Prime, P.O. Box 692169, Orlando, FL 32869. 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 are 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 888-346-3731 (TTY: 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 (e.g., diagnosis codes, dates of service, etc.), 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 136-137 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 healthcare 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 healthcare 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 or to make an inquiry 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 call your Plan's customer service representative at the telephone number found on your enrollment card, our brochure, or our website (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 telephone 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 healthcare 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.

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, FEHB 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;
- Your daytime telephone number and the best time to call; and
- 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 healthcare 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 telephone 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 FEHB 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 healthcare 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 healthcare 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 on NAIC rules regarding the coordinating of benefits, visit our website at www.fepblue.org/coordinationofbenefits.

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 156). 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 healthcare 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 healthcare 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 www.BENEFEDS.com or by telephone at 877-888-3337, TTY: 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 73-80. **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 telephone 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 (U.S. 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 800-MEDICARE (800-633-4227), TTY: 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 153.
- 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 800-772-1213, TTY: 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 800-772-1213, TTY: 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 healthcare. 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 155 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 telephone 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 healthcare 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**

If you are enrolled in Medicare Part B, 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 healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227), TTY: 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 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:	
	Standard Option	**Basic Option**
Participates with Medicare or accepts Medicare assignment for the claim and is in our Preferred network	your deductibles, coinsurance, and copayments.	your copayments and coinsurance.
Participates with Medicare or accepts Medicare assignment and is not in our Preferred network	your deductibles, coinsurance, and copayments, and any balance up to the Medicare-approved amount.	all charges.
Does not participate with Medicare and is in our Preferred network 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.	your deductibles, coinsurance, and copayments, and any balance up to 115% of the Medicare-approved amount.	your copayments and coinsurance, and any balance up to 115% of the Medicare-approved amount.
Does not participate with Medicare and is not in our Preferred network	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare-approved amount.	all charges.
Does not participate with Medicare and is not a member of our PPO network	your out-of-network deductibles, coinsurance, and any balance up to 115% of the Medicare-approved amount.	your out-of-network deductibles, coinsurance, and any balance up to 115% of the Medicare-approved amount.

- continued on next page

If your physician:	Then you are responsible for:	
(cont.)	**Standard Option**	**Basic Option**
Opts-out of Medicare via private contract	your deductibles, coinsurance, copayments, and any balance your physician charges.	your deductibles, coinsurance, copayments, and any balance your physician 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.

Physicians Who Opt-Out of Medicare

A physician may have opted-out of Medicare and may or may not ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. This is different than a Non-participating doctor, and we recommend you ask your physician if he or she has opted-out of Medicare. Should you visit an opt-out physician, the physician will not be limited to 115% of the Medicare-approved amount. You may be responsible for paying the difference between the billed amount and our regular in-network/out-of-network benefits.

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, you pay nothing for covered charges (see note below for Basic Option).
- If your physician **does not accept** Medicare assignment, 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.

Advanced care planning — Receiving information on the types of life-sustaining treatments that are available, completing advance directives and other standard forms, and/or if you are diagnosed with a terminal illness and making decisions about the care you would want to receive if you become unable to speak for yourself.

Agents — Medications 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 medications 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. Benefits provided under the contract are not assignable by the member to any person without express written approval of the Carrier, and in the absence of such approval, any such assignment shall be void.

Please visit www.fepblue.org to obtain a valid authorization form.

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.

Biologic drug — A complex drug or product that is manufactured in a living organism, or its components, that is used as a diagnostic, preventive or therapeutic agent.

Biosimilar drug — A U.S. FDA-approved biologic drug, which is considered highly similar to an original brand-name biologic drug, with no clinically meaningful differences from the original biologic drug in terms of safety, purity and potency.

Biosimilar, interchangeable drug — A U.S. FDA-approved biosimilar drug that may be automatically substituted for the original brand-name biologic drug.

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.

Clinical trials — 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 U.S. Food and Drug Administration (U.S. 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 30.

Concurrent care claims — A claim for continuing care or an ongoing course of treatment that is subject to prior approval. See page 27 in Section 3.

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; ambiguous genitalia; and webbed fingers and toes. Note: Congenital anomalies do not include conditions related to the teeth or intra-oral structures supporting the teeth.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 29.

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 healthcare 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.

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:

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

3. Reliable evidence shows that the consensus of opinion among experts regarding the healthcare 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
4. Reliable evidence shows that the healthcare 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:

1. Published reports and articles in the authoritative medical and scientific literature;
2. 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
3. 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 a U.S. 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 U.S. FDA as interchangeable with your brand-name drug.

Group health coverage — Healthcare 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).

Healthcare professional — A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law. See page 18 for information about how we determine which healthcare 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 healthcare provider. For more information, visit our website, www.fepblue.org.

Inpatient — You are an inpatient when you are formally admitted to a hospital with a doctor's order.

Note: Inpatient care requires precertification. For some services and procedures prior approval must also be obtained. See pages 22-28.

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 use disorders. 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 healthcare 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:

1. In accordance with generally accepted standards of medical practice in the United States; and
2. 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
3. Not primarily for the convenience of the patient, physician, or other healthcare 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
4. Not part of or associated with scholastic education or vocational training of the patient; and
5. In the case of inpatient care, able to be provided safely only in the inpatient 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.

Minor acute conditions

Under the telehealth benefit you have on-demand access to care for common, non-emergent conditions. Examples of common conditions include sinus problems, rashes, allergies, cold and flu symptoms, etc.

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.

Outpatient

You are an outpatient if you are getting emergency department services, observation services, outpatient surgery, lab tests, X-rays, or any other hospital services, and the doctor has not written an order to admit you to a hospital as an inpatient. In these cases, you are an outpatient even if you are admitted to a room in the hospital for observation and spend the night at the hospital.

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 healthcare 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 128 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 healthcare 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 Local Plan Allowance. The Local Plan Allowance varies by region and is determined by each Plan. 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 emergency deliveries, our allowance is the billed amount;
  - For outpatient, non-emergency 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 Local Plan Allowance. This allowance applies to all of the covered surgical services billed by the hospital. If you plan on using a Non-member hospital, or other Non-member facility, for your outpatient procedure, please call us before you receive services at the customer service telephone 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 to use our National Doctor and Hospital Finder, or call us at the customer service telephone number on the back of your ID card;
  - For outpatient 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 healthcare 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 Local Plan Allowance. In the absence of a Medicare participating fee schedule amount or ASP for any service, drug, or supply, our allowance is the Local Plan Allowance. 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 healthcare 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 Local Plan Allowance 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 the Overseas Assistance Center (provided by GMMI, Inc.), 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, D.C., 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 telephone 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 99-102).

For more information, see *Differences between our allowance and the bill* in Section 4. For more information about how we pay providers overseas, see pages 33 and 135.

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, healthcare institutions, and other covered healthcare 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 healthcare 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, and latent tuberculosis; screening for alcohol/substance use disorders; 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; osteoporosis screening, as specifically stated in this brochure; and immunizations as licensed by the U.S. Food and Drug Administration (U.S. FDA).

Note: Anesthesia services and pathology services associated with preventive colorectal surgical screenings are also paid as preventive care.

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 22-25.

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 page 149).

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.

Telehealth dermatology

Under the telehealth benefit, dermatologic conditions seen and treated include but are not limited to acne, dermatitis, eczema, psoriasis, rosacea, seborrheic keratosis, fungal infections, scabies, suspicious moles, and warts. Members capture important digital images, combine those with the comprehensive questionnaire responses, and send those to the dermatology network without requiring a telephone or video interaction.

Telehealth services

Non-emergency services provided by telephone or secure online video for minor acute conditions (see page 160 for definition), dermatology care, and behavioral health and substance use disorder counseling. Go to www.fepblue.org/telehealth or call 855-636-1579, TTY: 855-636-1578, toll free to access this benefit. After your telehealth visit, please follow up with your primary care provider.

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 four 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 healthcare 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.

Fourth, the **Federal Employees' Group Life Insurance Program (FEGLI)** can help protect your family from burdensome funeral costs and the unexpected loss of your income.

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 healthcare flexible spending account (HCFSA) or a limited expense healthcare spending account (LEX HCFSA) is $2,650 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 healthcare 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 877-FSAFEDS, 877-372-3337 (TTY: 866-353-8058), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time.

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. Beginning in 2019, FEDVIP is also available to TRICARE eligible retirees and their families during the 2018 Federal Benefits Open Season. Active duty family members are eligible to enroll in FEDVIP vision insurance. Both retirees and active duty family members must be enrolled in a TRICARE health plan in order to enroll in a FEDVIP vision plan.

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/. This site also provides 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 877-888-3337 (TTY: 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. Long term care can be received in your home, in a nursing home, in an assisted living facility, or in adult day care. You must apply and pass a medical screening (called underwriting), and be approved for enrollment. Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Your qualified relatives can apply even if you do not. 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 800-LTC-FEDS (800-582-3337), (TTY: 800-843-3557), or visit www.ltcfeds.com.

The Federal Employees' Group Life Insurance Program – *FEGLI*

Peace of Mind for You and Your Family

The Federal Employees' Group Life Insurance Program (FEGLI) can help protect your family from burdensome funeral costs and the unexpected loss of your income. You can get life insurance coverage starting at one year's salary to more than six times your salary and many options in between. You can also get coverage on the lives of your spouse and unmarried dependent children under age 22. You can continue your coverage into retirement if you meet certain requirements. For more information, visit www.opm.gov/life.

Index

Do not rely only 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. Page numbers in **bold** type are main entries.

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Summary of Benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2019

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 healthcare professional, you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown below.

You can obtain a copy of our Affordable Care Act Summary of Benefits and Coverage at www.fepblue.org/brochure.

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 healthcare professionals $35 per office visit for specialists Non-PPO: 35%* of our allowance	40-50
• Telehealth services	PPO: $10 Non-PPO: You pay all charges	40, 104
Services provided by a hospital:		
• Inpatient	PPO: $350 per admission Non-PPO: $450 per admission, plus 35% of our allowance	84-86
• Outpatient	PPO: 15%* of our allowance Non-PPO: 35%* of our allowance	86-90
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	100-101
• 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)	101-102

Standard Option Benefits	You pay	Page
Mental health and substance use disorder 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	103-107
Prescription drugs	**Retail Pharmacy Program:** • PPO: $7.50 for each purchase of up to a 30-day supply generic ($5.00 for a 30-day supply if you have Medicare Part B primary)/30% of our allowance Preferred brand-name/50% 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 Part B primary)/$90 Preferred brand-name/$125 non-preferred brand-name per prescription; up to a 90-day supply **Specialty Drug Pharmacy Program:** • $50 preferred specialty drug for a purchase of up to a 30-day supply; $70 non-preferred specialty drug for a purchase of up to a 30-day supply	113-125
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	128
Wellness and other special features: Health Tools; Blue Health Assessment; MyBlue® Customer eService; Diabetes Management Incentive Program; National Doctor and Hospital Finder; Healthy Families; travel benefit/services overseas; Care Management Programs; and Flexible benefits option		130-134
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.	33-34

Summary of Benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2019

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.

You can obtain a copy of our Affordable Care Act Summary of Benefits and Coverage at www.fepblue.org/brochure.

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 healthcare professionals; $40 per office visit for specialists Non-PPO: You pay all charges	40-50
• Telehealth services	PPO: $15 Non-PPO: You pay all charges	40, 104
Services provided by a hospital:		
• Inpatient	PPO: $175 per day up to $875 per admission Non-PPO: You pay all charges	84-86
• Outpatient	PPO: $100 per day per facility Non-PPO: You pay all charges	86-90
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	100-101
• Medical emergency	Same as for accidental injury	101-102
Mental health and substance use disorder 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	103-107

Basic Option Benefits	You pay	Page
Prescription drugs	**Retail Pharmacy Program:** • PPO: $10 generic/$50 Preferred brand-name per prescription ($45 if you have primary Medicare Part B)/60% coinsurance ($75 minimum) for non-preferred brand-name drugs (50% ($60 minimum) if you have primary Medicare Part B) • Non-PPO: You pay all charges **Specialty Drug Pharmacy Program:** • $70 preferred specialty drug for a purchase of up to a 30-day supply; $95 non-preferred specialty drug for a purchase of up to a 30-day supply **Mail Service Prescription Drug Program** (for primary Medicare Part B members only): • $20 generic/$90 Preferred brand-name/$125 non-preferred brand-name per prescription; up to a 90-day supply	113-125
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	129
Wellness and other special features: Health Tools; Blue Health Assessment; MyBlue® Customer eService; Diabetes Management Incentive Program; National Doctor and Hospital Finder; Healthy Families; travel benefit/services overseas; Care Management Programs; and Flexible benefits option		130-134
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.	33-34

2019 Rate Information for the Blue Cross and Blue Shield Service Benefit Plan

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

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 certain United States Postal Service employees as follows:

- Postal Category 1 rates apply to career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NALC, NPMHU, and NRLCA.
- If you are a career bargaining unit employee represented by the agreement with NPPN, you will find your premium rates on https://liteblue.usps.gov/fehb.
- Postal Category 2 rates apply to career bargaining unit employees who are represented by the following agreement: PPOA.

Non-Postal rates apply to all career non-bargaining unit Postal Service employees. Postal rates do not apply to non-career Postal employees, Postal retirees, and associate members of any Postal employee organization who are not career Postal employees.

If you are a Postal Service employee and have questions or require assistance, please contact:

USPS Human Resources Shared Service Center: 877-477-3273, option 5, Federal Relay Service 800-877-8339

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
Basic Option Self Only	111	$221.18	$73.72	$479.21	$159.74	$70.78	$61.19
Basic Option Self Plus One	113	$492.27	$170.57	$1,066.59	$369.56	$163.73	$143.22
Basic Option Self and Family	112	$525.32	$177.24	$1,138.19	$384.02	$169.94	$148.06
Standard Option Self Only	104	$230.18	$112.23	$498.72	$243.17	$109.03	$99.44
Standard Option Self Plus One	106	$492.27	$256.54	$1,066.59	$555.83	$249.70	$229.19
Standard Option Self and Family	105	$525.32	$268.21	$1,138.19	$581.13	$260.91	$239.03

EXHIBIT K

Blue Cross® and Blue Shield® Service Benefit Plan

www.fepblue.org

2020

A Fee-For-Service Plan (FEP Blue Standard and FEP Blue Basic Options) with a Preferred Provider Organization

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. This Plan is accredited. See page 13.

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

IMPORTANT

- Rates: Back Cover
- Changes for 2020: Page 15
- Summary of Benefits: Page 166

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

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

The Office of Personnel Management (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 800-772-1213, TTY 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 800-MEDICARE 800-633-4227, TTY 877-486-2048.

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Introduction

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Standard and FEP Blue Basic Options** 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 healthcare benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2020, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2020, and changes are summarized on pages 15-16. Rates are shown on the back cover of this brochure.

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 healthcare 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 healthcare provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare 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 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 800-FEP-8440 (800-337-8440) and explain the situation.
  - If we do not resolve the issue:

CALL – THE HEALTH CARE FRAUD HOTLINE

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)
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
  - A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- 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 (TCC).
- 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.

Discrimination is Against the Law

The Blue Cross and Blue Shield Service Benefit Plan complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, we do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

We:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator of your Local Plan by contacting your Local Plan at the telephone number appearing on the back of your ID card.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator of your Local Plan. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, your Local Plan's Civil Rights Coordinator is available to help you.

Members may file a complaint with the HHS Office of Civil Rights, OPM, or FEHB Program Carriers.

You can also file a civil rights complaint with the Office of Personnel Management by mail at:

Office of Personnel Management
Healthcare and Insurance
Federal Employee Insurance Operations
Attention: Assistant Director, FEIO
1900 E Street NW, Suite 3400-S
Washington, D.C. 20415-3610

For further information about how to file a civil rights complaint, go to www.fepblue.org/en/rights-and-responsibilities/, or call the customer service telephone number on the back of your member ID card. For TTY, dial 711.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. 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 take notes, ask questions and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medications or give your doctor and pharmacist a list of all the medications and dosages that you take, including non-prescription (over-the-counter) medications 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 medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by telephone, mail, through the Plan or Provider's portal?
- Do not assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

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

For more information on patient safety, please visit:

- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. 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 healthcare providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- 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 healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not 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, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

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. When such an event occurs, neither you nor your FEHB Plan will incur costs to correct the medical error.

You will not be billed for inpatient services when care is related to treatment of specific hospital-acquired conditions if you use Preferred or Member hospitals. This policy helps to protect you from having to pay for the cost of treating these conditions, and it encourages hospitals to improve the quality of care they provide.

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. 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 and one eligible family member, or 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 Plus One or Self and Family 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 are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

  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, you or they cannot be enrolled in or covered as a family member by another enrollee in 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 your spouse, or one other 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.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

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 or children.

If this law applies to you, you must enroll in 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 lowest-cost nationwide Plan option as determined by OPM.
- 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 lowest-cost nationwide plan option as determined by OPM.

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 does not 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 does not 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 2020 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 2019 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 family members 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 assistance with enrolling in a conversion policy (non-FEHB individual policy). FEP helps members with Temporary Continuation of Coverage (TCC) and with finding replacement coverage.

- **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 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. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- **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 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 coverage.

  We also want to inform you that the Patient Protection and ACA did not eliminate TCC or change the TCC rules.

- **Finding replacement coverage**

  If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please refer to the next Section of this brochure. 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 ACA's Health Insurance Marketplace. These rules are established by the Federal Government agencies that have responsibility for implementing the ACA and by the Marketplace.

- **Health Insurance Marketplace**

  If you would like to purchase health insurance through the ACA'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 healthcare 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.

OPM requires that FEHB plans be accredited to validate that Plan operations and/or care management meet nationally recognized standards. The local Plans and vendors that support the Blue Cross and Blue Shield Service Benefit Plan hold accreditation from National Committee for Quality Assurance (NCQA) and/or URAC. To learn more about this Plan's accreditations, please visit the following websites:

- National Committee for Quality Assurance (www.ncqa.org);
- URAC (www.URAC.org).

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 healthcare 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 Preferred 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. 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 20 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 telephone 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 healthcare facilities, physicians, and other healthcare 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 160-162). 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 20 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.

- **Pilot Programs.** We may implement pilot programs in one or more Local Plan areas and overseas to test the feasibility and examine the impact of various initiatives. The pilot programs do not affect all Plan areas. Information on specific pilots is not published in this brochure; it is communicated to members and network providers in accordance with our agreement with OPM. Certain pilot programs may incorporate benefits that are different from those described in this brochure. For example, certain pilot programs may revise the Plan Allowance for Non-participating providers described in Section 10 of this brochure.

Your rights and responsibilities

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/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence
- Profit status
- Care management, including case management and disease management programs
- How we determine if procedures are experimental or investigational

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, at www.fepblue.org/en/rights-and-responsibilities.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.fepblue.org/en/terms-and-privacy/notice-of-privacy-practices/ to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

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 2020

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.

Changes to our Standard Option only

- We now provide the first two telehealth visits at no member cost-share. Previously, your cost-share under Standard Option was $10 (no deductible). (See pages 39 and 102.)
- We now provide an enhanced benefit for hip and knee replacement or revision surgeries, and certain spine surgeries performed outpatient at a designated Blue Distinction Center for hip/knee/spine surgeries. Under Standard Option, you pay $100 per day per facility with no deductible. Previously, there was no enhanced outpatient Blue Distinction Center benefit. (See page 89.)
- We now apply a member cost-share for traditional home hospice care for Member and Non-member facilities. The Member/Non-member facility copayment is $450 per episode copayment (no deductible). Previously, there was no member cost-share. (See page 94.)
- We now provide benefits for continuous home hospice care received from Preferred providers at no member cost-share. Previously, you paid a $350 copayment. (See page 94.)
- Your cost-share for inpatient admissions to any facility overseas is waived. Previously, members were responsible for a copayment or co-insurance for these admissions. Your deductible is waived for all overseas services. (See page 133.)

Changes to our Basic Option only

- We now provide the first two telehealth visits at no member cost-share. Previously, your cost-share under Basic Option was $15. (See pages 39 and 102.)
- We now provide an enhanced benefit for hip and knee replacement or revision surgeries and certain spine surgeries performed outpatient at a designated Blue Distinction Center for hip/knee/spine surgeries. Under Basic Option, you pay $25 per day per facility. Previously, there was no enhanced outpatient Blue Distinction Center benefit. (See page 89.)
- You now pay all charges for traditional home hospice care from Member/Non-member facilities. Previously, there was no member cost-share. (See page 94.)
- We now provide benefits for continuous home hospice care received from Preferred providers at no member cost-share. Previously, you paid a $150 copayment, up to a $750 maximum per episode. (See page 94.)
- We now provide a reimbursement account for up to $800 for Medicare Part B premiums to any member with Medicare Part A and Part B. Previously, the reimbursement was $600. (See page 130.)

Changes to both our Standard and Basic Options

- We are adding FEP Blue to our Standard and Basic Option names in select places in the brochure. The You Pay columns in Section 5 and its subsections will remain as Standard Option and Basic Option for this year.
- We now provide a preventive telehealth benefit for nutritional counseling with no member cost-share. Previously, there was no telehealth benefit for preventive nutritional counseling. (See pages 17, 43, 48, 132, and 163.)
- We now provide benefits for medically necessary bone-anchored hearing aids without diagnosis restrictions. Previously, bone-anchored hearing aid benefits were restricted to certain diagnoses. (See page 60.)
- We now provide autologous blood or bone marrow stem cell transplant benefits for scleroderma without requiring a clinical trial. Previously, a clinical trial was required. (See page 75.)
- We now define an episode of care for traditional home hospice as one home hospice treatment plan per calendar year. Previously, there was no description for an episode of care. (See page 94.)

- You do not need to be enrolled in a traditional home hospice program to be eligible for the first continuous home hospice care. You must be enrolled in a home hospice program to receive benefits for subsequent continuous home hospice care. Previously, you had to be enrolled in a traditional home hospice care program. (See page 94.)
- You may receive continuous home hospice care without 21 days of traditional home hospice care between each episode. Previously, each episode of continuous home hospice care had to be separated by at least 21 days of traditional home hospice care. (See page 94.)
- You may receive inpatient hospice care without 21 days of traditional home hospice care between each episode. Previously, each episode of inpatient hospice care had to be separated by at least 21 days of traditional home hospice care. (See page 94.)
- We now include syringes, pens and pen needles at the reduced cost-share for Preferred diabetic medications, test strips, and supplies. Previously, they were not included in the reduced cost-share benefit. (See page 115.)
- We now provide only pharmacy benefits for prescription vitamin D. Previously, vitamin D supplements were available under the preventive care adult benefits with no member cost-share.
- You no longer have to complete the Blue Health Assessment Questionnaire (BHA) to be eligible to participate in incentive programs. All covered members are eligible for the incentive programs for which they may qualify. Previously, you had to complete the BHA to be eligible for the incentive programs, which were limited to the contract holder and spouse. (See pages 120, 128-130.)
- We now offer a program to help members manage diabetes. This program is offered at no cost to the member. Previously, there was no program. (See page 128.)
- We now provide an Online Health Coach module for hypertension management. You must complete the BHA to be eligible. Previously, there was no Online Health Coach Module. (See page 129.)
- We now limit the timely filing for overseas pharmacy claims to one year from the prescription fill date. Previously, you had to submit your overseas pharmacy claims by December 31 of the year after the year you received the service. (See pages 134 and 141.)
- We have added to the preventive care adult definition that screening for intimate partner violence for women of reproductive age is covered under this benefit. (See page 162.)

Section 3. How You Get Care

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 20 for the exceptions to this requirement. Refer to page 13 for more information about Preferred providers.

Under both Standard and Basic Option, you can also get care for the treatment of minor acute conditions (see page 159 for definition), dermatology care (see page 39), counseling for behavioral health and substance use disorder (see page 102), and nutritional counseling (see pages 43 and 48), using teleconsultation services delivered via telephone by calling 855-636-1579, TTY: 855-636-1578, or via secure online video/messaging at www.fepblue.org/telehealth.

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. Covered professional providers are healthcare 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 healthcare 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 are physicians and other healthcare providers, 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.**

If you have questions about covered providers or would like the names of PPO (Preferred) providers, please contact the Local Plan where services will be performed.

- **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-Preferred (Member/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 surgicenter, 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 use disorder. Accredited healthcare 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 use disorder 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 90-91 and 103-104. If you have questions about treatment at an RTC, please contact us at the customer service telephone number listed on the back of your ID card.

Blue Distinction® Specialty Care

Blue Distinction Specialty Care, our centers of excellence program, focuses on effective treatment for specialty procedures, such as: Bariatric Surgery, Cardiac Care, Knee and Hip Replacement, Spine Surgery, Transplants, Cancer Care, Cellular Immunotherapy (CAR-T), Gene Therapy, Maternity Care, and Substance Use Treatment and Recovery. Using national evaluation criteria developed with input from medical experts, the Blue Distinction Centers offer comprehensive care delivered by multidisciplinary teams with subspecialty training and distinguished clinical expertise. Providers demonstrate quality care, treatment expertise and better overall patient results.

We cover specialty care at designated Blue Distinction Centers at Preferred benefit levels. See pages 89-90 for information regarding enhanced inpatient and outpatient benefits for bariatric, spine, knee and hip surgeries performed at a Blue Distinction Center. We also provide enhanced benefits for covered transplant services performed at the Blue Distinction Centers for Transplant designated centers as described on pages 78-79.

For listings of Blue Distinction Centers, visit https://www.bcbs.com/blue-distinction-center/facility; access our National Doctor & Hospital Finder via www.fepblue.org/provider/; or call us at the customer service telephone number listed on the back of your ID card.

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 telephone 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 73).

Skilled Nursing Facility (SNF)

A SNF is a freestanding institution or a distinct part of a hospital which customarily bills insurance as a skilled nursing facility and meets the following criteria:

- Is Medicare-certified as a skilled nursing facility;
- Is licensed in accordance with state or local law or is approved by the state or local licensing agency as meeting the licensing standards (where state or local law provides for the licensing of such facilities);
- Has a transfer agreement in effect with one or more Preferred hospitals; and
- Is primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care; or rehabilitation services for the rehabilitation of injured, disabled or sick persons.

To be covered, skilled nursing facility care cannot be maintenance or custodial care. The term skilled nursing facility does not include any institution that is primarily for the care and treatment of mental diseases.

Note: Additional criteria apply when Medicare Part A is not the primary payor (see page 91).

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.

Exceptions:

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 telephone 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 may require precertification and prior approval. If you do not obtain precertification, there may be a reduction or denial of benefits. Be sure to read all of the precertification and prior approval information below and on pages 22-26.

- **Inpatient hospital admission, inpatient residential treatment center admission, or skilled nursing facility admission**

Precertification is the process by which – prior to your inpatient 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, inpatient residential treatment center, or skilled nursing facility whether or not they have contacted us and provided all necessary information. You may contact us at the telephone number on the back of your ID card to ask if we have received the request for precertification. You are also responsible for enrolling in case management and working with your case manager if your care involves residential treatment or a skilled nursing facility. For information about precertification of an emergency inpatient hospital admission, please see page 26.

Warning: We will reduce our benefits for the inpatient hospital stay by $500, even if you have obtained prior approval for the service or procedure being performed during the stay, 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: If precertification was not obtained prior to admission, inpatient benefits (such as room and board) are not available for inpatient care at a residential treatment center, or, when Medicare Part A is not the primary payor, at a skilled nursing facility. 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; with the exception of admissions for gender reassignment surgery and admissions to residential treatment centers, and skilled nursing facilities.
- You have another group health insurance policy that is the primary payor for the hospital stay; with the exception of admissions for gender reassignment surgery. (See page 79 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)
- Medicare Part A is the primary payor for the hospital or skilled nursing facility stay; with the exception of admissions for gender reassignment surgery. (See page 79 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 68-69 in order for benefits to be provided for the admission and surgical procedure.

- **Other services**

You must obtain prior approval for these services under both Standard and Basic Option. Precertification is also required if the service or procedure requires an inpatient hospital admission. All gender reassignment surgeries require prior approval; if inpatient admission is necessary, precertification is also required. Contact us using the customer service telephone 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:

- **Gene therapy and cellular immunotherapy, for example CAR-T and T-Cell receptor therapy**
- **Air Ambulance Transport (non-emergent)** – Air ambulance transport related to immediate care of a medical emergency or accidental injury does not require prior approval; see Section 5 (c), page 95, for more information.
- **Outpatient sleep studies performed outside the home** – Prior approval is required for sleep studies performed in a provider's office, sleep center, clinic, outpatient center, hospital, skilled nursing facility, residential treatment center and any other location that is not your home.
- **Applied behavior analysis (ABA)** – Prior approval is required for ABA and all related services, including assessments, evaluations, and treatments.
- **Gender reassignment surgery –** Prior to surgical treatment of gender dysphoria, your provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and your provider later modifies the plan.
- **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.

  Note: You must receive genetic counseling and evaluation services before preventive BRCA testing is performed. See page 44.
- **Surgical services** – The surgical services on the following list 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 page 68-69.
  - Outpatient surgical correction of congenital anomalies (see definition on page 157);
  - Outpatient surgery needed to correct accidental injuries (see definition on page 156) to jaws, cheeks, lips, tongue, roof and floor of mouth; and
  - Gender reassignment surgery.
- **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 93 for information about the exception to this requirement.

- **Organ/tissue transplants** – See page 72 for the list of covered organ/tissue transplants. **Prior approval is required** for both the procedure and the facility. Contact us at the customer service telephone 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 pages 73-74 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. Contact your local Plan for Medicare's approved transplant programs.

  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 telephone number listed on the back of your ID card.

  The blood or marrow stem cell transplants listed on pages 74-76 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 77** must be performed at a FACT-accredited facility. See page 19 for more information about these types of facilities.

  Not every transplant program 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 telephone number listed 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 76-77 for the list of conditions covered **only** in clinical trials. Contact us at the customer service telephone 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.

  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 Blue Distinction Center for Transplants to treat your condition. If your physician has recommended you receive a transplant or that you participate in a transplant clinical trial, we encourage you to contact the Case Management Department at your Local Plan.

  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 76) where the procedure is to be performed.
- **Transplant travel –** 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 companions. If the transplant recipient is age 21 or younger, we pay up to $10,000 for eligible travel costs for the member and companions. Reimbursement is subject to IRS regulations.

- **Prescription drugs and supplies – Certain prescription drugs and supplies require prior approval.** Contact CVS Caremark, our Pharmacy Program administrator, at 800-624-5060, TTY: 800-624-5077, 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 pages 109-110 for more information 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.

  Note: The Specialty Drug Pharmacy Program will not fill your prescription until you have obtained prior approval. AllianceRx Walgreens Prime, 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.
- **Medical foods covered under the pharmacy benefit require prior approval.** See Section 5 (f), page 112, for more information.

- **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 telephone 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 73-77) – 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 telephone number;
  - Reason for inpatient admission, proposed treatment, or surgery;
  - Name and telephone 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 90-91 and 103-104 for additional information.

Note: If we approve the request for prior approval or precertification, you will be provided with a notice that identifies the approved services and the authorization period. You must contact us with a request for a new approval five (5) business days prior to a change to the approved original request, and for requests for an extension beyond the approved authorization period in the notice you received. We will advise you of the information needed to review the request for change and/or extension.

- **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 or not 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 FEHB 1 at (202) 606-0727 between 8 a.m. and 5 p.m. Eastern Time (excluding holidays) 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, 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* below.

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, your physician or the hospital must contact us for precertification of additional days. Further, if your newborn stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your newborn.

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. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **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, 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 on the next page. Note that these procedures apply to requests for reconsideration of concurrent care claims as well (see page 156 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 verbal 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.

- **The Federal Flexible Spending Account Program – FSAFEDS**

  Health Care FSA (HCFSA) – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, 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).

  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 4. Your Costs for Covered Services

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

Cost-share/Cost-sharing

Cost-share or 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 84). 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 86).

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. See Section 5(i) for information about the deductible and overseas benefits.

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 or not 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 telephone 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 20 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**

  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 20 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 telephone 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 160-162). 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 20 for the exceptions to this requirement.

The following tables 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 39; see page 84 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 telephone 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 20 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 inpatient facility care you receive overseas, we provide benefits in full for admissions to a Department of Defense (DoD) facility, or when the Overseas Assistance Center (provided by GMMI, Inc.) has arranged direct billing or acceptance of a guarantee of benefits with the facility. If a direct billing arrangement or guarantee of benefits is not accepted by the facility, you are responsible for the applicable copayment or coinsurance. For outpatient 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 20 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 healthcare 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 29-30;
- 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 20 for the exceptions to the requirement to use Preferred providers.

If your provider's prescription allows for generic substitution and you select a brand-name drug, your expenses for the difference in cost-share do not count toward your catastrophic protection out-of-pocket maximum (see page 106 for additional information).

Carryover

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 above) from that point until the effective date of your new plan.

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

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.

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.

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 contract holder.

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. Benefits

See page 15 for how our benefits changed this year. Pages 166-169 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.

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Standard and Basic Option Overview

The benefit package for Standard and Basic Options are described in Section 5, which is divided into subsections 5(a) through 5(i). Make sure that you review the benefits that are available under the option in which you are enrolled.

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 Retail Pharmacy Program, a Mail Service Prescription Drug Program, and a 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 Retail Pharmacy Program and a 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 Healthcare 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 Get Care*, for information on covered professional providers and other healthcare 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 healthcare 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 or facility bills for the service.
- The services listed in this Section are for the charges billed by a physician or other healthcare 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.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 117 for information about Tier 4 and Tier 5 specialty drug fills from Preferred providers and Preferred pharmacies. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731. Basic Option members must use Preferred providers and Preferred pharmacies (see page 119).
- We waive the cost-share for the first 2 visits for telehealth per calendar year. This applies to a combined total for treatment of minor acute conditions, dermatology care, and mental health and substance use disorder conditions. (See pages 39 and 102.)
- **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 20 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 healthcare 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 40-42 for our coverage of laboratory, X-ray, and other diagnostic tests billed for by a healthcare professional, and to page 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 healthcare 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 healthcare 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 156 for more information about "agents.") Participating/Non-participating: You pay all charges
Telehealth professional services for: • Minor acute conditions (see page 159 for definition) • Dermatology care (see page 163 for definition) Note: Refer to Section 5(h), *Wellness and Other Special Features*, for information on telehealth services and how to access a provider. Note: Benefits are combined with telehealth services listed in Section 5(e), see page 102.	Preferred Telehealth Provider: Nothing (no deductible) for the first 2 visits per calendar year for any covered telehealth service $10 copayment per visit (no deductible) after the 2nd visit Participating/Non-participating: You pay all charges	Preferred Telehealth Provider: Nothing for the first 2 visits per calendar year for any covered telehealth service $15 copayment per visit after the 2nd visit 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	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

Benefit Description	You Pay	
Diagnostic and Treatment Services (cont.)	**Standard Option**	**Basic Option**
• 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	See previous page	See previous page
Not covered: • *Routine services except for those Preventive care services described on pages 42-49* • *Telephone consultations and online medical evaluation and management services except as shown in Section 5(a) page 39 and Section 5(e) page 102* • *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	**Standard Option**	**Basic Option**
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 156 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

Benefit Description	You Pay	
Lab, X-ray and Other Diagnostic Tests (cont.)	**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 156 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 page 44 in this Section for coverage of genetic counseling and testing services related to family history of cancer or other disease.	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 for bone density tests, CT scans/MRIs/PET scans, angiographies, genetic testing, nuclear medicine, and sleep studies performed outside the home Preferred: $40 copayment for sleep studies performed at home Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 156 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.

Lab, X-ray and Other Diagnostic Tests - continued on next page

Benefit Description	You Pay	
Lab, X-ray and Other Diagnostic Tests (cont.)	**Standard Option**	**Basic Option**
• Nuclear medicine • Sleep studies Note: Prior approval is required for sleep studies performed in a location other than the home. Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.	See previous page	See previous page
Preventive Care, Adult	**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). Covered services include: • Visits/exams for preventive care Note: See the definition of Preventive Care, Adult, on page 162 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 use disorder Note: See pages 64 and 113 for our coverage of smoking, tobacco, and E-cigarette cessation treatment. • Screening for chlamydial infection • Screening for gonorrhea infection • Screening for human immunodeficiency virus (HIV) infection • Screening for syphilis infection	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

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
• Screening for latent tuberculosis 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.	See previous page	See previous page
• 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 - DNA analysis of stool samples • Prostate cancer tests – Prostate Specific Antigen (PSA) test • Cervical cancer screening tests - Pap tests of the cervix - Human papillomavirus (HPV) tests of the cervix • Screening mammograms, including mammography using digital technology 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 ages 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 Note: Benefits are limited to individual nutritional counseling services. We do not provide benefits for group counseling services. Note: When nutritional counseling is via the contracted telehealth provider network, we provide benefits as shown here for Preferred providers. Refer to Section 5(h), *Wellness and Other Special Features*, for information on how to access a telehealth provider.	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

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
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.	See previous page	See previous page
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 next page for members of Ashkenazi Jewish heritage): • Individual from a family with a known harmful mutation in BRCA1 and/or BRCA2 gene; or • Two first-degree female relatives with breast cancer, one of whom was diagnosed at age 50 or younger; or • A combination of three or more first- or second-degree female relatives with breast cancer regardless of age at diagnosis; or • 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

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
• 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 • A first-degree female relative with bilateral breast cancer; or • A combination of two or more first- or second-degree female relatives with ovarian cancer regardless of age at diagnosis; or • A history of pancreatic or prostate cancer diagnosed in a first- or second-degree relative; or • 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: • Individual from a family with a known harmful mutation in BRCA1 and/or BRCA2 gene; or • Any first-degree relative with breast or ovarian cancer; or • A history of pancreatic or prostate cancer diagnosed in a first- or second-degree relative; or • 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.	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

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
Immunizations limited to the following vaccines as licensed by the U.S. Food and Drug Administration (U.S. FDA): • 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 • Varicella Many Preferred retail pharmacies participate in our vaccine network. See page 114 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 115 for our payment levels for medications 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, Child*, this Section.) Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/	See above and pages 42-45	See above and pages 42-45

Preventive Care, Adult - continued on next page

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
HHS: www.healthcare.gov/preventive-care-benefits A complete list of women's preventive services can be found at www.healthcare.gov/preventive-care-women/ For additional information: www.healthfinder.gov/myhealthfinder/default.aspx	See pages 42-46	See pages 42-46
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* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure. Medical benefits may be available for these services.*	*All charges*	*All charges*
Preventive Care, Child	**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 as described in the Bright Future Guidelines provided by the American Academy of Pediatrics (AAP). 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)	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.	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.

Preventive Care, Child - continued on next page

Benefit Description	You Pay	
Preventive Care, Child (cont.)	**Standard Option**	**Basic Option**
• Immunizations as licensed by the U.S. Food and Drug Administration (U.S. FDA) limited to the following vaccines: - 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 vaccines to specific age ranges, frequencies, and/or other patient-specific indications, including gender. • Nutritional counseling Note: Benefits are limited to individual nutritional counseling services. We do not provide benefits for group counseling services. Note: When nutritional counseling is via the contracted telehealth provider network, we provide benefits as shown here for Preferred providers. Refer to Section 5(h), *Wellness and Other Special Features*, for information on how to access a telehealth provider. 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 • Cervical cancer screening tests - Pap tests of the cervix - Human papillomavirus (HPV) tests of the cervix • Screening for human immunodeficiency virus (HIV) infection • Screening for syphilis infection • Screening for latent tuberculosis infection for children ages 18 through 21 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.	Continued from previous page: 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.	Continued from previous page: 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.

Preventive Care, Child - continued on next page

Benefit Description	You Pay	
Preventive Care, Child (cont.)	**Standard Option**	**Basic Option**
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: See page 115 for our payment levels for medications to promote better health as recommended under the Affordable Care Act. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ A complete list of women's preventive services can be found at www.healthcare.gov/preventive-care-women/ HHS: www.healthcare.gov/preventive-care-benefits For additional information: www.healthfinder.gov/myhealthfinder/default.aspx Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines, go to www.brightfutures.aap.org/Pages/default.aspx	See previous page	See previous page
Maternity Care	**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 healthcare providers such as physicians, physician assistants, midwives, nurse practitioners/clinical specialists, and lactation consultants Note: See page 51 for our coverage of breast pump kits.	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	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 the notes on pages 84-88. 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

Benefit Description	You Pay	
Maternity Care (cont.)	**Standard Option**	**Basic Option**
• 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 (skilled) 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 115 for more information. See Section 5(f) for other prescription drug coverage. Note: Here are some things to keep in mind: • You do not need to precertify your delivery; see page 26 for other circumstances, such as extended stays for you or your newborn. • You may remain in the hospital up to 48 hours after a vaginal 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 when performed during the covered portion of the mother's maternity stay and billed by the facility. We cover other care of a newborn who requires professional services or non-routine treatment, only if we cover the newborn under a Self Plus One or Self and Family enrollment. Surgical benefits apply to circumcision when billed by a professional provider for a male newborn. • Hospital services are listed in Section 5(c) and Surgical benefits are in Section 5(b). Note: See page 160 for our payment for inpatient stays resulting from an emergency delivery at a hospital or other facility not contracted with your Local Plan. 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.	Continued from previous page: 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 telephone number on the back of your ID card to obtain information about your coverage and the Plan allowance for the services.	See previous page

Maternity Care - continued on next page

Benefit Description	You Pay	
Maternity Care (cont.)	**Standard Option**	**Basic Option**
• Breast pump kit, limited to one of the two kits listed below, per calendar year, for members 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 800-262-7890.	Nothing (no deductible)	Nothing
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 above on this page* • *Breastfeeding supplies other than those contained in the breast pump kit described above on this page 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 members not enrolled in the Service Benefit Plan*	*All charges*	*All charges*

Benefit Description	You Pay	
Family Planning	**Standard Option**	**Basic Option**
A range of voluntary family planning services for women, limited to: • Contraceptive counseling • Diaphragms and contraceptive rings • Injectable contraceptives • Intrauterine devices (IUDs) • Implantable contraceptives • Tubal ligation or tubal occlusion/tubal blocking procedures only Family planning services for men, limited to: • Vasectomy Note: We also provide benefits for professional services associated with tubal ligation/occlusion/blocking procedures, vasectomy, 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
• 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 113 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*

Benefit Description	You Pay	
Reproductive Services	**Standard Option**	**Basic Option**
Diagnosis and treatment of infertility including covered: • Diagnostic and treatment services • Laboratory tests • Diagnostic tests • Surgical procedures • Prescription drugs Note: See Section 5(a) for covered labs, diagnostic tests, and X-rays. Note: See Section 5(b) for covered surgical services. Note: See Section 5(f) for covered prescription drugs. Note: See below for a list of services not covered as treatments for infertility or as alternatives to conventional conception.	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 healthcare 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 156 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.
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) and 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*

Benefit Description	You Pay	
Allergy Care	**Standard Option**	**Basic Option**
• Allergy testing • Allergy treatment • Sublingual allergy desensitization drugs as licensed by the U.S. FDA 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 healthcare 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 156 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 healthcare 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*

Benefit Description	You Pay	
Treatment Therapies	**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 21-24). • 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 22 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 • Pulmonary rehabilitation therapy • Applied behavior analysis (ABA) for the treatment of an autism spectrum disorder (see prior approval requirements on page 22) 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 healthcare 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 156 for more information about “agents.”) Participating/Non-participating: You pay all charges
• Auto-immune infusion medications: Remicade, Renflexis and Inflectra Note: See above for your costs for intravenous (IV)/ infusion therapy - Home IV or infusion therapy.	Preferred: 10% 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 billed amount	Preferred: 15% of the Plan allowance Member or Non-member: You pay all charges

Treatment Therapies - continued on next page

Benefit Description	You Pay	
Treatment Therapies (cont.)	**Standard Option**	**Basic Option**
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 21-24). • 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.) • Applied behavior analysis (ABA) for the treatment of an autism spectrum disorder (see prior approval requirements on page 22)	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 Rehabilitation Therapy	**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 healthcare 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.	Preferred primary care provider or other healthcare 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 156 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.

Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Rehabilitation Therapy - continued on next page

Benefit Description	You Pay	
Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Rehabilitation Therapy (cont.)	**Standard Option**	**Basic Option**
	Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown on page 56, according to the contracting status of the facility.	
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* • *Equine therapy and hippotherapy (exercise on horseback)* • *Massage therapy*	*All charges*	*All charges*
Hearing Services (Testing, Treatment, and Supplies)	**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 60.	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 healthcare 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 156 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 60)*	*All charges*	*All charges*
Vision Services (Testing, Treatment, and Supplies)	**Standard Option**	**Basic Option**
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;	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies)	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges

Vision Services (Testing, Treatment, and Supplies) - continued on next page

Benefit Description	You Pay	
Vision Services (Testing, Treatment, and Supplies) (cont.)	**Standard Option**	**Basic Option**
• For the nonsurgical treatment for amblyopia and strabismus, for children from birth through age 21 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 and on page 57.	Continued from previous page: Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	See previous page
• Eye examinations related to a specific medical condition • Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 21 Note: See above and on page 57 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 40-42 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 above.	Preferred primary care provider or other healthcare 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 healthcare 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 156 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 above and on page 57* • *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 above*	*All charges*	*All charges*

Benefit Description	You Pay	
Foot Care	**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 healthcare 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 healthcare 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 156 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	**Standard Option**	**Basic Option**
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 limited to treatment of erectile dysfunction or as part of an approved plan for gender reassignment surgery • Surgical implants 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

Benefit Description	You Pay	
Orthopedic and Prosthetic Devices (cont.)	**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, 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)*	*All charges*	*All charges*
Durable Medical Equipment (DME)	**Standard Option**	**Basic Option**
Durable medical equipment (DME) is equipment and supplies that are: 1. Prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Medically necessary; 3. Primarily and customarily used only for a medical purpose; 4. Generally useful only to a person with an illness or injury; 5. Designed for prolonged use; and 6. Used to 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	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.

Durable Medical Equipment (DME) - continued on next page

Benefit Description	You Pay	
Durable Medical Equipment (DME) (cont.)	**Standard Option**	**Basic Option**
• 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.	See previous page	See previous page
• 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
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 51* • *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 above)* • *Equipment for cosmetic purposes* • *Topical Hyperbaric Oxygen Therapy (THBO)*	*All charges*	*All charges*
Medical Supplies	**Standard Option**	**Basic Option**
• Medical foods and nutritional supplements when administered by catheter or nasogastric tubes Note: See Section 10, *Definitions*, for more information about medical foods. • Ostomy and catheter supplies	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

Medical Supplies - continued on next page

Benefit Description	You Pay	
Medical Supplies (cont.)	**Standard Option**	**Basic Option**
• 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.	See previous page	See previous page
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* • *Medical foods administered orally, except as described in Section 5(f)*	*All charges*	*All charges*
Home Health Services	**Standard Option**	**Basic Option**
Home nursing care (skilled) 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 156 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*	*All charges*	*All charges*

Home Health Services - continued on next page

Benefit Description	You Pay	
Home Health Services (cont.)	**Standard Option**	**Basic Option**
• *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 pages 91-92.* • *Private duty nursing*	*All charges*	*All charges*
Manipulative Treatment	**Standard Option**	**Basic Option**
Manipulative treatment performed by a professional provider, 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. 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: $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	**Standard Option**	**Basic Option**
Acupuncture Note: Acupuncture must be performed and billed by a healthcare 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 17 for more information. Note: When billed by a facility such as the outpatient department of a hospital, you are limited to the number of visits per calendar year listed on this page. See Section 5(c) for your cost-share. Note: See page 80 for our coverage of acupuncture when provided as anesthesia for covered surgery. Note: See page 49 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 healthcare 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

Alternative Treatments - continued on next page

Benefit Description	You Pay	
Alternative Treatments (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Biofeedback* • *Self-care or self-help training*	*All charges*	*All charges*
Educational Classes and Programs	**Standard Option**	**Basic Option**
• Smoking, tobacco, and E-cigarette cessation treatment - Individual counseling for smoking, tobacco, and E-cigarette cessation Note: Benefits are not available for group counseling. - Smoking, tobacco, and E-cigarette cessation classes Note: See Section 5(f) for our coverage of smoking, tobacco, and E-cigarette 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 40, 43 and 48 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 healthcare 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, or applied behavior analysis (ABA), when performed as part of an educational class or program* • *Premenstrual syndrome (PMS), lactation (except as described on page 49), headache, eating disorder (except as described on pages 40 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*	*All charges*	*All charges*

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare 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 healthcare 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 healthcare 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*, page 156) 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.**
- **YOU MUST GET PRIOR APPROVAL for gender reassignment surgery. Prior to any gender reassignment surgery, your provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and your provider later modifies the plan (including changes to the procedures to be performed or the anticipated dates for the procedures). See page 22 and page 67 for additional information. If your surgical procedure requires an inpatient admission, YOU MUST ALSO GET PRECERTIFICATION of the inpatient care.**
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 117 for information about Tier 4 and Tier 5 specialty drug fills from Preferred providers and Preferred pharmacies. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731. Basic Option members must use Preferred providers and Preferred pharmacies (see page 119).
- **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 20 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 • Assistant surgeons/surgical assistance if required because of the complexity of the surgical 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 70) • 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.	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 156 for more information about "agents.") Participating/Non-participating: You pay all charges

Surgical Procedures - continued on next page

Benefit Description	You Pay	
Surgical Procedures (cont.)	**Standard Option**	**Basic Option**
• **Gender reassignment surgical benefits** are limited to the following: - For female to male surgery: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty, electrolysis (hair removal at the covered operative site), and placement of testicular and erectile prosthesis - For male to female surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, labiaplasty, and electrolysis (hair removal at the covered operative site) **Note: Prior approval is required for gender reassignment surgery.** For more information about prior approval, please refer to page 22. Note: Benefits for gender reassignment surgery are limited to once per covered procedure, per lifetime. Benefits are not available for repeat or revision procedures when benefits were provided for the initial procedure. Benefits are not available for gender reassignment surgery for any condition other than gender dysphoria. • Gender reassignment surgery on an inpatient or outpatient basis is subject to the pre-surgical requirements listed below. **The member must meet all requirements**. - **Prior approval is obtained** - **Member must be at least 18 years of age at the time prior approval is requested and the treatment plan is submitted** - Diagnosis of gender dysphoria by a qualified healthcare professional • New gender identity has been present for at least 24 continuous months • Member has a strong desire to be rid of primary and/or secondary sex characteristics because of a marked incongruence with the member's identified gender • Member's gender dysphoria is not a symptom of another mental disorder or chromosomal abnormality • Gender dysphoria causes clinical distress or impairment in social, occupational, or other important areas of functioning - Member must meet the following criteria: • Living 12 months of continuous, full-time, real-life experience in the desired gender (including place of employment, family, social and community activities) • 12 months of continuous hormone therapy appropriate to the member's gender identity	See page 66	See page 66

Surgical Procedures - continued on next page

Benefit Description	You Pay	
Surgical Procedures (cont.)	**Standard Option**	**Basic Option**
• Two referral letters from qualified mental health professionals – one must be from a psychotherapist who has treated the member for a minimum of 12 months. Letters must document: diagnosis of persistent and chronic gender dysphoria; any existing co-morbid conditions are stable; member is prepared to undergo surgery and understands all practical aspects of the planned surgery • If medical or mental health concerns are present, they are being optimally managed and are reasonably well-controlled • **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. Benefits are available only for the following procedures: - Roux-en-Y - Gastric bypass - Laparoscopic adjustable gastric banding - Sleeve gastrectomy - Biliopancreatic bypass with duodenal switch **Note: Benefits for the surgical treatment of morbid obesity are subject to the requirements listed on pages 65-66.** 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 89-90 for information. 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 above) for a period of 1 year 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 pages 43 and 48 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	See page 66	See page 66

Surgical Procedures - continued on next page

Benefit Description	You Pay	
Surgical Procedures (cont.)	**Standard Option**	**Basic Option**
- 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 102 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 use disorder for 1 year prior to surgery and there is no evidence of substance use disorder 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, except when the subsequent surgery is necessary to treat a complication from the prior morbid obesity surgery. - 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	See page 66	See page 66
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*	*All charges*	*All charges*

Surgical Procedures - continued on next page

Benefit Description	You Pay	
Surgical Procedures (cont.)	**Standard Option**	**Basic Option**
• *LASIK, INTACS, radial keratotomy, and other refractive surgery* • *Surgeries related to sexual inadequacy (except surgical placement of penile prostheses to treat erectile dysfunction and gender reassignment surgeries specifically listed as covered)* • *Reversal of gender reassignment surgery*	*All charges*	*All charges*
Reconstructive Surgery	**Standard Option**	**Basic Option**
• Surgery to correct a functional defect • Surgery to correct a congenital anomaly (See Section 10, page 157, for definition.) • 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 156 for more information about "agents.") Participating/Non-participating: You pay all charges

Reconstructive Surgery - continued on next page

Benefit Description	You Pay	
Reconstructive Surgery (cont.)	**Standard Option**	**Basic Option**
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 sexual dysfunction or sexual inadequacy (except surgical placement of penile prostheses to treat erectile dysfunction and gender reassignment surgeries specifically listed as covered)* • *Reversal of gender reassignment surgery*	*All charges*	*All charges*
Oral and Maxillofacial Surgery	**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 telephone 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 156 for more information about "agents.") Participating/Non-participating: You pay all charges

Oral and Maxillofacial Surgery - continued on next page

Benefit Description	You Pay	
Oral and Maxillofacial Surgery (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Oral implants and transplants except for those required to treat accidental injuries as specifically described on page 71 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 on page 71 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 on page 71 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 on page 71 and in Section 5(g)*	*All charges*	*All charges*

Organ/Tissue Transplants

Prior approval requirements:

You must obtain prior approval (see page 23) 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: Pages 76-77 have **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 21-22 for information about precertification of inpatient care.

Covered organ/tissue transplants are listed on pages 73-74. 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. Contact your local Plan for Medicare's approved transplant programs.

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 telephone number on the back of your ID card.

Blood or marrow stem cell transplants are covered as shown on pages 74-78. 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 74-78, the medical necessity limitation is considered satisfied if the patient meets the staging description.

The blood or marrow stem cell transplants listed on pages 74-76 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 77** must be performed at a FACT-accredited facility. See page 19 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 telephone number listed 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 74-75 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 76-77 for information about **blood or marrow stem cell transplants covered only in clinical trials** and the **additional requirements** that apply.

Note: See pages 147-148 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 79 for more information).

Benefit Description	You Pay	
Organ/Tissue Transplants	**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	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.

Organ/Tissue Transplants - continued on next page

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
• 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 pages 72-73 for the prior approval and facility requirements that apply to **organ/tissue transplants**.	See previous page	Continued from previous page: 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 for the diagnoses as indicated below: • 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, Hurler's syndrome and Maroteaux-Lamy syndrome variants) • 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)	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

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
• Primary immunodeficiencies (e.g., severe combined immunodeficiency, Wiskott-Aldrich syndrome, hemophagocytic lymphohistiocytosis, X-linked lymphoproliferative syndrome, Kostmann's syndrome, leukocyte adhesion deficiencies) Note: See pages 72-73 for the prior approval and facility requirements that apply to **blood or marrow stem cell transplants**. Note: Refer to pages 76-78 for information about **blood or marrow stem cell transplants covered only in clinical trials**.	See previous page	See previous page
Autologous blood or marrow stem cell transplants for the diagnoses as indicated below: • 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) • Scleroderma Note: See pages 72-73 for the prior approval and facility requirements that apply to **blood or marrow stem cell transplants.** Note: Refer to pages 76-78 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

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
Blood or marrow stem cell transplants for the diagnoses as indicated below, **only** when performed as part of a clinical trial that meets the facility criteria described on page 72 and the **requirements** listed on page 77: • Allogeneic blood or marrow stem cell transplants for: - Breast cancer - Colon cancer - Epidermolysis bullosa - Glial tumors (e.g., anaplastic astrocytoma, choroid plexus tumors, ependymoma, glioblastoma multiforme) - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Retinoblastoma - Rhabdomyosarcoma - Sarcoma - Wilm's tumor • Autologous blood or marrow stem cell transplants for: - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - 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 77 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

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
Blood or marrow stem cell transplants for the diagnoses as indicated below, **only** when performed at a FACT-accredited facility (see page 19) as part of a **clinical trial** that meets the **requirements** listed below: • Allogeneic blood or marrow stem cell transplants for: - Autoimmune disease (limited to: multiple sclerosis, scleroderma, systemic lupus erythematosus and chronic inflammatory demyelinating polyneuropathy) • Autologous blood or marrow stem cell transplants for: - Autoimmune disease (limited to: multiple sclerosis, systemic lupus erythematosus and 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 telephone 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 76, 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.	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

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
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 pages 147-148 for our coverage of other costs associated with clinical trials.	See previous page	See previous page
Related transplant services: • Extraction or reinfusion of blood or marrow stem cells as part of a covered allogeneic or autologous 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 74-77 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 74-77 • Covered medical and hospital expenses of the donor, when we cover the recipient • Covered 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 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 163 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 telephone 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 74-77
- Related transplant services listed on page 78

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 companions. If the transplant recipient is age 21 or younger, we pay up to $10,000 for eligible travel costs for the member and companions. Reimbursement is subject to IRS regulations.

Note: You must obtain prior approval for travel benefits (see page 24).

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 pages 73-74 for benefit information for these transplants.

Note: See Section 5(c) for our benefits for facility care.

Note: See pages 73-79 for requirements related to blood or marrow stem cell transplant coverage.

Benefit Description	You Pay	
Organ/Tissue Transplants	**Standard Option**	**Basic Option**
Not covered: • *Any transplant not listed as covered and transplants for any diagnosis not listed as covered* • *Donor screening tests and donor search expenses, including associated travel expenses, except as defined on page 78* • *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 pages 73-74* • *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*

Benefit Description	You Pay	
Anesthesia	**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: Anesthesia acupuncture services do not accumulate toward the member's annual maximum. 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 AND SKILLED NURSING FACILITY 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 85. See page 159 for more information about these types of services.
- **YOU MUST GET PRIOR APPROVAL for the following services if they are to be performed on an outpatient basis: sleep studies performed outside the home, surgery for morbid obesity; surgical correction of congenital anomalies; and outpatient surgery needed to correct accidental injuries (see *Definitions*, page 156) to jaws, cheeks, lips, tongue, roof and floor of mouth. Please refer to page 22 for more information.**
- **YOU MUST GET PRIOR APPROVAL for gender reassignment surgery. See page 22 for prior approval and pages 67-68 for the surgical benefit.**
- 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 healthcare 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 or facility bills for the service.
- 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.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 117 for information about Tier 4 and Tier 5 specialty drug fills from Preferred providers and Preferred pharmacies. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731. Basic Option members must use Preferred providers and Preferred pharmacies (see page 119).
- **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 20 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 pages 159-161 for more information. See pages 90-91 and 103-104 for inpatient residential treatment center. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • 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 159 for more information about these types of services.	Preferred facilities: $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 facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: $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 facilities: $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 facilities: You pay all charges

Inpatient Hospital - continued on next page

Benefit Description	You Pay	
Inpatient Hospital (cont.)	**Standard Option**	**Basic Option**
Note: Here are some things to keep in mind: • You do not need to precertify your delivery; see page 26 for other circumstances, such as extended stays for you or your newborn. • 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 page 26 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 49-51 for other covered maternity services. Note: See page 62 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 pages 89-90 for information.	See previous page	See previous page
Not covered: • *Admission to non-covered facilities, such as nursing homes, extended care facilities, schools, or residential treatment centers (except as described on pages 90-91 and 103-104)* • *Personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services* • *Private duty nursing* • *Facility room and board expenses when, in our judgment, an 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* • *Care that is 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.*	*All charges*	*All charges*

Inpatient Hospital - continued on next page

Benefit Description	You Pay	
Inpatient Hospital (cont.)	**Standard Option**	**Basic Option**
- *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 an inpatient 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 18-19).*	*All charges*	*All charges*
Outpatient Hospital or Ambulatory Surgical Center	**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 • Acupuncture • 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 pages 43-44). 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	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 facilities: $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 156 for more information about "agents.") Member/Non-member facilities: You pay all charges

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**Standard Option**	**Basic Option**
• Other medical supplies, including oxygen • Surgical implants Notes: • See pages 98-100 for our payment levels for care related to a medical emergency or accidental injury. • See page 52 for our coverage of family planning services. • For our coverage of hospital-based clinic visits, please refer to the professional benefits described on pages 39-40 and page 58 for vision services. • 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 89-90 for information. • 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 49-51 for other included maternity services. • See page 88 for outpatient drugs, medical devices, and durable medical equipment billed for by a facility. • 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.	See previous page	See previous page
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 82-84 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 facilities: $350 copayment for the duration of services (no deductible) Member facilities: $450 copayment for the duration of services, plus 35% of the Plan allowance (no deductible) Non-member facilities: $450 copayment for the duration of services, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred facilities: $175 per day copayment up to $875 Member/Non-member facilities: You pay all charges

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**Standard Option**	**Basic Option**
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 Note: Prior approval is required for sleep studies performed in a location other than your home.	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 facilities: $150 copayment per day per facility Member facilities: $150 copayment per day per facility Non-member facilities: $150 copayment per day per facility, plus any difference between our allowance and the billed amount Note: For unattended sleep studies and for sleep studies performed in the home, you pay a $40 cost share. Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 156 for more information about “agents.”)
Outpatient **diagnostic testing services** performed and billed by a facility, such as: • 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 facilities: $40 copayment per day per facility Member facilities: $40 copayment per day per facility Non-member facilities: $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 156 for more information about “agents.”)

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**Standard Option**	**Basic Option**
Outpatient **treatment and therapy services** performed and billed by a facility, limited to: • Cognitive rehabilitation therapy • Physical, occupational, and speech therapy - Standard Option benefits are limited to a combined total of 75 visits per person per calendar year - Basic Option benefits are limited to a combined total of 50 visits per person per calendar year • Manipulative treatment services - Standard Option benefits are limited to a combined total of 12 visits per person per calendar year - Basic Option benefits are limited to a combined total of 20 visits per person per calendar year	Preferred facilities: $25 copayment per day per facility (no deductible) 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 facilities: $30 copayment per day per facility Member/Non-member facilities: You pay all charges Note: You pay 30% of the Plan allowance for supplies or drugs administered or obtained in connection with your care.
Outpatient **treatment services** performed and billed by a facility, limited to: • Cardiac rehabilitation • Pulmonary rehabilitation • Applied behavior analysis (ABA) for an autism spectrum disorder (see prior approval requirements on page 22)	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 facilities: $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 156 for more information about “agents.”) Member/Non-member facilities: You pay all charges

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**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 facilities: Nothing Member facilities: Nothing Non-member facilities: 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 156 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 pages 47-48 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 facilities: Nothing Member/Non-member facilities: 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 • Surgical implants 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. Note: Certain self-injectable drugs are covered only when dispensed by a pharmacy under the pharmacy benefit. These drugs will be covered once per lifetime per therapeutic category of drugs when dispensed by a non-pharmacy-benefit provider. This benefit limitation does not apply if you have primary Medicare Part B coverage.	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 facilities: 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 84-87 for specific coverage information. Member/Non-member facilities: You pay all charges

Benefit Description	You Pay	
Blue Distinction® Specialty Care	**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 Knee and Hip Replacement, Blue Distinction Center for Spine Surgery, or Blue Distinction Center for Comprehensive Bariatric Surgery. • Bariatric surgeries covered are: - Roux-en-Y - Gastric bypass - Laparoscopic adjustable gastric banding - Sleeve gastrectomy - Biliopancreatic bypass with duodenal switch • 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 telephone 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 81-83 for regular inpatient hospital benefits and pages 84-88 for outpatient facility benefit levels. Note: See pages 18-19 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 specific covered bariatric surgical procedures, when the surgery is performed at a designated Blue Distinction Center for Bariatric Surgery. Outpatient facility services related to specific covered hip and knee replacement or revision surgeries and certain spine surgery procedures, when performed at a designated Blue Distinction Center for hip/knee/spine surgery.	Blue Distinction Center: $100 per day per facility (no deductible)	Blue Distinction Center: $25 per day per facility

Blue Distinction® Specialty Care - continued on next page

Benefit Description	You Pay	
Blue Distinction® Specialty Care (cont.)	**Standard Option**	**Basic Option**
Note: You must meet the pre-surgical requirements listed on pages 68-69 for bariatric surgeries. Note: 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 telephone 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 benefits do not apply to other types of outpatient surgical services, even when performed at a Blue Distinction Center. See pages 84-85 for the benefits we provide. Note: See pages 18-19 for more information about Blue Distinction Centers.	Blue Distinction Center: $100 per day per facility (no deductible)	Blue Distinction Center: $25 per day per facility
Residential Treatment Center	**Standard Option**	**Basic Option**
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 use disorder: • 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.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: 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 facilities: $175 per day copayment up to $875 per admission for unlimited days Member/Non-member facilities: You pay all charges

Residential Treatment Center - continued on next page

Benefit Description	You Pay	
Residential Treatment Center (cont.)	**Standard Option**	**Basic Option**
Note: Benefits are not available for non-covered services, including: respite care; outdoor residential programs; services provided outside of the provider's scope of licensure; recreational therapy; educational therapy; educational classes; biofeedback; Outward Bound programs; equine/hippotherapy 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. Note: For outpatient residential treatment center services, see page 104.	See previous page	See previous page
Extended Care Benefits/Skilled Nursing Care Facility Benefits	**Standard Option**	**Basic Option**
When Medicare Part A is not your primary payor: For members who do not have Medicare Part A, we cover skilled nursing facility (SNF) inpatient care for a maximum of 30 days annually, when the member can be expected to benefit from short-term SNF services with a goal of returning home. The following criteria must also be met: • Member is enrolled in case management prior to admission to the SNF (signed consent required), and actively participates in case management both prior to and during admission to the SNF. • Precertification is obtained prior to admission (including overseas care). • We approve the preliminary treatment plan prior to admission (plan must include proposed therapies and document the need for inpatient care). • Member participates in all treatment and care planning activities, including discharge planning/transition to home. Benefits are not available for inpatient SNF care solely for management of tube feedings, for home level dialysis treatment, as an interim transition to long term care placement, or for any other non-covered services. Note: No inpatient benefits (such as room and board) will be provided if precertification is not obtained prior to admission (see page 21). Members are responsible for enrolling in case management (see page 21).	Preferred facilities: $175 (no deductible) per admission Member facilities: $275 plus 35% of the Plan allowance (no deductible) per admission Non-member facilities: $275 plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment, per admission	All charges

Extended Care Benefits/Skilled Nursing Care Facility Benefits - continued on next page

Benefit Description	You Pay	
Extended Care Benefits/Skilled Nursing Care Facility Benefits (cont.)	**Standard Option**	**Basic Option**
When Medicare Part A is your primary payor: When Medicare Part A is the primary payor (meaning it pays first) and has made a 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. Note: See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c03.pdf for complete Medicare benefit period definition. 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 87 for benefits provided for outpatient physical, occupational, speech, and cognitive rehabilitation therapy, and manipulative treatment services when billed by a skilled nursing facility. See Section 5(f) for benefits for prescription drugs. ***Note: If Medicare Part A is your primary payor, we will only provide benefits if Medicare provided benefits for the admission.***	Preferred facilities: Nothing (no deductible) Member facilities: Nothing (no deductible) Non-member facilities: Nothing (no deductible) Note: You pay all charges not paid by Medicare after the 30th day.	All charges
Not covered: *Telephone, television, personal comfort items, such as guest meals and beds, beauty and barber services, recreational outings/trips, stretcher or wheelchair transportation, non-emergent 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, custodial or long term care (see* Definitions*), and domiciliary care provided because care in the home is not available or is unsuitable*	*All charges*	*All charges*
Hospice Care	**Standard Option**	**Basic Option**
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 pages 93-95	See pages 93-95

Hospice Care - continued on next page

Benefit Description	You Pay	
Hospice Care (cont.)	**Standard Option**	**Basic Option**
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
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 page 22 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 on this page and on pages 94-95. **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: • Advanced care planning (see Section 10, page 156) • Dietary counseling • Durable medical equipment rental • Medical social services • Medical supplies • Nursing care	See next page	See next page

Hospice Care - continued on next page

Benefit Description	You Pay	
Hospice Care (cont.)	**Standard Option**	**Basic Option**
• Oxygen therapy • Periodic physician visits • Physical therapy, occupational therapy, and speech therapy related to the terminal medical condition • Prescription drugs and medications • Services of home health aides (certified or licensed, if the state requires it, and provided by the home hospice agency)	See below	See below
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. An episode of care is one home hospice treatment plan per calendar year. See page 93 for prior approval requirements.	Preferred facilities: Nothing (no deductible) Member/Non-member facilities: $450 copayment per episode (no deductible)	Preferred facilities: Nothing Member/Non-member facilities: You pay all charges
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 93). An episode consists of up to seven consecutive days of continuous care. The member must be enrolled in a home hospice program in order to receive benefits for subsequent continuous home hospice care, and the services must be provided by the home hospice program in which the member is enrolled.	Preferred facilities: Nothing (no deductible) Member facilities: $450 per episode copayment (no deductible) Non-member facilities: $450 per episode copayment, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred facilities: Nothing Member/Non-member facilities: 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 30 consecutive days in a facility licensed as an inpatient hospice facility. 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 facilities: Nothing (no deductible) Member facilities: $450 per admission copayment, plus 35% of the Plan allowance (no deductible) Non-member facilities: $450 per admission copayment, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred facilities: Nothing Member/Non-member facilities: You pay all charges

Hospice Care - continued on next page

Benefit Description	You Pay	
Hospice Care (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Advanced care planning, except when provided as part of a covered hospice care treatment plan (see page 93)* • *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	**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. Note: Prior approval is required for all non-emergent air ambulance transport.	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 the Overseas Assistance Center (provided by GMMI, Inc.) by calling the center collect at 804-673-1678. See page 133 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 $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*	*All charges*	*All charges*

Ambulance - continued on next page

Benefit Description	You Pay	
Ambulance (cont.)	**Standard Option**	**Basic Option**
• *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 member, the health of the member and their 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: Nothing (no deductible)	Preferred emergency room: $125 copayment per day per facility Member emergency room: $125 copayment per day per facility Non-member emergency room: $125 copayment per day per facility 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 and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider	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

Benefit Description	You Pay	
Accidental Injury (cont.)	**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 on page 98 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	**Standard Option**	**Basic Option**
• **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)	Preferred emergency room: $125 copayment per day per facility Member emergency room: $125 copayment per day per facility Non-member emergency room: $125 copayment per day per facility 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.

Medical Emergency - continued on next page

Benefit Description	You Pay	
Medical Emergency (cont.)	**Standard Option**	**Basic Option**
		Note: All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.
• Urgent care center services and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider Note: Benefits for crutches, splints, braces, etc. when billed by a provider other than the urgent care center are stated in Section 5(a), pages 60-61.	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 98-99 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	**Standard Option**	**Basic Option**
See pages 95-96 for complete ambulance benefit and coverage information.		

Section 5(e). Mental Health and Substance Use Disorder 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 an acute 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 page 131. 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 healthcare 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.
- Every year, we conduct an analysis of the financial requirements and treatment limitations which apply to this Plan's mental health and substance use disorder benefits in compliance with the federal Mental Health Parity and Addiction Equity Act (the Act), and the Act's implementing regulations. Based on the results of this analysis, we may suggest changes to program benefits to OPM. More information on the Act is available on the following Federal Government websites:
  https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html
  https://www.dol.gov/ebsa/mentalhealthparity/
  www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL OR RESIDENTIAL TREATMENT CENTER STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY**. 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 use disorder 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 20 for the exceptions to this requirement.**
  - There is **no calendar year deductible.**
- You should be aware that some PPO inpatient facilities may have non-PPO professional providers on staff; see exceptions on page 20.

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 use disorder 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 use disorder 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 use disorder telephone number on the back of your ID card. Note: See pages 64 and 120 for our coverage of smoking, tobacco, and E-cigarette cessation treatment. Note: See page 50 for our coverage of mental health visits to treat postpartum depression and depression during pregnancy. Note: We cover outpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers at the levels shown here.	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
Telehealth professional services for: • Behavioral health counseling • Substance use disorder counseling Note: Refer to Section 5(h), *Wellness and Other Special Features*, for information on telehealth services and how to access our telehealth provider network. Note: Benefits are combined with telehealth services listed in Section 5(a), page 39.	Preferred Telehealth provider: Nothing (no deductible) for the first 2 visits per calendar year for any covered telehealth service $10 copayment per visit (no deductible) after the 2nd visit Participating/Non-participating: You pay all charges	Preferred Telehealth provider: Nothing for the first 2 visits per calendar year for any covered telehealth service $15 copayment per visit after the 2nd visit Participating/Non-participating: You pay all charges

Professional Services - continued on next page

Benefit Description	You Pay	
Professional Services (cont.)	**Standard Option**	**Basic Option**
• 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	**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 use disorder includes room and board and ancillary charges for confinements in a hospital/treatment facility for rehabilitative treatment of alcoholism or substance use disorder. Note: You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: 35% of the Plan allowance for unlimited days (no deductible), and any remaining balance after our payment	Preferred facilities: $175 per day copayment up to $875 per admission for unlimited days Member/Non-member facilities: You pay all charges
Residential Treatment Center	**Standard Option**	**Basic Option**
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.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible)	Preferred facilities: $175 per day copayment up to $875 per admission for unlimited days Member/Non-member facilities: You pay all charges

Residential Treatment Center - continued on next page

Benefit Description	You Pay	
Residential Treatment Center (cont.)	**Standard Option**	**Basic Option**
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 use disorder: • 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 102 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; biofeedback; Outward Bound programs; hippotherapy/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*, page 157); and domiciliary care provided because care in the home is not available or is unsuitable. Note: For outpatient residential treatment center services, see the next Section.	Non-member facilities: 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.	See previous page
Outpatient Hospital or Other Covered Facility	**Standard Option**	**Basic Option**
Outpatient services provided and billed by a covered facility Note: We cover outpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers at the levels shown here. • 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 Hospital or Other Covered Facility - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Other Covered Facility (cont.)	**Standard Option**	**Basic Option**
Outpatient services provided and billed by a covered facility • Diagnostic tests • Psychological testing Note: A residential treatment center is a covered facility for outpatient care (see Section 10, Definitions, for more information). We cover inpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers, other than room and board and inpatient physician care, at the levels shown here.	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)	**Standard Option**	**Basic Option**
• *Marital, family, educational, or other counseling or training services* • *Services performed by a non-covered provider* • *Testing for and treatment of learning disabilities and intellectual disability* • *Inpatient services performed or billed by residential treatment centers, except as described on pages 90-91 and 103-104* • *Services performed or billed by schools, halfway houses, group homes or members of their staffs* *Note: We cover professional services as described on pages 102-103 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.)* • *Hippotherapy/equine therapy (exercise on horseback)* • *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 111.
- If there is no generic drug available, you must pay the brand-name cost-sharing amount when you receive a brand-name drug.
- If there is a generic substitution available and you or your provider requests a brand-name drug, you will be responsible for the applicable tier cost-share plus the difference in the cost of the brand-name and generic drug. If the provider's prescription is for the brand-name drug and indicates "dispense as written," you are responsible only for the applicable tier cost-share.
- 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.
- Benefits for certain self-injectable (self-administered) drugs are provided only when they are dispensed by a pharmacy under the pharmacy benefit. See pages 117-118 for Tier 4 and Tier 5 specialty drug fills from a Preferred pharmacy.
- Benefits for certain auto-immune infusion medications (limited to Remicade, Renflexis and Inflectra) are covered only when they are obtained by a non-pharmacy provider, such as a physician or facility (hospital or ambulatory surgical center). See *Drugs From Other Sources* in this section, pages 122-123, for more 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.
- Medication prices vary among different retail pharmacies, the Mail Service Prescription Drug Program, and the Specialty Drug Pharmacy Program. **Review purchasing options for your prescriptions to get the best price.** A drug cost tool is available at www.fepblue.org or call:
  - **Retail Pharmacy Program: 800-624-5060, TTY: 800-624-5077**
  - **Mail Service Prescription Drug Program: 800-262-7890, TTY: 800-216-5343**
  - **Specialty Drug Pharmacy Program: 888-346-3731, TTY: 877-853-9549**
- **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 pages 109-110 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 or biosimilar becomes available or if new safety concerns arise. If your drug is moved to a higher tier, your cost-share will increase. See pages 117-119 for the amounts members pay for Preferred retail, mail service, and specialty drug purchases. If your drug is moved to non-covered, you pay the full cost of the medication. Tier reassignments during the year are not considered benefit changes.
- A pharmacy restriction may be applied for clinically inappropriate use of prescription drugs and supplies.
- The Standard Option and Basic Option formularies both contain a comprehensive list of drugs under all therapeutic categories with two exceptions: some drugs, nutritional supplements and supplies are not covered (see pages 121-122); we may also exclude certain U.S. FDA-approved drugs when multiple generic equivalents/alternative medications are available. See pages 107 and 108 for details.

- **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.
  - There is no calendar year deductible for 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 retail pharmacies or the Specialty Drug Pharmacy Program in order to receive benefits.** Our specialty drug pharmacy is a Preferred pharmacy.
  - The Mail Service Prescription Drug Program is available only to members with primary Medicare Part B coverage.
  - There is **no calendar year deductible.**
  - We use a managed formulary for certain drug classes.

We will send each new enrollee a Plan identification card, which covers pharmacy and medical benefits. 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 pre-addressed reply envelope.

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

- **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/certified provider with prescriptive authority prescribing within their scope of practice 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 163 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 163 for the definition of “specialty drugs.”

Under Standard Option and Basic Option

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.

Note: The Specialty Drug Pharmacy Program will not fill your prescription until you have obtained prior approval. AllianceRx Walgreens Prime, 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.

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 pages 118-119.

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 pages 117-118 for information about your cost-share for specialty drugs purchased at a Preferred retail pharmacy that are affected by these restrictions.

- **What is covered.**

  Under Basic Option, we use a managed formulary for certain drug classes. 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.

  Under Standard Option and Basic Option

  Note: Both formularies include lists of preferred drugs that are safe, effective and appropriate for our members, and are available at lower costs than non-preferred drugs. If your physician prescribed a more expensive non-preferred drug for you, we may ask that he or she prescribe a preferred drug instead; we encourage you to do the same. If you purchase a drug that is not on our preferred drug list, your cost will be higher. Your cooperation with our cost-savings efforts helps keep your premium affordable.

  Note: Some drugs, nutritional supplements, and supplies are not covered (see pages 121-122); we may also exclude certain U.S. FDA-approved drugs when multiple generic equivalents/alternative medications are available. If you purchase a drug, nutritional supplement, or supply that is not covered, you will be responsible for the full cost of the item.

  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. Changes to the preferred drug list are not considered benefit changes.

  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. 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 call 800-624-5060, TTY: 800-624-5077, for assistance. Changes to the formulary are not considered benefit changes. 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 requests a brand-name drug and indicates "dispense as written." Keep in mind that **Basic Option members must use Preferred providers in order to receive benefits.** See Section 10, *Definitions*, page 158, 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. 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 unless otherwise noted. 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.

  Under Standard Option and Basic Option

  Benefits for Tier 4 and Tier 5 specialty drugs purchased at a 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. 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 of the specialty drug. See page 119 for more information.

  Note: Certain drugs such as narcotics may have additional limits or requirements as established by the U.S. FDA or by national scientific or medical practice guidelines (such as Centers for Disease Control and Prevention, American Medical Association, etc.) 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 22, 30, and 90-day supplies of those medications. **In most cases, refills cannot be obtained until 75% of the prescription has been used. Controlled substances cannot be refilled until 80% of the prescription has been used.** Controlled substances are medications that can cause physical and mental dependence, and have restrictions on how they can be filled and refilled. They are regulated and classified by the DEA (Drug Enforcement Administration) based on how likely they are to cause dependence. 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.

  Note: Benefits for certain self-injectable (self-administered) drugs are provided only when they are dispensed by a pharmacy under the pharmacy benefit. Medical benefits will be provided for a once-per-lifetime dose per therapeutic category of drugs dispensed by your provider or any non-pharmacy-benefit provider. This benefit limitation does not apply if you have primary Medicare Part B coverage. See pages 117-118 for Tier 4 and Tier 5 specialty drug fills from a Preferred pharmacy.

  Note: Benefits for certain auto-immune infusion medications (Remicade, Renflexis and Inflectra) are provided only when obtained by a non-pharmacy provider, such as a physician or facility (hospital or ambulatory surgical center). See *Drugs From Other Sources* in this Section, page 123, for more information.

- **Important contact information**

  Retail Pharmacy Program: 800-624-5060, TTY: 800-624-5077;
  Mail Service Prescription Drug Program: 800-262-7890, TTY: 800-216-5343;
  Specialty Drug Pharmacy Program: 888-346-3731, TTY: 877-853-9549; or www.fepblue.org.

Patient Safety and Quality Monitoring (PSQM)

We have a special program to promote patient safety and monitor healthcare 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 on page 110, 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 U.S. FDA-approved recommendations, national scientific and generally accepted standards of medical practice guidelines (such as Centers for Disease Control and Prevention, American Medical Association, etc.), 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 800-624-5060, TTY: 800-624-5077.

Prior Approval

As part of our Patient Safety and Quality Monitoring (PSQM) program (see page 109), **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 generally 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 800-624-5060, TTY: 800-624-5077. You can also obtain the list and forms 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.

Note: It is your responsibility to know the prior approval authorization expiration date for your medication. We encourage you to work with your physician to obtain prior approval renewal in advance of the expiration date.

Standard Option Generic Incentive Program

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

Retail Pharmacy Program

- Your $7.50 copayment for each purchase of up to a 30-day supply ($5.00 when Medicare Part B is primary) is waived for the first 4 generic drug replacements filled (and/or refills ordered) per drug. You may receive up to 4 copayment waivers per drug change.
- If you switch from one generic drug to another, you will be responsible for your copayment.

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.

Note: The list of eligible generic drug replacements may change and is not considered a benefit change. For the most up-to-date information, please visit www.fepblue.org/en/benefit-plans/coverage/pharmacy/generic-incentive-program or call:

Retail Pharmacy Program: 800-624-5060, TTY: 800-624-5077
Mail Service Prescription Drug Program: 800-262-7890, TTY: 800-216-5343
Specialty Drug Pharmacy Program: 888-346-3731, TTY: 877-853-9549

Benefits 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	**Standard Option**	**Basic Option**
Asthma Medications **Preferred Retail Pharmacies:** Note: See page 24 for information about drugs and supplies that require prior approval.	Tier 1 (generic drug): $5 copayment (no deductible) Tier 2 (preferred brand-name drug): 20% of the Plan allowance (no deductible)	Tier 1 (generic drug): $5 copayment for each purchase of up to a 90-day supply Tier 2 (preferred brand-name drug): $35 copayment for each purchase of up to a 30-day supply ($105 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment Tier 2 (preferred brand-name drug): $30 copayment for each purchase of up to a 30-day supply ($90 copayment for a 31 to 90-day supply)
Mail Service Prescription Drug Program: 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 110. Note: See pages 117-119 for Tier 3, 4 and 5 prescription drug benefits.	Tier 1 (generic drug): $5 copayment (no deductible) Tier 2 (preferred brand-name drug): $65 copayment (no deductible)	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment Tier 2 (preferred brand-name drug): $75 copayment
Anti-hypertensive Medications **Preferred Retail Pharmacies:** Note: See page 24 for information about drugs and supplies that require prior approval.	Tier 1 (generic drug): $3 copayment (no deductible)	Tier 1 (generic drug): $5 copayment for each purchase of up to a 90-day supply
Mail Service Prescription Drug Program: 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 110. Note: See pages 117-119 for Tier 2, 3, 4, and 5 prescription drug benefits.	Tier 1 (generic drug): $3 copayment (no deductible)	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**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 pages 115-116 for our coverage of medications to promote better health as recommended under the Affordable Care Act. • Specialized nutritional formulas for children up to age 22 to treat inborn errors of amino acid metabolism - Must meet the definition of medical food (see definition on page 159) - Must be intended for use solely under medical supervision in the dietary management of an inborn error of amino acid metabolism - Must be receiving active, regular and ongoing medical supervision and must be unable to manage your condition by modification of diet alone • 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) in formula form only Note: A prescription and prior approval are required for medical foods provided under the pharmacy benefit. Note: See Section 5(a), page 61, 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	See page 111 and pages 113-119	See page 111 and pages 113-119

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
• Drugs to aid smoking, tobacco, and E-cigarette cessation that require a prescription by Federal law Note: We provide benefits for over-the-counter (OTC) smoking, tobacco, and E-cigarette cessation medications only as described on page 120. Note: You may be eligible to receive smoking, tobacco, and E-cigarette cessation medications at no charge. See page 120 for more information. • Drugs for the diagnosis and treatment of infertility, except as described on pages 121-122 • Drugs to treat gender dysphoria (gonadotropin-releasing hormone (GnRH) antagonists and testosterones) • 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 118 and 119 for details.	See below and pages 114-120	See below and pages 114-120
• 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 U.S. FDA standards for OTC products. To receive benefits, you must use a 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

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
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. See pages 46 and 48 for specific coverage. Note: Our vaccine network is a network of Preferred retail pharmacies that have agreements with us to administer one or more routine immunizations. Check with your pharmacy or call our Retail Pharmacy Program at 800-624-5060, TTY: 800-624-5077, to find out 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 every 365 days at no cost through our Diabetic Meter Program. To use this program, you must call the telephone 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 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. See page 115 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
Metformin and metformin extended release (excluding osmotic and modified release generic drugs) **Preferred Retail Pharmacies:** **Mail Service Prescription Drug Program:**	Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply (no deductible) Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply (no deductible)	Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Other Preferred Diabetic Medications, Test Strips, and Supplies **Preferred Retail Pharmacies:** **Mail Service Prescription Drug Program:** **Note: See pages 118-119 for Tier 2, 3, 4, and 5 prescription drug benefits.** Benefits will be provided for syringes, pens and pen needles and test strips at Tier 2 (diabetic medications and supplies) for Standard Option members, and Basic Option members with primary Medicare Part B, through the Mail Service Prescription Drug Program. See pages 118-119 for more information.	Tier 2 (preferred diabetic medications and supplies): 20% of the Plan allowance for each purchase of up to a 90-day supply (no deductible) Non-preferred retail pharmacies: You pay all charges Tier 2 (preferred brand-name drug): $40 copayment for each purchase of up to a 90-day supply (no deductible)	Tier 2 (preferred diabetic medications and supplies): $35 copayment for each purchase of up to a 30-day supply ($65 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 2 (preferred brand-name drugs): $30 copayment for each purchase of up to a 30-day supply ($60 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 2 (preferred brand-name drugs) $50 copayment for each purchase of up to a 90-day supply
Medications 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 • Low-dose aspirin (81 mg per day) for pregnant members at risk for preeclampsia • Aspirin for men age 45 through 79 and women age 50 through 79 • Generic cholesterol-lowering statin drugs Note: Benefits are not available for acetaminophen, ibuprofen, naproxen, etc.	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

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Note: Benefits for the medications listed on the previous page are subject to the dispensing limitations described on page 109 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/preventive-care-benefits. See pages 42-49 in Section 5(a) for information about other covered preventive care services. Note: See page 120 for our coverage of smoking, tobacco, and E-cigarette cessation medications.	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 medications (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 800-624-5060, TTY: 800-624-5077, to request this form. You can also obtain the Coverage Request Form through our website at www.fepblue.org.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges Mail Service Prescription Drug Program: Nothing (no deductible)	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
Opioid Reversal Agents: Tier 1 medications limited to Narcan nasal spray and naloxone generic injectable		
Preferred Retail Pharmacies	Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year (no deductible) Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost-share.	Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost-share.
Non-preferred Retail Pharmacies	You pay all charges	You pay all charges

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Opioid Reversal Agents (cont.) **Mail Service Prescription Drug Program**	Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year (no deductible) Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost-share.	**When Medicare Part B is primary, you pay the following:** Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost-share.
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 retail pharmacy to request your prescriptions online and delivery, if available. • For a listing of Preferred retail pharmacies, call the Retail Pharmacy Program at 800-624-5060, TTY: 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 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 119 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 Preferred 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 118.**	Tier 1 (generic drug): $7.50 copayment for each purchase of up to a 30-day supply ($22.50 copayment for a 31 to 90-day supply) (no deductible) Note: You pay a $5 copayment for each purchase of up to a 30-day supply ($15 copayment for a 31 to 90-day supply) 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 108 for information. Tier 2 (preferred brand-name drug): 30% of the Plan allowance for each purchase of up to a 90-day supply (no deductible) Tier 3 (non-preferred brand-name drug): 50% of the Plan allowance for each purchase of up to a 90-day supply (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 a 31 to 90-day supply) Tier 2 (preferred brand-name drug): $55 copayment for each purchase of up to a 30-day supply ($165 copayment for a 90-day supply) Tier 3 (non-preferred brand-name drug): 60% of the Plan allowance ($75 minimum) for each purchase of up to a 30-day supply ($210 minimum for a 31 to 90-day supply) Tier 4 (preferred specialty drug): $65 copayment limited to one purchase of up to a 30-day supply Tier 5 (non-preferred specialty drug): $90 copayment limited to one purchase of up to a 30-day supply **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): see above Tier 2 (preferred brand-name drug): $50 copayment for each purchase of up to a 30-day supply ($150 copayment for a 31 to 90-day supply) Tier 3 (non-preferred brand-name drug): 50% of the Plan allowance ($60 minimum) for each purchase of up to a 30-day supply ($175 minimum for a 31 to 90-day supply) Tier 4 (preferred specialty drug): $60 copayment limited to one purchase of up to a 30-day supply

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Note: For a list of the Preferred Network Long Term Care pharmacies, call 800-624-5060, TTY: 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 800-624-5060, TTY: 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.	See previous page	Continued from previous page: Tier 5 (non-preferred specialty drug): $80 copayment limited to one purchase of up to a 30-day supply
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 For Standard Option and Basic Option members when Medicare Part B is Primary, 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: 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 110. 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 119 for information about the Specialty Drug Pharmacy Program.	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 110 for information. Tier 2 (preferred brand-name drug): $90 copayment (no deductible) Tier 3 (non-preferred brand-name drug): $125 copayment (no deductible)	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $20 copayment Tier 2 (preferred brand-name drug): $100 copayment Tier 3 (non-preferred brand-name drug): $125 copayment **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 111 of this Section for our payment levels for drugs obtained through Preferred retail pharmacies.

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
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 800-262-7890, TTY: 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.	Continued from previous page: Note: The copayment amounts listed on the previous page 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.	See previous page
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 telephone number below or visit our website, www.fepblue.org. (See page 163 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 are most convenient for you, as well as ask you about any side effects you may be experiencing. See page 141 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 31 to 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 888-346-3731, TTY: 877-853-9549.	Specialty Drug Pharmacy Program: Tier 4 (preferred specialty drug): $50 copayment for each purchase of up to a 30-day supply ($140 copayment for a 31 to 90-day supply) (no deductible) Tier 5 (non-preferred specialty drug): $70 copayment for each purchase of up to a 30-day supply ($200 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): $70 copayment for each purchase of up to a 30-day supply ($210 copayment for a 31 to 90-day supply) Tier 5 (non-preferred specialty drug): $95 copayment for each purchase of up to a 30-day supply ($285 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 4 (preferred specialty drug): $65 copayment for each purchase of up to a 30-day supply ($185 copayment for a 31 to 90-day supply) Tier 5 (non-preferred specialty drug): $85 copayment for each purchase of up to a 30-day supply ($240 copayment for a 31 to 90-day supply)

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Smoking, Tobacco, and E-Cigarette Cessation Medications If you are a covered member, you may be eligible to obtain specific prescription generic and brand-name smoking, tobacco, and E-cigarette cessation medications at no charge. Additionally, you may be eligible to obtain over-the-counter (OTC) smoking, tobacco, and E-cigarette cessation medications, prescribed by your physician, at no charge. These benefits are only available when you use a Preferred retail pharmacy. To qualify, create a Tobacco Cessation Quit Plan using our Online Health Coach. For more information, see page 128. Note: There may be age-restrictions based on U.S. FDA guidelines for these medications. 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 continuing monthly pack - 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, tobacco, and E-cigarette 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, tobacco, and E-cigarette cessation medications not meeting these criteria. Benefits are not available for over-the-counter (OTC) smoking, tobacco, and E-cigarette cessation medications except as described above. Note: See page 64 for our coverage of smoking, tobacco, and E-cigarette cessation treatment, counseling, and classes.	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

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Remicade, Renflexis, and Inflectra are not covered for prescriptions obtained from a retail pharmacy, Mail Service Prescription or through the Specialty Drug Program* • *Medical foods administered orally are not covered if not obtained at a retail pharmacy or through the Mail Service Prescription Drug Program* • *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 61 and 112)* • *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* • *Products and foods other than liquid formulas or powders mixed to become formulas; foods and formulas readily available in a retail environment and marketed for persons without medical conditions; low-protein modified foods (e.g., pastas, breads, rice, sauces and baking mixes); nutritional supplements, energy products; and similar items* *Note: See page 115 for our coverage of medications recommended under the Affordable Care Act and page 120 for smoking, tobacco, and E-cigarette cessation medications.* *Note: See Section 5(a), page 61 for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube.* • *Infant formula other than described on pages 61 and 112* • *Drugs for which prior approval has been denied or not obtained* • *Drugs and supplies related to sexual dysfunction or sexual inadequacy*	*All charges*	*All charges*

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
• *Drugs and covered-drug-related supplies for the treatment of 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 113* • *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 113* • *Drugs used to terminate pregnancy* • *Sublingual allergy desensitization drugs, except as described on page 54*	*All charges*	*All charges*
Drugs From Other Sources	**Standard Option**	**Basic Option**
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. This includes drugs and supplies covered only under the medical benefit. 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 page 134 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 related to drugs obtained from other sources: - Physician's office – Section 5(a) - Facility (inpatient or outpatient) – Section 5(c) - Hospice agency – Section 5(c) • Please refer to page 117 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 professional provider: 35% of the Plan allowance (deductible applies) Non-participating professional provider: 35% of the Plan allowance (deductible applies) plus any difference between our allowance and the billed amount Member: 35% of the Plan allowance (deductible applies) 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 professional provider: You pay all charges Non-participating professional provider: You pay all charges Member or Non-member: You pay all charges

Drugs From Other Sources - continued on next page

Benefits Description	You Pay	
Drugs From Other Sources (cont.)	**Standard Option**	**Basic Option**
• Auto-immune infusion medications: Remicade, Renflexis and Inflectra Note: Benefits for certain auto-immune infusion medications (limited to Remicade, Renflexis and Inflectra) are covered only when they are obtained by a non-pharmacy provider, such as a physician or facility (hospital or ambulatory surgical center).	Preferred: 10% of the Plan allowance (deductible applies) Participating professional provider: 15% of the Plan allowance (deductible applies) Non-participating professional provider: 15% of the Plan allowance (deductible applies) plus any difference between our allowance and the billed amount Member: 15% of the Plan allowance (deductible applies) Non-member: 15% of the Plan allowance (deductible applies), plus any difference between our allowance and billed amount.	Preferred: 15% of the Plan allowance Participating professional provider: You pay all charges Non-participating professional provider: You pay all charges Member or Non-member: You pay 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.**

Benefit Description	You Pay	
Accidental Injury Benefit	**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.	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.

Accidental Injury Benefit - continued on next page

Benefit Description	You Pay	
Accidental Injury Benefit (cont.)	**Standard Option**	**Basic Option**
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.	See previous page	See previous page

Dental Benefits

What is Covered

Standard Option dental benefits are presented in the chart on the following page.

Basic Option dental benefits appear on page 127.

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 telephone 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 telephone 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 page. 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 page 125).

Standard Option Dental Benefits	Standard Option Only		
Covered Service	**We Pay to Age 13**	**We Pay Age 13 and Over**	**You Pay**
Clinical oral evaluations			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).
Periodic oral evaluation *(up to 2 per person per calendar year)*	$12	$8	
Limited oral evaluation	$14	$9	
Comprehensive oral evaluation	$14	$9	
Detailed and extensive oral evaluation	$14	$9	
Diagnostic imaging			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	
Palliative treatment			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).
Palliative treatment of dental pain – minor procedure	$24	$15	
Protective restoration	$24	$15	
Preventive			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).
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 (*up to 2 per person per calendar year*)	$13	$8	
Not covered: Any service not specifically listed above	*Nothing*	*Nothing*	*All charges*

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; see page 125). 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 telephone 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*)	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
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)*	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
Not covered: Any service not specifically listed above	*Nothing*	*All charges*

Section 5(h). Wellness and Other 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 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 healthcare 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 healthcare expenses. See below and page 129 for complete information. • **Online Health Coach (OHC)** – Manage your health proactively by setting and managing health goals, create a plan of care, track your progress, and pursue healthy activities. The OHC offers members a combination of guidance, support, and resources. • **Tobacco Cessation Incentive Program** – If you would like to quit smoking, you can participate in this program and receive tobacco cessation products at no charge. Create a Tobacco Cessation Quit Plan using our Online Health Coach. You will then be eligible to receive certain smoking, tobacco, and E-cigarette 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 page 120 for more information. Note: There may be age-restrictions based on U.S. FDA guidelines for these medications. • **Health Topics and WebMD Videos** offer an extensive variety of educational tools using videos, recorded messages, and colorful online materials that provide up-to-date information about a wide range of health-related topics.
Services for the Deaf and Hearing Impaired	All Blue Cross and Blue Shield Plans provide TTY 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 well-being. For more information, go to www.fepblue.org.
Diabetes Management Program	The Diabetes Management Program is a program to help members with diabetes manage their condition. All members with type 1 and type 2 diabetes, including those for whom Medicare is primary, are eligible for this program. You will receive a free glucose meter and have unlimited test strips and lancets shipped directly to you. Automated reordering is based on your usage. Personalized coaching and support are also provided. The program offers live interventions triggered by acute alerts based on your glucose meter test results. Member support is offered 24/7/365. For more information go to www.fepblue.org/diabetes.
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, both the contract holder and spouse 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, hypertension, 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, 2020**. 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 888-258-3432 toll-free.
Diabetes Management Incentive Program	The **Diabetes Management Incentive Program** is designed to encourage members to achieve and maintain control of their blood sugar and help manage or slow the progression of complications related to diabetes. Through this program you can earn a maximum of $100 toward a health account to be used for most qualified medical expenses. This incentive is in addition to other incentives described in this brochure and is available to all covered adult members, age 18 and over. To qualify for the Diabetes Management Incentive Program, each eligible member must have at least one medical claim that has been processed during the past 12 months with a reported diagnosis of diabetes and complete the following steps: • Provide us with lab test results for an HbA1c performed in the first 6 months of the calendar year (January 1 to June 30) to receive a $25 incentive reward. • Provide us with lab test results for an HbA1c performed in the last 6 months of the calendar year (July 1 to December 31) to receive a $75 incentive reward; the test results must show: - Your HbA1c result is less than 8 percent; or - If your HbA1c is greater than or equal to 8 percent, you will receive the incentive if we provided benefits for three nutritional counseling visits performed during the calendar year. Note: See pages 43 and 48 for information on nutritional counseling. Information on how to submit your HbA1c lab results can be found on our website, www.fepblue.org/diabetes. See page 114 for information about the Diabetic Meter Program.
Hypertension Management Program	The **Hypertension Management Program** gives members with hypertension (otherwise known as high blood pressure) 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 all covered adult members, age 18 and over. You will be automatically enrolled in the program, and will be informed of your eligibility to receive a free BPM after 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 calendar years. You must follow the directions in the letter, which include taking the letter to your healthcare 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 criteria or for those who obtain a BPM outside of this program. For more information, call us at the telephone number on the back of your ID card. See page 111 for information on preferred generic anti-hypertensive medications.
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. 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. All covered adult members, age 18 and over may be eligible for this incentive. To qualify for the Pregnancy Care Box, you must be pregnant. Information on the program is available on our website, www.fepblue.org. To qualify for the $75 incentive, you must meet the criteria above for the Pregnancy Care Box and send us a copy of your healthcare provider's medical record that confirms you had a prenatal care visit during the first trimester of your pregnancy. Information that must be included when submitting your medical record can be found on our website, www.fepblue.org/maternity. To receive 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 are limited to two pregnancies per calendar year.
Annual Incentive Limitation	Financial incentives earned through participation in the Blue Health Assessment, personalized goals through the Online Health Coach, the Diabetes Management Incentive Program, and the Pregnancy Care Incentive Program are limited to a total of $250 per person per calendar year for the contract holder and spouse.
Reimbursement Account for Basic Option Members Enrolled in Medicare Part A and Part B	Basic Option members enrolled in Medicare Part A and Part B are eligible to be reimbursed up to $800 per calendar year for their Medicare Part B premium payments. The account is used to reimburse member-paid Medicare Part B premiums. For more information on how to obtain reimbursement, please visit www.fepblue.org/mra or call 888-706-2583.
MyBlue® Customer eService	Visit **MyBlue Customer eService** at www.fepblue.org/myblue or use the fepblue mobile app 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 and Pharmacy Claims." From there you can search claims and select the "EOB" link next to each claim to access your EOB. You can also access EOBs via the fepblue mobile app. Simply link to MyBlue, and click on Claims. • **Opt In or Out of Mailed Paper EOBs** – The Service Benefit Plan offers an environmentally friendly way of accessing your EOBs via www.fepblue.org/myblue. You can opt in or out of receiving mailed paper EOBs by following 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.

	• **Financial Dashboard** – Log in to MyBlue to access important information in real time, including deductibles, out-of-pocket costs, remaining covered provider visits, medical claims, and pharmacy claims. You also can review your year-to-date summary of completed claims, MyBlue Wellness Card balance, and pharmacy spending throughout the year.
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 healthcare needs, the Service Benefit Plan offers two types of Care Management Programs that provide assistance with the coordination of your care, provide member education and clinical support. • **Case Management** provides members who have acute or chronic complex healthcare needs with the services and assistance of a licensed health care professional with a nationally recognized case management certification. Case managers may be a registered nurse, licensed social worker, or other licensed healthcare professional practicing within the scope of their license, who may work with you and your providers to assess your health care needs, coordinate needed care and available resources, evaluate the outcomes of your care, and support and monitor the progress of the member's treatment plan and healthcare needs. Some members may receive guidance and clinical support for an acute healthcare need while others may benefit from a short-term case management enrollment. Enrollment in case management requires your consent. Members in case management are asked to provide verbal consent prior to enrollment in case management and must provide written consent for case management. Note: Benefits for care provided by residential treatment centers and for inpatient care provided by skilled nursing facilities for members enrolled in Standard Option who do not have Medicare Part A require written consent and participation in Case Management prior to admission; please see pages 90-91, 103 and 133 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, including if you are eligible for enrollment and assistance with enrollment, please contact us at the customer service telephone 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 will review the member's healthcare needs and may at our sole discretion, identify a less costly alternative treatment plan for the member. The member (or their healthcare proxy) and provider(s) must cooperate in the process. Case Management Program enrollment is required for eligibility. Prior to the starting date of the alternative treatment plan, members who are eligible to receive services through the flexible benefits option are required to sign and return a written consent for case management and 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. **We must receive the consent for case management and the alternative benefits agreement signed by the member/healthcare proxy before you receive any services included in the alternative benefits agreement.** • Alternative benefits will be made available for a limited period of time and are subject to our ongoing review. You must cooperate with and participate in the review process. Your provider(s) must submit the information necessary for our reviews. You and/or your healthcare proxy must participate in care conferences and caregiver training as requested by your provider(s) or by us.

	• We may revoke the alternative benefits agreement immediately at any time, if we discover we were misled by the information given to us by you, your provider, or anyone else involved in your care, or that you are not meeting the terms of the agreement. • If we approve alternative benefits, we do not guarantee that they will be extended beyond the limited time period and/or scope of the alternative benefits agreement 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 at our sole discretion, 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 alternative benefits for the stated time period, unless we are misled by the information given to us or circumstances change. Benefits as stated in this brochure will apply to all services and dates of care not included in the alternative benefits agreement. You or your provider may request an extension of the time period initially approved for alternative benefits, no later than five business days prior to the end of the alternative benefits agreement. We will review the request, including the services proposed as an alternative and the cost of those services, but benefits as stated in this brochure will apply if we do not approve your request. Note: If we deny a request for precertification or prior approval of regular contract benefits, as stated in this brochure, 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).
Telehealth Services	Go to www.fepblue.org/telehealth or call 855-636-1579, TTY: 855-636-1578, toll free to access on-demand, affordable, high-quality care for adults and children experiencing non-emergency medical issues, including treatment of minor acute conditions (see page 159 for definition), dermatology care, counseling for behavioral health and substance use disorder, and nutritional counseling. Note: This benefit is available only through the contracted telehealth provider network.
The fepblue Mobile Application	Blue Cross and Blue Shield's new fepblue mobile application is available for download for both iOS and Android mobile telephones. The application provides members with 24/7 access to helpful features, tools and information related to Blue Cross and Blue Shield Service Benefit Plan benefits. Members can log in with their MyBlue® username and password to access personal healthcare information such as benefits, out-of-pocket costs, deductibles (if applicable) and physician visit limits. They can also view claims and approval status, view/share Explanations of Benefits (EOBs), view/share member ID cards, locate in-network providers, and connect with our telehealth services.

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 134-135 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 healthcare 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, with the exception of admissions for gender reassignment surgery (see pages 22 and 67-68 for information) and admissions to residential treatment centers and skilled nursing facilities. Prior approval is required for all non-emergent air ambulance transport services for overseas members (refer to page 95 for more information).

Overseas 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 Overseas 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 Overseas 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 Overseas Assistance Center (provided by GMMI, Inc.), by calling the center collect at 804-673-1678. Members in the United States, Puerto Rico, or the U.S. Virgin Islands should call 800-699-4337 or email the Overseas Assistance Center at fepoverseas@gmmi.com. GMMI, Inc., 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.

Hospital and professional provider benefits

For **professional care** you receive overseas, we provide benefits at Preferred benefit levels using either our Overseas Fee Schedule, a customary percentage of the billed charge, 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. **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. You must also pay any charges for noncovered services.

For **inpatient facility care** you receive overseas, we provide benefits at the Preferred level **under both Standard and Basic Options. For Basic Option, there is no member cost-share** for admissions to a DoD facility, or when the Overseas Assistance Center (provided by GMMI, Inc.) has arranged direct billing or acceptance of a guarantee of benefits with the facility. Standard Option members have no cost-share for inpatient facility care.

For **outpatient 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 have no deductible for overseas services.

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.

Pharmacy benefits

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 122 in Section 5(f) for more information.

Overseas claims payment

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.

Filing overseas claims

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 260070, Pembroke Pines, FL 33026.
2. Fax: 001-954-308-3957. 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 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@gmmi.com, or from your Local Plan.

Filing a claim for 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. Timely filing for overseas pharmacy claims is limited to one year from the prescription fill date. 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 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

These benefits are not part of the FEHB contract or premium, and you cannot file an FEHB dispute regarding these benefits. Fees paid 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 telephone number on the back of your ID card or visit our website at www.fepblue.org.

Blue365® – The Blue Cross and Blue Shield Service Benefit Plan presents Blue365, a program that offers exclusive health and wellness deals that will assist in your efforts to be healthy and happy, every day of the year. Blue365 delivers top discounts from national and local retailers such as hearing aids through TruHearing, healthy food delivery via Sun Basket, wearable devices from Fitbit, and genetic composition testing by Molecular Fitness, just to name a few. Each week, Blue365 members receive great health and wellness deals via email. With Blue365, there is no paperwork to fill out. Just 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 – Fitness Your Way by Tivity Health can help you meet your health and fitness goals, on your budget, and on your own time. Fitness Your Way by Tivity Health offers access to more than 10,000 different fitness locations for a discounted monthly rate. You'll have access to well-being support, health articles, and online health coaching, as well as exercise tracking and nutrition goals, social networking, rewards, and the Daily Challenge 24 hours a day, 7 days a week. For more information or to enroll, visit www.fepblue.org/healthclub or call customer service at 888-242-2060, Monday through Friday, 8 a.m. – 8 p.m., in all U.S. time zones.

Discount Drug Program – The Discount Drug Program is available to members 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 several drugs related to dental care, weight loss, hair removal and hair growth, and other miscellaneous health conditions. Please refer to www.fepblue.org/ddp for a full list of discounted drugs, including those that may be added to this list as they are approved by the U.S. Food and Drug Administration (U.S. FDA). To use the program, simply present a valid prescription and your Service Benefit Plan ID card at a Preferred 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 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 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.

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 159).
- Experimental or investigational procedures, treatments, drugs, or devices (see Section 5(b) 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 and gender reassignment surgeries specifically listed as covered).
- Travel expenses except as specifically provided for covered transplants performed in a Blue Distinction Center for Transplant (see page 79).
- 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 153), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge, see page 154), or state premium taxes however applied.
- Prescriptions, 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 provided 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, diagnostic tests, and procedures and services for the treatment of morbid obesity listed on page 68.
- 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 *Preventive Care, Child* in Sections 5(a) and 5(c), the preventive screenings specifically listed on pages 42-49 and page 88; and certain routine services associated with covered clinical trials (see page 147).
- Recreational or educational therapy, and any related diagnostic testing, except as provided by a hospital during a covered inpatient stay.
- Applied behavior analysis (ABA) and related services for any condition other than an autism spectrum disorder.
- Applied behavior analysis (ABA) services and related services performed as part of an educational program; or provided in or by a school/educational setting; or provided as a replacement for services that are the responsibility of the educational system.
- 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 121), meditation techniques, relaxation techniques, movement therapies, and energy therapies.
- Services, drugs, or supplies related to medical marijuana.
- Advanced care planning, except when provided as part of a covered hospice care treatment plan (see page 93).
- Membership or concierge service fees charged by a healthcare provider.
- Fees associated with copies, forwarding or mailing of records except as specifically described in Section 8.
- 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 telephone 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 provider 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, telephone 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, speech, or cognitive rehabilitation therapy, you must provide a written statement from the provider 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 provider's name, date, and charge. (See pages 140-141 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 (e.g., medical records) 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.

Preferred Retail Pharmacies – When you use Preferred retail pharmacies, show your Service Benefit Plan ID card. To find a Preferred retail 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 retail 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 paragraphs 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 800-624-5060 to request a retail prescription drug claim form to claim benefits. Hearing-impaired members with TTY equipment may call 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 800-262-7890, TTY: 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 telephone 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 119 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
Prescription drug claims	**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 888-346-3731, TTY: 877-853-9549, or you may send your prescription to: Specialty Drug Pharmacy Program, AllianceRx Walgreens Prime, P.O. Box 692169, Orlando, FL 32869. 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 are most convenient for you. To order refills, call the same telephone 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 888-346-3731, TTY: 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 (e.g., diagnosis codes, dates of service, etc.), you must resubmit it within 90 days, or before the timely filing period expires, whichever is later. Note: Timely filing for overseas pharmacy claims is limited to one year from the prescription fill date. 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 134-135 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 healthcare 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 healthcare 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 or to make an inquiry 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 call your Plan's customer service representative at the telephone number found on your enrollment card, our brochure, or our website (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 telephone 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 healthcare 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.

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, FEHB 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;
- Your daytime telephone number and the best time to call; and
- 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 healthcare 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 telephone 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 FEHB 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 healthcare 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 healthcare 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 on NAIC rules regarding the coordinating of benefits, visit our website at www.fepblue.org/coordinationofbenefits.

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 154). 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 healthcare 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 healthcare 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, 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 covered 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 72-79. **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 telephone 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 (U.S. 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 800-MEDICARE (800-633-4227), TTY: 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 151.
- 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 800-772-1213, TTY: 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 telephone number 800-772-1213, TTY: 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 did not 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 healthcare. 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 153 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 21 for exceptions).

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 telephone 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 healthcare 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 (skilled) 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**

If you are enrolled in Medicare Part B, 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 healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227), TTY: 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 20 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 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:	
	Standard Option	**Basic Option**
Participates with Medicare or accepts Medicare assignment for the claim and is in our Preferred network	your deductibles, coinsurance, and copayments.	your copayments and coinsurance.
Participates with Medicare or accepts Medicare assignment and is not in our Preferred network	your deductibles, coinsurance, and copayments, and any balance up to the Medicare-approved amount.	all charges.
Does not participate with Medicare and is in our Preferred network 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.	your deductibles, coinsurance, and copayments, and any balance up to 115% of the Medicare-approved amount.	your copayments and coinsurance, and any balance up to 115% of the Medicare-approved amount.
Does not participate with Medicare and is not in our Preferred network	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare-approved amount.	all charges.
Opts-out of Medicare via private contract	your deductibles, coinsurance, copayments, and any balance your physician charges.	your deductibles, coinsurance, copayments, and any balance your physician 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.

Physicians Who Opt-Out of Medicare

A physician may have opted-out of Medicare and may or may not ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. This is different than a Non-participating doctor, and we recommend you ask your physician if he or she has opted-out of Medicare. Should you visit an opt-out physician, the physician will not be limited to 115% of the Medicare-approved amount. You may be responsible for paying the difference between the billed amount and our regular in-network/out-of-network benefits.

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, you pay nothing for covered charges (see note below for Basic Option).
- If your physician **does not accept** Medicare assignment, 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 20 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.

Please review the following table illustrating your cost-share liabilities when Medicare is your primary payor **and** your provider is in our network and participates with Medicare compared to what you pay without Medicare. Please do not rely on this chart alone but read all information in this section of the brochure. You can find more information about how our Plan coordinates with Medicare in our *Medicare and You Guide for Federal Employees* available online at www.fepblue.org.

Benefit Description	**Standard Option** You Pay **Without** Medicare	**Standard Option** You Pay **With** Medicare Parts A & B	**Basic Option** You Pay **Without** Medicare	**Basic OptionWith** Medicare Parts A & B
Deductible	$350-Self $750-Family	$0.00	N/A	$0.00
Out of Pocket Maximum	$7,000-Self $14,000-Family	$7,000-Self $14,000-Family	$5,500-Self $11,000-Family	$5,500-Self $11,000-Family
Part B Premium Reimbursement	N/A	N/A	N/A	$800
Primary Care Physician	$25	$0.00	$30	$0.00
Specialist	$35	$0.00	$40	$0.00
Inpatient Hospital	$450	$0.00	$175/day up to $875	$0.00
Outpatient Hospital	15% or $25 copayment	$0.00	30% or $30-$500 copayment	$0.00
Incentives Offered	N/A	N/A	N/A	N/A

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.
Advanced care planning	Receiving information on the types of life-sustaining treatments that are available, completing advance directives and other standard forms, and/or if you are diagnosed with a terminal illness and making decisions about the care you would want to receive if you become unable to speak for yourself.
Agents	Medications 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 medications 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. Benefits provided under the contract are not assignable by the member to any person without express written approval of the Carrier, and in the absence of such approval, any such assignment shall be void. Please visit www.fepblue.org to obtain a valid authorization form.
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.
Biologic drug	A complex drug or product that is manufactured in a living organism, or its components, that is used as a diagnostic, preventive or therapeutic agent.
Biosimilar drug	A U.S. FDA-approved biologic drug, which is considered highly similar to an original brand-name biologic drug, with no clinically meaningful differences from the original biologic drug in terms of safety, purity and potency.
Biosimilar, interchangeable drug	A U.S. FDA-approved biosimilar drug that may be automatically substituted for the original brand-name biologic drug.
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.
Clinical trials	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 U.S. Food and Drug Administration (U.S. 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 29.
Concurrent care claims	A claim for continuing care or an ongoing course of treatment that is subject to prior approval. See page 26 in Section 3.

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; ambiguous genitalia; and webbed fingers and toes. Note: Congenital anomalies do not include conditions related to the teeth or intra-oral structures supporting the teeth.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 28.

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 healthcare 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.

Durable medical equipment

Equipment and supplies that are:

1. Prescribed by your physician (i.e., the physician who is treating your illness or injury);
2. Medically necessary;
3. Primarily and customarily used only for a medical purpose;
4. Generally useful only to a person with an illness or injury;
5. Designed for prolonged use; and
6. Used to serve a specific therapeutic purpose in the treatment of an illness or injury.

Experimental or investigational services

Experimental or investigational shall mean:

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

3. Reliable evidence shows that the consensus of opinion among experts regarding the healthcare 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
4. Reliable evidence shows that the healthcare 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:

1. Published reports and articles in the authoritative medical and scientific literature;
2. 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
3. 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 a U.S. 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 U.S. FDA as interchangeable with your brand-name drug.

Group health coverage Healthcare 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).

Healthcare professional A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law. See page 17 for information about how we determine which healthcare 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 healthcare provider. For more information, visit our website, www.fepblue.org.

Inpatient You are an inpatient when you are formally admitted to a hospital with a doctor's order.

Note: Inpatient care requires precertification. For some services and procedures prior approval must also be obtained. See pages 21-26.

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 use disorders. 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 healthcare 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:

1. In accordance with generally accepted standards of medical practice in the United States; and
2. 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
3. Not primarily for the convenience of the patient, physician, or other healthcare 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
4. Not part of or associated with scholastic education or vocational training of the patient; and
5. In the case of inpatient care, able to be provided safely only in the inpatient 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.

Minor acute conditions

Under the telehealth benefit you have on-demand access to care for common, non-emergent conditions. Examples of common conditions include sinus problems, rashes, allergies, cold and flu symptoms, etc.

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. For more information, see pages 7-8.

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.

Outpatient

You are an outpatient if you are getting emergency department services, observation services, outpatient surgery, lab tests, X-rays, or any other hospital services, and the doctor has not written an order to admit you to a hospital as an inpatient. In these cases, you are an outpatient even if you are admitted to a room in the hospital for observation and spend the night at the hospital.

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 healthcare 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 126 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 healthcare 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 Local Plan Allowance. The Local Plan Allowance varies by region and is determined by each Plan. If you would like additional information, or to obtain the current allowed amount, please call the customer service telephone number on the back of your ID card. For inpatient stays resulting from medical emergencies or accidental injuries, or for emergency deliveries, our allowance is the billed amount;
  - For outpatient, non-emergency 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 Local Plan Allowance. This allowance applies to all of the covered services billed by the hospital. If you plan on using a Non-member hospital, or other Non-member facility, for your outpatient procedure, please call us before you receive services at the customer service telephone 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 to use our National Doctor and Hospital Finder, or call us at the customer service telephone number on the back of your ID card;
  - For outpatient 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 healthcare 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 Local Plan Allowance. In the absence of a Medicare participating fee schedule amount or ASP for any service, drug, or supply, our allowance is the Local Plan Allowance. 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 healthcare 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 Local Plan Allowance 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 the Overseas Assistance Center (provided by GMMI, Inc.), 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, D.C., area, or a customary percent of billed charge, whichever is higher.

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 telephone 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 97-100).

	For more information, see *Differences between our allowance and the bill* in Section 4. For more information about how we pay providers overseas, see pages 32 and 133.
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, healthcare institutions, and other covered healthcare 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 healthcare 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, and latent tuberculosis; screening for alcohol/substance use disorders; counseling on reducing health risks; screening for depression; screening for chlamydia, syphilis, gonorrhea, HPV, and HIV; screening for intimate partner violence for women of reproductive age; administration and interpretation of a Health Risk Assessment questionnaire; cancer screenings including low-dose CT screening for lung cancer; screening for abdominal aortic aneurysms; osteoporosis screening, as specifically stated in this brochure; and immunizations as licensed by the U.S. Food and Drug Administration (U.S. FDA). Note: Anesthesia services and pathology services associated with preventive colorectal surgical screenings are also paid as preventive care.
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 21-24.
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 page 147).
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.

Telehealth dermatology

Under the telehealth benefit, dermatologic conditions seen and treated include but are not limited to acne, dermatitis, eczema, psoriasis, rosacea, seborrheic keratosis, fungal infections, scabies, suspicious moles, and warts. Members capture important digital images, combine those with the comprehensive questionnaire responses, and send those to the dermatology network without requiring a telephone or video interaction.

Telehealth services

Non-emergency services provided by telephone or secure online video/messaging for minor acute conditions (see page 159 for definition), dermatology care, behavioral health and substance use disorder counseling, and nutritional counseling. Go to www.fepblue.org/telehealth or call 855-636-1579, TTY: 855-636-1578, toll free to access this benefit. After your telehealth visit, please follow up with your primary care provider.

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 telephone 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.

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Do not rely only 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.

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Summary of Benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2020

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 healthcare professional, you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown below.

You can obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.fepblue.org/brochure.

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 healthcare professionals $35 per office visit for specialists Non-PPO: 35%* of our allowance	39-49
• Telehealth services	PPO: Nothing for the first 2 visits per calendar year after the 2nd visit: $10 copayment per visit Non-PPO: You pay all charges	39, 102
Services provided by a hospital:		
• Inpatient	PPO: $350 per admission Non-PPO: $450 per admission, plus 35% of our allowance	82-84
• Outpatient	PPO: 15%* of our allowance Non-PPO: 35%* of our allowance	84-88
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	98-99
• 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)	99-100

Standard Option Benefits	You pay	Page
Mental health and substance use disorder 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	101-105
Prescription drugs	**Retail Pharmacy Program:** • PPO: $7.50 for each purchase of up to a 30-day supply generic ($5.00 for a 30-day supply if you have Medicare Part B primary)/30% of our allowance Preferred brand-name/50% 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 Part B primary)/$90 Preferred brand-name/$125 non-preferred brand-name per prescription; up to a 90-day supply **Specialty Drug Pharmacy Program:** • $50 preferred specialty drug for a purchase of up to a 30-day supply; $70 non-preferred specialty drug for a purchase of up to a 30-day supply	111-123
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	126
Wellness and other special features: Health Tools; Blue Health Assessment; MyBlue® Customer eService; Diabetes Management Incentive Program; National Doctor and Hospital Finder; Healthy Families; travel benefit/services overseas; Care Management Programs; and Flexible benefits option		128-132
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 – 2020

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 20. There is no deductible for Basic Option.

You can obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.fepblue.org/brochure.

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 healthcare professionals; $40 per office visit for specialists Non-PPO: You pay all charges	39-49
• Telehealth services	PPO: Nothing for the first 2 visits per calendar year after the 2nd visit: $15 copayment per visit Non-PPO: You pay all charges	39, 102
Services provided by a hospital:		
• Inpatient	PPO: $175 per day up to $875 per admission Non-PPO: You pay all charges	82-84
• Outpatient	PPO: $100 per day per facility Non-PPO: You pay all charges	84-88
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	98-99
• Medical emergency	Same as for accidental injury	99-100
Mental health and substance use disorder 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	101-105

Basic Option Benefits	You pay	Page
Prescription drugs	**Retail Pharmacy Program:** • PPO: $10 generic/$55 Preferred brand-name per prescription ($50 if you have primary Medicare Part B)/60% coinsurance ($75 minimum) for non-preferred brand-name drugs (50% ($60 minimum) if you have primary Medicare Part B) • Non-PPO: You pay all charges **Specialty Drug Pharmacy Program:** • $70 preferred specialty drug for a purchase of up to a 30-day supply; $95 non-preferred specialty drug for a purchase of up to a 30-day supply **Mail Service Prescription Drug Program** (for primary Medicare Part B members only): • $20 generic/$100 Preferred brand-name/$125 non-preferred brand-name per prescription; up to a 90-day supply	111-123
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	127
Wellness and other special features: Health Tools; Blue Health Assessment; MyBlue® Customer eService; Diabetes Management Incentive Program; National Doctor and Hospital Finder; Healthy Families; travel benefit/services overseas; Care Management Programs; and Flexible benefits option		128-132
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

2020 Rate Information for the Blue Cross and Blue Shield Service Benefit Plan

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

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 certain United States Postal Service employees as follows:

- **Postal Category 1** rates apply to career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NALC, and NPMHU.
- If you are a career bargaining unit employee represented by the agreement with NPPN, you will find your premium rates on https://liteblue.usps.gov/fehb.
- **Postal Category 2** rates apply to career bargaining unit employees who are represented by the following agreement: PPOA.

Non-Postal rates apply to all career non-bargaining unit Postal Service employees and career employees represented by the NRLCA agreement. Postal rates do not apply to non-career Postal employees, Postal retirees, and associate members of any Postal employee organization who are not career Postal employees.

If you are a Postal Service employee and have questions or require assistance, please contact:

USPS Human Resources Shared Service Center: 877-477-3273, option 5, Federal Relay Service 800-877-8339

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	$235.77	$116.91	$510.84	$253.30	$113.63	$103.81
Standard Option Self Plus One	106	$504.12	$267.15	$1,092.26	$578.83	$260.15	$239.14
Standard Option Self and Family	105	$546.47	$286.74	$1,184.02	$621.27	$279.15	$256.39
Basic Option Self Only	111	$227.84	$75.94	$493.64	$164.55	$72.91	$63.03
Basic Option Self Plus One	113	$504.12	$178.61	$1,092.26	$386.99	$171.61	$150.60
Basic Option Self and Family	112	$546.47	$191.22	$1,184.02	$414.31	$183.63	$160.87

EXHIBIT L

Blue Cross® and Blue Shield® Service Benefit Plan

www.fepblue.org

2021

A Fee-For-Service Plan (FEP Blue Standard and FEP Blue Basic Options) with a Preferred Provider Organization

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. This Plan is accredited. See page 13.

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

IMPORTANT
- Rates: Back Cover
- Changes for 2021: Page 15
- Summary of Benefits: Page 163

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

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 71-005

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

The Office of Personnel Management (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 is 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 800-772-1213, TTY 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 800-MEDICARE 800-633-4227, TTY 877-486-2048.

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Introduction

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Standard and FEP Blue Basic Options** under 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 phone 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 healthcare benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2021, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2021, and changes are summarized on pages 15-16. Rates are shown on the back cover of this brochure.

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 and each covered 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 healthcare 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 phone or to people you do not know, except for your healthcare provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare 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 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 800-FEP-8440 (800-337-8440) and explain the situation.
  - If we do not resolve the issue:

CALL – THE HEALTH CARE FRAUD HOTLINE

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)
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
  - A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- 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 (TCC).
- 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.

Discrimination is Against the Law

The Blue Cross and Blue Shield Service Benefit Plan complies with all applicable Federal civil rights laws, including Title VII of the Civil Rights Act of 1964.

We:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator of your Local Plan by contacting your Local Plan at the phone number appearing on the back of your ID card.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator of your Local Plan. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, your Local Plan's Civil Rights Coordinator is available to help you.

Members may file a complaint with the HHS Office of Civil Rights, OPM, or FEHB Program Carriers.

You can also file a civil rights complaint with the Office of Personnel Management by mail at:

Office of Personnel Management
Healthcare and Insurance
Federal Employee Insurance Operations
Attention: Assistant Director, FEIO
1900 E Street NW, Suite 3400-S
Washington, D.C. 20415-3610

For further information about how to file a civil rights complaint, go to www.fepblue.org/en/rights-and-responsibilities/, or call the customer service phone number on the back of your member ID card. For TTY, dial 711.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. 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 take notes, ask questions and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medications or give your doctor and pharmacist a list of all the medications and dosages that you take, including non-prescription (over-the-counter) medications 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 medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Do not assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

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

For more information on patient safety, please visit:

- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. 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 healthcare providers and improve the quality of care you receive.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- 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 healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not 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, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

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. When such an event occurs, neither you nor your FEHB Plan will incur costs to correct the medical error.

You will not be billed for inpatient services when care is related to treatment of specific hospital-acquired conditions if you use Preferred or Member hospitals. This policy helps to protect you from having to pay for the cost of treating these conditions, and it encourages hospitals to improve the quality of care they provide.

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. 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 for you and one eligible family member. Self and Family coverage is for you and one eligible family member, or 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 Plus One or Self and Family 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 are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

  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, you or they cannot be enrolled in or covered as a family member by another enrollee in 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 your spouse, or one other 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.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

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 or children.

If this law applies to you, you must enroll in 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 lowest-cost nationwide Plan option as determined by OPM.
- 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 lowest-cost nationwide plan option as determined by OPM.

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 does not 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 does not 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 processed according to the 2021 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2020 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 family members 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 assistance with enrolling in a conversion policy (non-FEHB individual policy). FEP helps members with Temporary Continuation of Coverage (TCC) and with finding replacement coverage.

- **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 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. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- **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 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 coverage.

  We also want to inform you that the Patient Protection and ACA did not eliminate TCC or change the TCC rules.

- **Finding replacement coverage**

  If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please refer to the next Section of this brochure. We will help you find replacement coverage inside or outside the Marketplace. For assistance, please contact your Local Plan at the phone 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 ACA's Health Insurance Marketplace. These rules are established by the Federal Government agencies that have responsibility for implementing the ACA and by the Marketplace.

- **Health Insurance Marketplace**

  If you would like to purchase health insurance through the ACA'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 healthcare 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.

OPM requires that FEHB plans be accredited to validate that Plan operations and/or care management meet nationally recognized standards. The local Plans and vendors that support the Blue Cross and Blue Shield Service Benefit Plan hold accreditation from National Committee for Quality Assurance (NCQA) and/or URAC. To learn more about this Plan's accreditations, please visit the following websites:

- National Committee for Quality Assurance (www.ncqa.org);
- URAC (www.URAC.org).

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 healthcare 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 Preferred 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. 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 20 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 phone 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 healthcare facilities, physicians, and other healthcare 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 156-158). 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 20 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.
- **Pilot Programs.** We may implement pilot programs in one or more Local Plan areas and overseas to test the feasibility and examine the impact of various initiatives. The pilot programs do not affect all Plan areas. Information on specific pilots is not published in this brochure; it is communicated to members and network providers in accordance with our agreement with OPM. Certain pilot programs may incorporate benefits that are different from those described in this brochure. For example, certain pilot programs may revise the Plan Allowance for Non-participating providers described in Section 10 of this brochure.

Your rights and responsibilities

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/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence
- Profit status
- Care management, including case management and disease management programs
- How we determine if procedures are experimental or investigational

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, at www.fepblue.org/en/rights-and-responsibilities.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.fepblue.org/en/terms-and-privacy/notice-of-privacy-practices/ to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

If you want more information about us, call or write to us. Our phone 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 2021

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.

Changes to our Standard Option only

- We now provide benefits for phone consultations and online medical evaluation and management services (telemedicine). You pay a $25 copayment (no deductible) for a Preferred primary care provider or other healthcare professional; a $35 copayment (no deductible) for a Preferred specialist; 35% of the Plan allowance (deductible applies) for a Participating provider; and 35% of the Plan allowance (deductible applies) plus any difference between our allowance and the billed amount for a Non-participating provider. Previously, there was no benefit. (See pages 39, 40, 99, and 159.)
- We now provide benefits for certain bowel preparation medications with no member cost-share for the first prescription filled when obtained from a Preferred retail pharmacy or the Mail Service Prescription Drug Program. Previously, members paid a generic or preferred brand-name drug copayment or coinsurance. (See pages 44 and 113.)
- We now provide a preventive drug benefit with no member cost-share for certain prophylactic antiretroviral therapy medications, for those at risk of HIV but do not have HIV, when obtained from a Preferred retail pharmacy or the Mail Service Prescription Drug Program. Previously, members paid a preferred brand-name drug copayment or coinsurance. (See pages 44 and 113.)
- The Tier 2 (preferred brand-name drug) $90 copayment, Tier 3 (non-preferred brand-name drug) $125 copayment, Tier 4 (preferred specialty drug) $140 copayment for a 31 to 90-day supply, and the Tier 5 (preferred specialty drug) $200 copayment for a 31 to 90-day supply are no longer reduced after the 30th prescription is filled. Previously, the copayment was reduced to $50 for the 31st and subsequent prescription refills.
- The member cost-share for Tier 4 preferred specialty drugs is now a $65 copayment for each purchase of up to a 30-day supply ($185 copayment for a 31 to 90-day supply), and the member cost-share for Tier 5 non-preferred specialty drugs is now an $85 copayment for each purchase of up to a 30-day supply ($240 copayment for a 31 to 90-day supply). Previously, your cost-share for Tier 4 preferred specialty drugs was a $50 copayment for each purchase of up to a 30-day supply ($140 copayment for a 31 to 90-day supply), and the member cost-share for Tier 5 non-preferred specialty drugs was a $70 copayment for each purchase of up to a 30-day supply ($200 copayment for a 31 to 90-day supply). (See page 116.)

Changes to our Basic Option only

- We now provide benefits for phone consultations and online medical evaluation and management services (telemedicine). Under Basic Option, you pay a $30 copayment for a Preferred primary care provider or other healthcare professional or a $40 copayment for a Preferred specialist. Previously, there was no benefit. (See pages 39, 40, 99 and 159.)
- We now provide benefits for certain bowel preparation medications with no member cost-share for the first prescription filled when obtained from a Preferred retail pharmacy and, for those who have Medicare Part B, the Mail Service Prescription Drug Program. Previously, members paid a generic or preferred brand-name drug copayment. (See pages 44 and 113.)
- We now provide a preventive drug benefit with no member cost-share for certain prophylactic antiretroviral therapy medications, for those at risk of HIV but do not have HIV, when obtained from a Preferred retail pharmacy, and for those who have Medicare Part B, the Mail Service Prescription Drug Program. Previously, members paid a preferred brand-name drug copayment. (See pages 44 and 113.)
- Your member cost-share for outpatient emergency room facility care related to an accidental injury is now a $175 copayment per day per facility. Previously, your member cost-share was $125.00. (See pages 95 and 165.)
- Your member cost-share for outpatient emergency room facility care related to a medical emergency is now a $175 copayment per day per facility. Previously, your member cost-share was $125.00. (See page 96.)

- The member cost-share for Tier 4 preferred specialty drugs is now an $85 copayment for each purchase of up to a 30-day supply ($235 copayment for a 31 to 90-day supply), and the member cost-share for Tier 5 non-preferred specialty drugs is now a $110 copayment for each purchase of up to a 30-day supply ($300 copayment for a 31 to 90-day supply). Previously, your cost-share for Tier 4 preferred specialty drugs was a $70 copayment for each purchase of up to a 30-day supply ($210 copayment for a 31 to 90-day supply), and the member cost-share for Tier 5 non-preferred specialty drugs was a $95 copayment for each purchase of up to a 30-day supply ($285 copayment for a 31 to 90-day supply). (See page 116.)
- For members with primary Medicare Part B, the member cost-share for Tier 4 preferred specialty drugs is now an $80 copayment for each purchase of up to a 30-day supply ($210 copayment for a 31 to 90-day supply), and the member cost-share for Tier 5 non-preferred specialty drugs is now a $100 copayment for each purchase of up to a 30-day supply ($255 copayment for a 31 to 90-day supply). Previously, your cost-share for Tier 4 preferred specialty drugs was a $65 copayment for each purchase of up to a 30-day supply ($185 copayment for a 31 to 90-day supply), and the member cost-share for Tier 5 non-preferred specialty drugs was an $85 copayment for each purchase of up to a 30-day supply ($240 copayment for a 31 to 90-day supply). (See page 116.)

Changes to both our Standard and Basic Options

- We now provide only medical benefits for chest X-rays. Previously, one chest X-ray per calendar year was covered under the preventive care adult benefit with no member cost-share.
- We now provide a preventive benefit for hepatitis C screening beginning at age 18. Previously, there was no preventive screening for individuals ages 18 through 21.
- We now provide hearing aids for adults age 22 and over, limited to $2,500 every 5 calendar years. Previously, the limit was every 3 calendar years. (See page 57.)
- You must complete the Blue Health Assessment Questionnaire (BHA) to be eligible to participate in the Hypertension Management Program. This benefit is limited to the contract holder and spouse age 18 and older. Previously, you did not have to complete the BHA and it was not limited to the contract holder and spouse. (See page 126.)

Section 3. How You Get Care

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 20 for the exceptions to this requirement. Refer to page 13 for more information about Preferred providers.

Under both Standard and Basic Option, you can also get care for the treatment of minor acute conditions (see page 155 for definition), dermatology care (see page 39), counseling for behavioral health and substance use disorder (see page 99), and nutritional counseling (see pages 43 and 46), using teleconsultation services delivered via phone by calling 855-636-1579, TTY: 855-636-1578, or via secure online video/messaging at www.fepblue.org/telehealth.

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. Covered professional providers within the United States, Puerto Rico, and the U.S. Virgin Islands are healthcare 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 healthcare services in the normal course of business. Covered services must be provided in the state in which the provider is licensed or certified. **If the state has no applicable licensing or certification requirement, the provider must meet the requirements of the Local Plan.** 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.

If you have questions about covered providers or would like the names of PPO (Preferred) providers, please contact the Local Plan where services will be performed.

- **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-Preferred (Member/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 surgicenter, 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 use disorder. Accredited healthcare 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 use disorder 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 87-88 and 100-101. If you have questions about treatment at an RTC, please contact us at the customer service phone number listed on the back of your ID card.

Blue Distinction® Specialty Care

Blue Distinction Specialty Care, our centers of excellence program, focuses on effective treatment for specialty procedures, such as: Bariatric Surgery, Cardiac Care, Knee and Hip Replacement, Spine Surgery, Transplants, Cancer Care, Cellular Immunotherapy (CAR-T), Gene Therapy, Maternity Care, and Substance Use Treatment and Recovery. Using national evaluation criteria developed with input from medical experts, the Blue Distinction Centers offer comprehensive care delivered by multidisciplinary teams with subspecialty training and distinguished clinical expertise. Providers demonstrate quality care, treatment expertise and better overall patient results.

We cover specialty care at designated Blue Distinction Centers at Preferred benefit levels. See pages 86-87 for information regarding enhanced inpatient and outpatient benefits for bariatric, spine, knee and hip surgeries performed at a Blue Distinction Center. We also provide enhanced benefits for covered transplant services performed at the Blue Distinction Centers for Transplant designated centers as described on pages 75-76.

For listings of Blue Distinction Centers, visit https://www.bcbs.com/blue-distinction-center/facility; access our National Doctor & Hospital Finder via www.fepblue.org/provider/; or call us at the customer service phone number listed on the back of your ID card.

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 phone 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 70).

Skilled Nursing Facility (SNF)

A SNF is a freestanding institution or a distinct part of a hospital which customarily bills insurance as a skilled nursing facility and meets the following criteria:

- Is Medicare-certified as a skilled nursing facility;
- Is licensed in accordance with state or local law or is approved by the state or local licensing agency as meeting the licensing standards (where state or local law provides for the licensing of such facilities);
- Has a transfer agreement in effect with one or more Preferred hospitals; and
- Is primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care; or rehabilitation services for the rehabilitation of injured, disabled or sick persons.

To be covered, skilled nursing facility care cannot be maintenance or custodial care. The term skilled nursing facility does not include any institution that is primarily for the care and treatment of mental diseases.

Note: Additional criteria apply when Medicare Part A is not the primary payor (see page 88).

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.

Exceptions:

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 phone number listed in your local phone directory. If you already have your new Service Benefit Plan ID card, call us at the phone 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 may require precertification and prior approval. If you do not obtain precertification, there may be a reduction or denial of benefits. Be sure to read all of the precertification and prior approval information below and on pages 22-26.

- **Inpatient hospital admission, inpatient residential treatment center admission, or skilled nursing facility admission**

Precertification is the process by which – prior to your inpatient 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, inpatient residential treatment center, or skilled nursing facility whether or not they have contacted us and provided all necessary information. You may contact us at the phone number on the back of your ID card to ask if we have received the request for precertification. You are also responsible for enrolling in case management and working with your case manager if your care involves residential treatment or a skilled nursing facility. For information about precertification of an emergency inpatient hospital admission, please see page 26.

Warning: We will reduce our benefits for the inpatient hospital stay by $500, even if you have obtained prior approval for the service or procedure being performed during the stay, 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: If precertification was not obtained prior to admission, inpatient benefits (such as room and board) are not available for inpatient care at a residential treatment center, or, when Medicare Part A is not the primary payor, at a skilled nursing facility. 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; with the exception of admissions for gender reassignment surgery and admissions to residential treatment centers, and skilled nursing facilities.
- You have another group health insurance policy that is the primary payor for the hospital stay; with the exception of admissions for gender reassignment surgery. (See page 76 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)
- Medicare Part A is the primary payor for the hospital or skilled nursing facility stay; with the exception of admissions for gender reassignment surgery. (See page 76 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 65-66 in order for benefits to be provided for the admission and surgical procedure.

- **Other services**

You must obtain prior approval for these services under both Standard and Basic Option. Precertification is also required if the service or procedure requires an inpatient hospital admission. All gender reassignment surgeries require prior approval; if inpatient admission is necessary, precertification is also required. Contact us using the customer service phone 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:

- **Gene therapy and cellular immunotherapy, for example CAR-T and T-Cell receptor therapy**
- **Air Ambulance Transport (non-emergent)** – Air ambulance transport related to immediate care of a medical emergency or accidental injury does not require prior approval; see Section 5 (c), page 92, for more information.
- **Outpatient facility-based sleep studies** – Prior approval is required for sleep studies performed in a provider's office, sleep center, clinic, any type of outpatient center, or any location other than your home.
- **Applied behavior analysis (ABA)** – Prior approval is required for ABA and all related services, including assessments, evaluations, and treatments.
- **Gender reassignment surgery –** Prior to surgical treatment of gender dysphoria, your provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and your provider later modifies the plan.
- **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.
  Note: You must receive genetic counseling and evaluation services before preventive BRCA testing is performed. See page 44.
- **Surgical services** – The surgical services on the following list 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 page 65-66.
  - Outpatient surgical correction of congenital anomalies (see definition on page 152);
  - Outpatient surgery needed to correct accidental injuries (see definition on page 152) to jaws, cheeks, lips, tongue, roof and floor of mouth; and
  - Gender reassignment surgery.
- **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 page 69 for the list of covered organ/tissue transplants. **Prior approval is required** for both the procedure and the facility. Contact us at the customer service phone 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 pages 70-71 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. Contact your local Plan for Medicare's approved transplant programs.

  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 phone number listed on the back of your ID card.

  The blood or marrow stem cell transplants listed on pages 71-73 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 74** must be performed at a FACT-accredited facility. See page 19 for more information about these types of facilities.

  Not every transplant program 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 phone number listed 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 73-74 for the list of conditions covered **only** in clinical trials. Contact us at the customer service phone 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.

  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 Blue Distinction Center for Transplants to treat your condition. If your physician has recommended you receive a transplant or that you participate in a transplant clinical trial, we encourage you to contact the Case Management Department at your Local Plan.

  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 73) where the procedure is to be performed.
- **Transplant travel –** 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 companions. If the transplant recipient is age 21 or younger, we pay up to $10,000 for eligible travel costs for the member and companions. Reimbursement is subject to IRS regulations.

- **Prescription drugs and supplies – Certain prescription drugs and supplies require prior approval.** Contact CVS Caremark, our Pharmacy Program administrator, at 800-624-5060, TTY: 800-624-5077, 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 pages 106-107 for more information 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 for a drug requiring prior approval 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 unable to be filled and a letter will be mailed to you explaining the prior approval procedures.

  Note: The Specialty Drug Pharmacy Program will not fill your prescription for a drug requiring prior approval until you have obtained prior approval. AllianceRx Walgreens Prime, 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 unable to be filled and a letter will be mailed to you explaining the prior approval procedures.
- **Medical foods covered under the pharmacy benefit require prior approval.** See Section 5 (f), page 109, for more information.

- **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 phone 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 70-74) – 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 phone 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 87-88 and 100-101 for additional information.

Note: If we approve the request for prior approval or precertification, you will be provided with a notice that identifies the approved services and the authorization period. You must contact us with a request for a new approval five (5) business days prior to a change to the approved original request, and for requests for an extension beyond the approved authorization period in the notice you received. We will advise you of the information needed to review the request for change and/or extension.

- **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 27.) If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not 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 phone number listed on the back of your Service Benefit Plan ID card. You may also call OPM's FEHB 1 at 202-606-0727 between 8 a.m. and 5 p. m. Eastern Time (excluding holidays) 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 phone 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, 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 phone 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 phone 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* below.

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, your physician or the hospital must contact us for precertification of additional days. Further, if your newborn stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your newborn.

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. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **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, 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 on the next page. Note that these procedures apply to requests for reconsideration of concurrent care claims as well (see page 152 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 verbal or written requests for appeals and the exchange of information by phone, 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.

- **The Federal Flexible Spending Account Program – FSAFEDS**

Health Care FSA (HCFSA) – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, 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).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 4. Your Costs for Covered Services

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

Cost-share/Cost-sharing

Cost-share or 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 81). 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 83).

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 prior 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. See Section 5(i) for information about the deductible and overseas benefits.

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 or not 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 phone 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 20 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 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 20 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 phone 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 156-158). 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 20 for the exceptions to this requirement.

The following tables 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 39; see page 81 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 62). 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 phone 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 20 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 inpatient facility care you receive overseas, we provide benefits in full for admissions to a Department of Defense (DoD) facility, or when the Overseas Assistance Center (provided by GMMI, Inc.) has arranged direct billing or acceptance of a guarantee of benefits with the facility. If a direct billing arrangement or guarantee of benefits is not accepted by the facility, you are responsible for the applicable copayment or coinsurance. For outpatient facility care you receive overseas, we provide benefits in full after you pay the applicable copayment or coinsurance. 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 20 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 healthcare 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 29-30;
- 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 facility;
- 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 20 for the exceptions to the requirement to use Preferred providers.

If your provider's prescription allows for generic substitution and you select a brand-name drug, your expenses for the difference in cost-share do not count toward your catastrophic protection out-of-pocket maximum (see page 103 for additional information).

Carryover

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 above) from that point until the effective date of your new plan.

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

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 prior 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.

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.

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 contract holder.

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. Benefits

See page 15 for how our benefits changed this year. Pages 163-166 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.

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Standard and Basic Option Overview

The benefit package for Standard and Basic Options are described in Section 5, which is divided into subsections 5(a) through 5(i). Make sure that you review the benefits that are available under the option in which you are enrolled.

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 phone number on the back of your Service Benefit Plan ID card or on our website at www.fepblue.org. Each option offers unique features. Members do not need to have referrals to see specialists.

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 Retail Pharmacy Program, a Mail Service Prescription Drug Program, and a 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). 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 Retail Pharmacy Program and a 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 Healthcare 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 Get Care*, for information on covered professional providers and other healthcare 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 healthcare 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 or facility bills for the service.
- The services listed in this Section are for the charges billed by a physician or other healthcare 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.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 114 for information about Tier 4 and Tier 5 specialty drug fills from Preferred providers and Preferred pharmacies. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731. Basic Option members must use Preferred providers and Preferred pharmacies (see page 116).
- We waive the cost-share for the first 2 visits for telehealth per calendar year. This applies to a combined total for treatment of minor acute conditions, dermatology care, and mental health and substance use disorder conditions. (See pages 39 and 99.)
- **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 20 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 healthcare professionals: • Consultations • Genetic counseling • 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) • Phone consultations and online medical evaluation and management services (telemedicine) Note: Please refer to pages 40-42 for our coverage of laboratory, X-ray, and other diagnostic tests billed for by a healthcare professional, and to page 83 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 healthcare 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 healthcare 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 152 for more information about “agents.”) Participating/Non-participating: You pay all charges
Telehealth professional services for: • Minor acute conditions (see page 155 for definition) • Dermatology care (see page 159 for definition) Note: Refer to Section 5(h), *Wellness and Other Special Features*, for information on telehealth services and how to access a provider. Note: Benefits are combined with telehealth services listed in Section 5(e), see page 99.	Preferred Telehealth Provider: Nothing (no deductible) for the first 2 visits per calendar year for any covered telehealth service $10 copayment per visit (no deductible) after the 2nd visit Participating/Non-participating: You pay all charges	Preferred Telehealth Provider: Nothing for the first 2 visits per calendar year for any covered telehealth service $15 copayment per visit after the 2nd visit 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	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

Benefit Description	You Pay	
Diagnostic and Treatment Services (cont.)	**Standard Option**	**Basic Option**
• 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	See previous page	See previous page
Not covered: • *Routine services except for those Preventive care services described on pages 42-46* • *Costs associated with enabling or maintaining providers' telehealth (telemedicine) technologies, non-interactive telecommunication such as email communications, or store-and-forward telehealth 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	**Standard Option**	**Basic Option**
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	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 152 for more information about “agents.”)

Lab, X-ray and Other Diagnostic Tests - continued on next page

Benefit Description	You Pay	
Lab, X-ray and Other Diagnostic Tests (cont.)	**Standard Option**	**Basic Option**
See previous page	Continued from previous page: 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.	Continued from previous page: 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.
Diagnostic tests including but not limited to: • Cardiovascular monitoring • EEGs • Home-based/unattended sleep studies • 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 152 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 • Nuclear medicine • Facility-based sleep studies (prior approval required) • 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.	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 152 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.

Lab, X-ray and Other Diagnostic Tests - continued on next page

Benefit Description	You Pay	
Lab, X-ray and Other Diagnostic Tests (cont.)	**Standard Option**	**Basic Option**
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 page 44). Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.	See previous page	See previous page
Preventive Care, Adult	**Standard Option**	**Basic Option**
Routine physical exams and the preventive care benefits separately listed below are limited to one per calendar year and to members age 22 and over. The **following** preventive services are covered at the time interval recommended at each of the links below as adopted by December 31, 2019. Covered services include: • 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. See Section 5(h) for complete information. • Basic or comprehensive metabolic panel test • CBC • Cervical cancer screening tests - Human papillomavirus (HPV) tests of cervix - Pap tests of the cervix • Colorectal cancer tests, including: - Colonoscopy, with or without biopsy (see page 63 for our payment levels for diagnostic colonoscopies) - DNA analysis of stool samples - Double contrast barium enema - Fecal occult blood test - Sigmoidoscopy • EKG • Fasting lipoprotein profile (total cholesterol, LDL, HDL, and/or triglycerides) • General health panel • Individual counseling on prevention and reducing health risks	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. 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.	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

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
• Nutritional counseling Note: When nutritional counseling is via the contracted telehealth provider network, we provide benefits as shown here for Preferred providers. Refer to Section 5 (h), *Wellness and Other Special Features*, for information on how to access a telehealth provider. Note: Benefits are limited to individual nutritional counseling services. We do not provide benefits for group counseling services. • Prostate cancer test – Prostate Specific Antigen (PSA) • Screening for chlamydial infection • Screening for diabetes mellitus • Screening for gonorrhea infection • Screening for human immunodeficiency virus (HIV) • Screening mammograms, including mammography using digital technology • Ultrasound for abdominal aortic aneurysm for adults, ages 65 to 75, limited to one screening per lifetime • Urinalysis • Visits/exams for preventive care Note: See the definition of Preventive Care, Adult, on page 158 for included health screening services. • Immunizations such as Pneumococcal, influenza, shingles, tetanus/DTaP) and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules. 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. • USPSTF A and B recommended screenings such as cancer, osteoporosis, depression, and high blood pressure. For a complete list of covered A and B recommendation screenings and age and frequency limitations go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org • Well woman care such as gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of Well Women preventive care services go to the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/	Continued from previous page: Note: Many Preferred retail pharmacies participate in our vaccine network. See page 111 for our coverage of these vaccines when provided by pharmacies in the vaccine network.	Continued from previous page: 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: Many Preferred retail pharmacies participate in our vaccine network. See page 111 for our coverage of these vaccines when provided by pharmacies in the vaccine network.

Preventive Care, Adult - continued on next page

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
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. If you receive both preventive and diagnostic services from your Provider on the same day, you are responsible for paying you cost-share for the diagnostic services.	See previous page	See previous page
Hereditary Breast and Ovarian Cancer Screening Benefits are available for screening members, age 18 and over limited to one of each type of test per lifetime, 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 and additional BRCA coverage or call the phone number on the back of your ID card for additional policy information. Note: Preventive care benefits are not available for surgical removal of breasts, ovaries, or prostate. See page 63 for the surgical benefits available for these services. Note: See page 112 for our payment levels for medications to promote better health as recommended under the Affordable Care Act. Note: See page 113 for our payment levels for certain bowel preparation medications, and antiretroviral medications for the prevention of HIV. Note: Unless otherwise noted, the benefits listed above and on pages 42-43 do not apply to children up to age 22. (See benefits under *Preventive Care, Child*, this Section.)	See page 42	See page 42

Preventive Care, Adult - continued on next page

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance and deductible.	See page 42	See page 42
Not covered: • *Genetic testing related to family history of cancer or other disease, except as described on page 44* *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* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure. Medical benefits may be available for these services.* • *Phone consultations and online medical evaluation and management services (telemedicine) for preventive services, except as noted on page 43 for nutritional counseling.*	*All charges*	*All charges*
Preventive Care, Child	**Standard Option**	**Basic Option**
Benefits are provided for preventive care services for children up to age 22. This includes: • Well-child visits, examinations, and other preventive services as adopted by December 31, 2019, and described in the Bright Future Guidelines as provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Future Guidelines go to https://brightfutures.aap.org • Immunizations such as DTaP, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html Note: U.S. FDA licensure may restrict the use of the immunizations and vaccines listed above to specific age ranges, frequencies, and/or other patient-specific indications, including gender.	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.

Preventive Care, Child - continued on next page

Benefit Description	You Pay	
Preventive Care, Child (cont.)	**Standard Option**	**Basic Option**
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 • Cervical cancer screening tests - Pap tests of the cervix - Human papillomavirus (HPV) tests of the cervix • Screening for human immunodeficiency virus (HIV) infection • Screening for syphilis infection • Screening for latent tuberculosis infection for children ages 18 through 21 • Nutritional counseling 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. Note: Benefits are limited to individual nutritional counseling services. We do not provide benefits for group counseling services. Note: When nutritional counseling is via the contracted telehealth provider network, we provide benefits as shown here for Preferred providers. Refer to Section 5(h), *Wellness and Other Special Features*, for information on how to access a telehealth provider. Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: See page 112 for our payment levels for medications to promote better health as recommended under the Affordable Care Act.	Continued from previous page: 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.	Continued from previous page: 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	**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	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.	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 the notes on pages 82-85.

Maternity Care - continued on next page

Benefit Description	You Pay	
Maternity Care (cont.)	**Standard Option**	**Basic Option**
• 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 healthcare providers such as physicians, physician assistants, midwives, nurse practitioners/clinical specialists, and lactation consultants Note: See page 48 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 (skilled) related to covered maternity care are subject to the visit limitations described on page 59. Note: Maternity care benefits are not provided for prescription drugs required during pregnancy, except as recommended under the Affordable Care Act. See page 112 for more information. See Section 5(f) for other prescription drug coverage. Note: Here are some things to keep in mind: • You do not need to precertify your delivery; see page 26 for other circumstances, such as extended stays for you or your newborn. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary.	Continued from previous page: 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 phone number on the back of your ID card to obtain information about your coverage and the Plan allowance for the services.	Continued from previous page: 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

Benefit Description	You Pay	
Maternity Care (cont.)	**Standard Option**	**Basic Option**
• We cover routine nursery care of the newborn when performed during the covered portion of the mother's maternity stay and billed by the facility. We cover other care of a newborn who requires professional services or non-routine treatment, only if we cover the newborn under a Self Plus One or Self and Family enrollment. Surgical benefits apply to circumcision when billed by a professional provider for a male newborn. • Hospital services are listed in Section 5(c) and Surgical benefits are in Section 5(b). Note: See page 156 for our payment for inpatient stays resulting from an emergency delivery at a hospital or other facility not contracted with your Local Plan. 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 63 for our payment levels for circumcision.	See previous page	See previous page
• Breast pump kit, limited to one of the two kits listed below, per calendar year, for members 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 800-262-7890.	Nothing (no deductible)	Nothing
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 above on this page*	*All charges*	*All charges*

Maternity Care - continued on next page

Benefit Description	You Pay	
Maternity Care (cont.)	**Standard Option**	**Basic Option**
• *Breastfeeding supplies other than those contained in the breast pump kit described on the previous page 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 members not enrolled in the Service Benefit Plan*	*All charges*	*All charges*
Family Planning	**Standard Option**	**Basic Option**
A range of voluntary family planning services for women, limited to: • Contraceptive counseling • Diaphragms and contraceptive rings • Injectable contraceptives • Intrauterine devices (IUDs) • Implantable contraceptives • Tubal ligation or tubal occlusion/tubal blocking procedures only Family planning services for men, limited to: • Vasectomy Note: We also provide benefits for professional services associated with tubal ligation/occlusion/blocking procedures, vasectomy, 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
• 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 110 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*

Benefit Description	You Pay	
Reproductive Services	**Standard Option**	**Basic Option**
Diagnosis and treatment of infertility including covered: • Diagnostic and treatment services • Laboratory tests • Diagnostic tests • Surgical procedures • Prescription drugs Note: See Section 5(a) for covered labs, diagnostic tests, and X-rays. Note: See Section 5(b) for covered surgical services. Note: See Section 5(f) for covered prescription drugs. Note: See below for a list of services not covered as treatments for infertility or as alternatives to conventional conception.	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 healthcare 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 152 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.
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) and 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*

Benefit Description	You Pay	
Allergy Care	**Standard Option**	**Basic Option**
• Allergy testing • Allergy treatment • Sublingual allergy desensitization drugs as licensed by the U.S. FDA 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 healthcare 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 152 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 healthcare 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*

Benefit Description	You Pay	
Treatment Therapies	**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 21-24). • 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 22 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 59. • Outpatient cardiac rehabilitation • Pulmonary rehabilitation therapy • Applied behavior analysis (ABA) for the treatment of an autism spectrum disorder (see prior approval requirements on page 22) Note: See Section 5(c) for our payment levels for treatment therapies billed for by the outpatient department of a hospital. Note: See page 60 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 healthcare 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 152 for more information about “agents.”) Participating/Non-participating: You pay all charges
• Auto-immune infusion medications: Remicade, Renflexis and Inflectra Note: See above for your costs for intravenous (IV)/ infusion therapy - Home IV or infusion therapy.	Preferred: 10% 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 billed amount	Preferred: 15% of the Plan allowance Member or Non-member: You pay all charges

Treatment Therapies - continued on next page

Benefit Description	You Pay	
Treatment Therapies (cont.)	**Standard Option**	**Basic Option**
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 21-24). • 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.) • Applied behavior analysis (ABA) for the treatment of an autism spectrum disorder (see prior approval requirements on page 22)	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 Rehabilitation Therapy	**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 healthcare 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.	Preferred primary care provider or other healthcare 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 152 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.

Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Rehabilitation Therapy - continued on next page

Benefit Description	You Pay	
Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Rehabilitation Therapy (cont.)	**Standard Option**	**Basic Option**
See previous page	Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown on page 53, according to the contracting status of the facility.	See previous page
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* • *Equine therapy and hippotherapy (exercise on horseback)* • *Massage therapy*	*All charges*	*All charges*
Hearing Services (Testing, Treatment, and Supplies)	**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 57.	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 healthcare 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 152 for more information about “agents.”) Participating/Non-participating: You pay all charges
Not covered: • *Routine hearing tests (except as indicated on page 45)* • *Hearing aids (except as described on page 57)*	*All charges*	*All charges*
Vision Services (Testing, Treatment, and Supplies)	**Standard Option**	**Basic Option**
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;	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies)	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges

Vision Services (Testing, Treatment, and Supplies) - continued on next page

Benefit Description	You Pay	
Vision Services (Testing, Treatment, and Supplies) (cont.)	**Standard Option**	**Basic Option**
• For the nonsurgical treatment for amblyopia and strabismus, for children from birth through age 21 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 and on page 54.	Continued from previous page: Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	See previous page
• Eye examinations related to a specific medical condition • Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 21 Note: See above and on page 54 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 40-42 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 above.	Preferred primary care provider or other healthcare 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 healthcare 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 152 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 above and on page 54* • *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 above*	*All charges*	*All charges*

Benefit Description	You Pay	
Foot Care	**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 healthcare 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 healthcare 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 152 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	**Standard Option**	**Basic Option**
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 limited to treatment of erectile dysfunction or as part of an approved plan for gender reassignment surgery • Surgical implants 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

Benefit Description	You Pay	
Orthopedic and Prosthetic Devices (cont.)	**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 5 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, 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* • *Over the counter hearing aids, enhancement devices, accessories or supplies (including remote controls and warranty packages)*	*All charges*	*All charges*
Durable Medical Equipment (DME)	**Standard Option**	**Basic Option**
Durable medical equipment (DME) is equipment and supplies that are: 1. Prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Medically necessary; 3. Primarily and customarily used only for a medical purpose; 4. Generally useful only to a person with an illness or injury; 5. Designed for prolonged use; and 6. Used to 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	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.

Durable Medical Equipment (DME) - continued on next page

Benefit Description	You Pay	
Durable Medical Equipment (DME) (cont.)	**Standard Option**	**Basic Option**
• 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.	See previous page	See previous page
• 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
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 48* • *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 above)* • *Equipment for cosmetic purposes* • *Topical Hyperbaric Oxygen Therapy (THBO)*	*All charges*	*All charges*
Medical Supplies	**Standard Option**	**Basic Option**
• Medical foods and nutritional supplements when administered by catheter or nasogastric tubes Note: See Section 10, *Definitions*, for more information about medical foods. • Ostomy and catheter supplies	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

Medical Supplies - continued on next page

Benefit Description	You Pay	
Medical Supplies (cont.)	**Standard Option**	**Basic Option**
• 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.	See previous page	See previous page
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* • *Medical foods administered orally, except as described in Section 5(f)*	*All charges*	*All charges*
Home Health Services	**Standard Option**	**Basic Option**
Home nursing care (skilled) 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 152 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*	*All charges*	*All charges*

Home Health Services - continued on next page

Benefit Description	You Pay	
Home Health Services (cont.)	**Standard Option**	**Basic Option**
• *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 pages 88-89.* • *Private duty nursing*	*All charges*	*All charges*
Manipulative Treatment	**Standard Option**	**Basic Option**
Manipulative treatment performed by a professional provider, 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. 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: $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	**Standard Option**	**Basic Option**
Acupuncture Note: Acupuncture must be performed and billed by a healthcare 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 17 for more information. Note: When billed by a facility such as the outpatient department of a hospital, you are limited to the number of visits per calendar year listed on this page. See Section 5(c) for your cost-share. Note: See page 77 for our coverage of acupuncture when provided as anesthesia for covered surgery. Note: See page 46 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 healthcare 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

Alternative Treatments - continued on next page

Benefit Description	You Pay	
Alternative Treatments (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Biofeedback* • *Self-care or self-help training*	*All charges*	*All charges*
Educational Classes and Programs	**Standard Option**	**Basic Option**
• Smoking and tobacco cessation treatment - Individual counseling for smoking and tobacco 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 40, 43 and 46 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 healthcare 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, or applied behavior analysis (ABA), when performed as part of an educational class or program* • *Premenstrual syndrome (PMS), lactation (except as described on page 47), headache, eating disorder (except as described on pages 40 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*	*All charges*	*All charges*

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare 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 healthcare 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 healthcare 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*, page 152) 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.**
- **YOU MUST GET PRIOR APPROVAL for gender reassignment surgery. Prior to any gender reassignment surgery, your provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and your provider later modifies the plan (including changes to the procedures to be performed or the anticipated dates for the procedures). See page 22 and page 64 for additional information. If your surgical procedure requires an inpatient admission, YOU MUST ALSO GET PRECERTIFICATION of the inpatient care.**
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 114 for information about Tier 4 and Tier 5 specialty drug fills from Preferred providers and Preferred pharmacies. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731. Basic Option members must use Preferred providers and Preferred pharmacies (see page 116).
- **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 20 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 • Assistant surgeons/surgical assistance if required because of the complexity of the surgical 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 42). 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 67) • 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.	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 152 for more information about "agents.") Participating/Non-participating: You pay all charges

Surgical Procedures - continued on next page

Benefit Description	You Pay	
Surgical Procedures (cont.)	**Standard Option**	**Basic Option**
• **Gender reassignment surgical benefits** are limited to the following: - For female to male surgery: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty, electrolysis (hair removal at the covered operative site), and placement of testicular and erectile prosthesis - For male to female surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, labiaplasty, and electrolysis (hair removal at the covered operative site) **Note: Prior approval is required for gender reassignment surgery.** For more information about prior approval, please refer to page 22. Note: Benefits for gender reassignment surgery are limited to once per covered procedure, per lifetime. Benefits are not available for repeat or revision procedures when benefits were provided for the initial procedure. Benefits are not available for gender reassignment surgery for any condition other than gender dysphoria. • Gender reassignment surgery on an inpatient or outpatient basis is subject to the pre-surgical requirements listed below. **The member must meet all requirements**. - **Prior approval is obtained** - **Member must be at least 18 years of age at the time prior approval is requested and the treatment plan is submitted** - Diagnosis of gender dysphoria by a qualified healthcare professional • New gender identity has been present for at least 24 continuous months • Member has a strong desire to be rid of primary and/or secondary sex characteristics because of a marked incongruence with the member's identified gender • Member's gender dysphoria is not a symptom of another mental disorder or chromosomal abnormality • Gender dysphoria causes clinical distress or impairment in social, occupational, or other important areas of functioning - Member must meet the following criteria: • Living 12 months of continuous, full-time, real-life experience in the desired gender (including place of employment, family, social and community activities) • 12 months of continuous hormone therapy appropriate to the member's gender identity	See page 63	See page 63

Surgical Procedures - continued on next page

Benefit Description	You Pay	
Surgical Procedures (cont.)	**Standard Option**	**Basic Option**
• Two referral letters from qualified mental health professionals – one must be from a psychotherapist who has treated the member for a minimum of 12 months. Letters must document: diagnosis of persistent and chronic gender dysphoria; any existing co-morbid conditions are stable; member is prepared to undergo surgery and understands all practical aspects of the planned surgery • If medical or mental health concerns are present, they are being optimally managed and are reasonably well-controlled • **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. Benefits are available only for the following procedures: - Roux-en-Y - Gastric bypass - Laparoscopic adjustable gastric banding - Sleeve gastrectomy - Biliopancreatic bypass with duodenal switch **Note: Benefits for the surgical treatment of morbid obesity are subject to the requirements listed on pages 62-63.** 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 86-87 for information. 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 above) for a period of 1 year 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 pages 43 and 46 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	See page 63	See page 63

Surgical Procedures - continued on next page

Benefit Description	You Pay	
Surgical Procedures (cont.)	**Standard Option**	**Basic Option**
- 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 use disorder for 1 year prior to surgery and there is no evidence of substance use disorder 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, except when the subsequent surgery is necessary to treat a complication from the prior morbid obesity surgery. - 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	See page 63	See page 63
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*	*All charges*	*All charges*

Surgical Procedures - continued on next page

Benefit Description	You Pay	
Surgical Procedures (cont.)	**Standard Option**	**Basic Option**
• *LASIK, INTACS, radial keratotomy, and other refractive surgery* • *Surgeries related to sexual inadequacy (except surgical placement of penile prostheses to treat erectile dysfunction and gender reassignment surgeries specifically listed as covered)* • *Reversal of gender reassignment surgery*	*All charges*	*All charges*
Reconstructive Surgery	**Standard Option**	**Basic Option**
• Surgery to correct a functional defect • Surgery to correct a congenital anomaly (See Section 10, page 152, for definition.) • 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 152 for more information about "agents.") Participating/Non-participating: You pay all charges

Reconstructive Surgery - continued on next page

Benefit Description	You Pay	
Reconstructive Surgery (cont.)	**Standard Option**	**Basic Option**
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 sexual dysfunction or sexual inadequacy (except surgical placement of penile prostheses to treat erectile dysfunction and gender reassignment surgeries specifically listed as covered)* • *Reversal of gender reassignment surgery*	*All charges*	*All charges*
Oral and Maxillofacial Surgery	**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 phone 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 152 for more information about “agents.”) Participating/Non-participating: You pay all charges

Oral and Maxillofacial Surgery - continued on next page

Benefit Description	You Pay	
Oral and Maxillofacial Surgery (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Oral implants and transplants except for those required to treat accidental injuries as specifically described on page 68 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 on page 68 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 on page 68 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 on page 68 and in Section 5(g)*	*All charges*	*All charges*

Organ/Tissue Transplants

Prior approval requirements:

You must obtain prior approval (see page 23) 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: Pages 73-74 have **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 21-22 for information about precertification of inpatient care.

Covered organ/tissue transplants are listed on pages 70-71. 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. Contact your local Plan for Medicare's approved transplant programs.

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 phone number on the back of your ID card.

Blood or marrow stem cell transplants are covered as shown on pages 71-75. 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 71-75, the medical necessity limitation is considered satisfied if the patient meets the staging description.

The blood or marrow stem cell transplants listed on pages 71-73 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 74** must be performed at a FACT-accredited facility. See page 19 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 phone number listed 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 71-72 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 73-74 for information about **blood or marrow stem cell transplants covered only in clinical trials** and the **additional requirements** that apply.

Note: See pages 144-145 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 76 for more information).

Benefit Description	You Pay	
Organ/Tissue Transplants	**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	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.

Organ/Tissue Transplants - continued on next page

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
• 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 pages 69-70 for the prior approval and facility requirements that apply to **organ/tissue transplants**.	See previous page	Continued from previous page: 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 for the diagnoses as indicated below: • 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, Hurler's syndrome and Maroteaux-Lamy syndrome variants) • 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)	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

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
• Primary immunodeficiencies (e.g., severe combined immunodeficiency, Wiskott-Aldrich syndrome, hemophagocytic lymphohistiocytosis, X-linked lymphoproliferative syndrome, Kostmann's syndrome, leukocyte adhesion deficiencies) Note: See pages 69-70 for the prior approval and facility requirements that apply to **blood or marrow stem cell transplants**. Note: Refer to pages 73-75 for information about **blood or marrow stem cell transplants covered only in clinical trials**.	See previous page	See previous page
Autologous blood or marrow stem cell transplants for the diagnoses as indicated below: • 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) • Scleroderma Note: See pages 69-70 for the prior approval and facility requirements that apply to **blood or marrow stem cell transplants.** Note: Refer to pages 73-75 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

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
Blood or marrow stem cell transplants for the diagnoses as indicated below, **only** when performed as part of a clinical trial that meets the facility criteria described on page 69 and the **requirements** listed on page 74: • Allogeneic blood or marrow stem cell transplants for: - Breast cancer - Colon cancer - Epidermolysis bullosa - Glial tumors (e.g., anaplastic astrocytoma, choroid plexus tumors, ependymoma, glioblastoma multiforme) - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Retinoblastoma - Rhabdomyosarcoma - Sarcoma - Wilm's tumor • Autologous blood or marrow stem cell transplants for: - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - 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 74 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

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
Blood or marrow stem cell transplants for the diagnoses as indicated below, **only** when performed at a FACT-accredited facility (see page 19) as part of a **clinical trial** that meets the **requirements** listed below: • Allogeneic blood or marrow stem cell transplants for: - Autoimmune disease (limited to: multiple sclerosis, scleroderma, systemic lupus erythematosus and chronic inflammatory demyelinating polyneuropathy) • Autologous blood or marrow stem cell transplants for: - Autoimmune disease (limited to: multiple sclerosis, systemic lupus erythematosus and 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 phone 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 73, 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.	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

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
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 pages 144-145 for our coverage of other costs associated with clinical trials.	See previous page	See previous page
Related transplant services: • Extraction or reinfusion of blood or marrow stem cells as part of a covered allogeneic or autologous 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 71-74 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 71-74 • Covered medical and hospital expenses of the donor, when we cover the recipient • Covered 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 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 159 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 phone 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 71-74
- Related transplant services listed on page 75

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 companions. If the transplant recipient is age 21 or younger, we pay up to $10,000 for eligible travel costs for the member and companions. 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 pages 70-71 for benefit information for these transplants.

Note: See Section 5(c) for our benefits for facility care.

Note: See pages 70-76 for requirements related to blood or marrow stem cell transplant coverage.

Benefit Description	You Pay	
Organ/Tissue Transplants	**Standard Option**	**Basic Option**
Not covered: • *Any transplant not listed as covered and transplants for any diagnosis not listed as covered* • *Donor screening tests and donor search expenses, including associated travel expenses, except as defined on page 75* • *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 pages 70-71* • *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*

Benefit Description	You Pay	
Anesthesia	**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: Anesthesia acupuncture services do not accumulate toward the member's annual maximum. 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
Not covered: • *Anesthesia related to non-covered surgeries or procedures*	*All charges*	*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 AND SKILLED NURSING FACILITY 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 82. See page 155 for more information about these types of services.
- **YOU MUST GET PRIOR APPROVAL for the following services if they are to be performed on an outpatient basis: facility-based sleep studies; surgery for morbid obesity; surgical correction of congenital anomalies; and outpatient surgery needed to correct accidental injuries (see *Definitions*, page 152) to jaws, cheeks, lips, tongue, roof and floor of mouth. Please refer to page 22 for more information.**
- **YOU MUST GET PRIOR APPROVAL for gender reassignment surgery. See page 22 for prior approval and pages 64-65 for the surgical benefit.**
- 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 healthcare 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 or facility bills for the service.
- 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.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 114 for information about Tier 4 and Tier 5 specialty drug fills from Preferred providers and Preferred pharmacies. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731. Basic Option members must use Preferred providers and Preferred pharmacies (see page 116).
- **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 20 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 pages 155-157 for more information. See pages 87-88 and 100-101 for inpatient residential treatment center. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • 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 82. See page 155 for more information about these types of services.	Preferred facilities: $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 facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: $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 facilities: $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 facilities: You pay all charges

Inpatient Hospital - continued on next page

Benefit Description	You Pay	
Inpatient Hospital (cont.)	**Standard Option**	**Basic Option**
Note: Here are some things to keep in mind: • You do not need to precertify your delivery; see page 26 for other circumstances, such as extended stays for you or your newborn. • 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 page 26 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 46-48 for other covered maternity services. Note: See page 59 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 pages 86-87 for information.	See previous page	See previous page
Not covered: • *Admission to non-covered facilities, such as nursing homes, extended care facilities, schools, or residential treatment centers (except as described on pages 87-88 and 100-101)* • *Personal comfort items, such as guest meals and beds, phone, television, beauty and barber services* • *Private duty nursing* • *Facility room and board expenses when, in our judgment, an 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* • *Care that is 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.*	*All charges*	*All charges*

Inpatient Hospital - continued on next page

Benefit Description	You Pay	
Inpatient Hospital (cont.)	**Standard Option**	**Basic Option**
- *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 an inpatient 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 18-19).*	*All charges*	*All charges*
Outpatient Hospital or Ambulatory Surgical Center	**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 • Acupuncture • 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 42). 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	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 facilities: $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 152 for more information about "agents.") Member/Non-member facilities: You pay all charges

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**Standard Option**	**Basic Option**
• Other medical supplies, including oxygen • Surgical implants Notes: • See pages 95-97 for our payment levels for care related to a medical emergency or accidental injury. • See page 49 for our coverage of family planning services. • For our coverage of hospital-based clinic visits, please refer to the professional benefits described on pages 39-40 and page 55 for vision services. • 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 86-87 for information. • 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 46-48 for other included maternity services. • See page 85 for outpatient drugs, medical devices, and durable medical equipment billed for by a facility. • 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.	See previous page	See previous page
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 facilities: $350 copayment for the duration of services (no deductible) Member facilities: $450 copayment for the duration of services, plus 35% of the Plan allowance (no deductible) Non-member facilities: $450 copayment for the duration of services, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred facilities: $175 per day copayment up to $875 Member/Non-member facilities: You pay all charges

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**Standard Option**	**Basic Option**
Outpatient **diagnostic testing and treatment services** performed and billed by a facility, limited to: • Angiographies • Bone density tests • CT scans/MRIs/PET scans • Nuclear medicine • Facility-based sleep studies (prior approval is required) • 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.	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 facilities: $150 copayment per day per facility Member facilities: $150 copayment per day per facility Non-member facilities: $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 152 for more information about “agents.”)
Outpatient **diagnostic testing services** performed and billed by a facility, such as: • Cardiovascular monitoring • EEGs • Home-based/unattended sleep studies • 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 facilities: $40 copayment per day per facility Member facilities: $40 copayment per day per facility Non-member facilities: $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 152 for more information about “agents.”)

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**Standard Option**	**Basic Option**
Outpatient **treatment and therapy services** performed and billed by a facility, limited to: • Cognitive rehabilitation therapy • Physical, occupational, and speech therapy - Standard Option benefits are limited to a combined total of 75 visits per person per calendar year - Basic Option benefits are limited to a combined total of 50 visits per person per calendar year • Manipulative treatment services - Standard Option benefits are limited to a combined total of 12 visits per person per calendar year - Basic Option benefits are limited to a combined total of 20 visits per person per calendar year	Preferred facilities: $25 copayment per day per facility (no deductible) 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 facilities: $30 copayment per day per facility Member/Non-member facilities: You pay all charges Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 152 for more information about “agents.”)
Outpatient **treatment services** performed and billed by a facility, limited to: • Cardiac rehabilitation • Pulmonary rehabilitation • Applied behavior analysis (ABA) for an autism spectrum disorder (see prior approval requirements on page 22)	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 facilities: $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 152 for more information about “agents.”) Member/Non-member facilities: You pay all charges

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**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 facilities: Nothing Member facilities: Nothing Non-member facilities: 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 152 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 42-45 • Cancer screenings listed on page 42-43 and ultrasound screening for abdominal aortic aneurysm Note: See page 44 for our coverage requirements for preventive BRCA testing. Note: See pages 45-46 for our payment levels for covered preventive care services for children billed for by facilities and performed on an outpatient basis.	See page 42 for our payment levels for covered preventive care services for adults	Preferred facilities: Nothing Member/Non-member facilities: 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 • Surgical implants 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. Note: Certain self-injectable drugs are covered only when dispensed by a pharmacy under the pharmacy benefit. These drugs will be covered once per lifetime per therapeutic category of drugs when dispensed by a non-pharmacy-benefit provider. This benefit limitation does not apply if you have primary Medicare Part B coverage.	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 facilities: 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 81-84 for specific coverage information. Member/Non-member facilities: You pay all charges

Benefit Description	You Pay	
Blue Distinction® Specialty Care	**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 Knee and Hip Replacement, Blue Distinction Center for Spine Surgery, or Blue Distinction Center for Comprehensive Bariatric Surgery. • Bariatric surgeries covered are: - Roux-en-Y - Gastric bypass - Laparoscopic adjustable gastric banding - Sleeve gastrectomy - Biliopancreatic bypass with duodenal switch • 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 phone 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 78-80 for regular inpatient hospital benefits and pages 81-85 for outpatient facility benefit levels. Note: See pages 18-19 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 specific covered bariatric surgical procedures, when the surgery is performed at a designated Blue Distinction Center for Bariatric Surgery. Outpatient facility services related to specific covered hip and knee replacement or revision surgeries and certain spine surgery procedures, when performed at a designated Blue Distinction Center for hip/knee/spine surgery.	Blue Distinction Center: $100 per day per facility (no deductible)	Blue Distinction Center: $25 per day per facility

Blue Distinction® Specialty Care - continued on next page

Benefit Description	You Pay	
Blue Distinction® Specialty Care (cont.)	**Standard Option**	**Basic Option**
Note: You must meet the pre-surgical requirements listed on pages 65-66 for bariatric surgeries. Note: 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 phone 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 benefits do not apply to other types of outpatient surgical services, even when performed at a Blue Distinction Center. See pages 81-82 for the benefits we provide. Note: See pages 18-19 for more information about Blue Distinction Centers.	Blue Distinction Center: $100 per day per facility (no deductible)	Blue Distinction Center: $25 per day per facility
Residential Treatment Center	**Standard Option**	**Basic Option**
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 use disorder: • 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.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: 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 facilities: $175 per day copayment up to $875 per admission for unlimited days Member/Non-member facilities: You pay all charges

Residential Treatment Center - continued on next page

Benefit Description	You Pay	
Residential Treatment Center (cont.)	**Standard Option**	**Basic Option**
Note: Benefits are not available for non-covered services, including: respite care; outdoor residential programs; services provided outside of the provider's scope of licensure; recreational therapy; educational therapy; educational classes; biofeedback; Outward Bound programs; equine/hippotherapy provided during the approved stay; personal comfort items, such as guest meals and beds, phone, 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. Note: For outpatient residential treatment center services, see page 101.	See previous page	See previous page
Extended Care Benefits/Skilled Nursing Care Facility Benefits	**Standard Option**	**Basic Option**
When Medicare Part A is not your primary payor: For members who do not have Medicare Part A, we cover skilled nursing facility (SNF) inpatient care for a maximum of 30 days annually, when the member can be expected to benefit from short-term SNF services with a goal of returning home. The following criteria must also be met: • Member is enrolled in case management prior to admission to the SNF (signed consent required), and actively participates in case management both prior to and during admission to the SNF. • Precertification is obtained prior to admission (including overseas care). • We approve the preliminary treatment plan prior to admission (plan must include proposed therapies and document the need for inpatient care). • Member participates in all treatment and care planning activities, including discharge planning/transition to home. Benefits are not available for inpatient SNF care solely for management of tube feedings, for home level dialysis treatment, as an interim transition to long term care placement, or for any other non-covered services. Note: No inpatient benefits (such as room and board) will be provided if precertification is not obtained prior to admission (see page 21). Members are responsible for enrolling in case management (see page 21).	Preferred facilities: $175 (no deductible) per admission Member facilities: $275 plus 35% of the Plan allowance (no deductible) per admission Non-member facilities: $275 plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment, per admission	All charges

Extended Care Benefits/Skilled Nursing Care Facility Benefits - continued on next page

Benefit Description	You Pay	
Extended Care Benefits/Skilled Nursing Care Facility Benefits (cont.)	**Standard Option**	**Basic Option**
When Medicare Part A is your primary payor: When Medicare Part A is the primary payor (meaning it pays first) and has made a 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. Note: See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c03.pdf for complete Medicare benefit period definition. 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 84 for benefits provided for outpatient physical, occupational, speech, and cognitive rehabilitation therapy, and manipulative treatment services when billed by a skilled nursing facility. See Section 5(f) for benefits for prescription drugs. ***Note: If Medicare Part A is your primary payor, we will only provide benefits if Medicare provided benefits for the admission.***	Preferred facilities: Nothing (no deductible) Member facilities: Nothing (no deductible) Non-member facilities: Nothing (no deductible) Note: You pay all charges not paid by Medicare after the 30th day.	All charges
Not covered: *Phone, television, personal comfort items, such as guest meals and beds, beauty and barber services, recreational outings/trips, stretcher or wheelchair transportation, non-emergent 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, custodial or long term care (see* Definitions*), and domiciliary care provided because care in the home is not available or is unsuitable*	*All charges*	*All charges*
Hospice Care	**Standard Option**	**Basic Option**
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 pages 90-92	See pages 90-92

Hospice Care - continued on next page

Benefit Description	You Pay	
Hospice Care (cont.)	**Standard Option**	**Basic Option**
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
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 page 22 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 on this page and on pages 91-92. **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: • Advanced care planning (see Section 10, page 152) • Dietary counseling • Durable medical equipment rental • Medical social services • Medical supplies • Nursing care	See next page	See next page

Hospice Care - continued on next page

Benefit Description	You Pay	
Hospice Care (cont.)	**Standard Option**	**Basic Option**
• Oxygen therapy • Periodic physician visits • Physical therapy, occupational therapy, and speech therapy related to the terminal medical condition • Prescription drugs and medications • Services of home health aides (certified or licensed, if the state requires it, and provided by the home hospice agency)	See below	See below
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. An episode of care is one home hospice treatment plan per calendar year. See page 90 for prior approval requirements.	Preferred facilities: Nothing (no deductible) Member/Non-member facilities: $450 copayment per episode (no deductible)	Preferred facilities: Nothing Member/Non-member facilities: You pay all charges
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. The member must be enrolled in a home hospice program in order to receive benefits for subsequent continuous home hospice care, and the services must be provided by the home hospice program in which the member is enrolled.	Preferred facilities: Nothing (no deductible) Member facilities: $450 per episode copayment (no deductible) Non-member facilities: $450 per episode copayment, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred facilities: Nothing Member/Non-member facilities: 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 30 consecutive days in a facility licensed as an inpatient hospice facility. 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 facilities: Nothing (no deductible) Member facilities: $450 per admission copayment, plus 35% of the Plan allowance (no deductible) Non-member facilities: $450 per admission copayment, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred facilities: Nothing Member/Non-member facilities: You pay all charges

Hospice Care - continued on next page

Benefit Description	You Pay	
Hospice Care (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Advanced care planning, except when provided as part of a covered hospice care treatment plan (see page 90)* • *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	**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. Note: Prior approval is required for all non-emergent air ambulance transport.	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 the Overseas Assistance Center (provided by GMMI, Inc.) by calling the center collect at 804-673-1678. See page 130 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 $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*	*All charges*	*All charges*

Ambulance - continued on next page

Benefit Description	You Pay	
Ambulance (cont.)	**Standard Option**	**Basic Option**
• *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 member, the health of the member and their 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: Nothing (no deductible)	Preferred emergency room: $175 copayment per day per facility Member emergency room: $175 copayment per day per facility Non-member emergency room: $175 copayment per day per facility Note: If you are admitted directly to the hospital from the emergency room, you do not have to pay the $175 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 and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider	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

Benefit Description	You Pay	
Accidental Injury (cont.)	**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 on page 95 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	**Standard Option**	**Basic Option**
• **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)	Preferred emergency room: $175 copayment per day per facility Member emergency room: $175 copayment per day per facility Non-member emergency room: $175 copayment per day per facility Note: If you are admitted directly to the hospital from the emergency room, you do not have to pay the $175 emergency room copayment. However, the $175 per day copayment for Preferred inpatient care still applies.

Medical Emergency - continued on next page

Benefit Description	You Pay	
Medical Emergency (cont.)	**Standard Option**	**Basic Option**
See previous page	See previous page	Note: All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.
• Urgent care center services and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider Note: Benefits for crutches, splints, braces, etc. when billed by a provider other than the urgent care center are stated in Section 5(a), pages 57-58.	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 95-96 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	**Standard Option**	**Basic Option**
See pages 92-93 for complete ambulance benefit and coverage information.		

Section 5(e). Mental Health and Substance Use Disorder 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 an acute 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 page 128. Contact us at the phone number listed on the back of your Service Benefit Plan ID card if you have any questions or would like to discuss your healthcare 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.
- Every year, we conduct an analysis of the financial requirements and treatment limitations which apply to this Plan's mental health and substance use disorder benefits in compliance with the federal Mental Health Parity and Addiction Equity Act (the Act), and the Act's implementing regulations. Based on the results of this analysis, we may suggest changes to program benefits to OPM. More information on the Act is available on the following Federal Government websites:
  https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html
  https://www.dol.gov/ebsa/
  www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL OR RESIDENTIAL TREATMENT CENTER STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY**. 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 use disorder 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 20 for the exceptions to this requirement.**
  - There is **no calendar year deductible.**
- You should be aware that some PPO inpatient facilities may have non-PPO professional providers on staff; see exceptions on page 20.

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 use disorder 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 use disorder practitioners when acting within the scope of their license • Individual psychotherapy • Group psychotherapy • Pharmacologic (medication) management • Psychological testing • Office visits • Clinic visits • Home visits • Phone consultations and online medical evaluation and management services (telemedicine) 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 use disorder phone number on the back of your ID card. Note: See pages 61 and 117 for our coverage of smoking and tobacco cessation treatment. Note: See page 47 for our coverage of mental health visits to treat postpartum depression and depression during pregnancy. Note: We cover outpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers at the levels shown here.	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
Telehealth professional services for: • Behavioral health counseling • Substance use disorder counseling Note: Refer to Section 5(h), *Wellness and Other Special Features*, for information on telehealth services and how to access our telehealth provider network. Note: Benefits are combined with telehealth services listed in Section 5(a), page 39.	Preferred Telehealth provider: Nothing (no deductible) for the first 2 visits per calendar year for any covered telehealth service $10 copayment per visit (no deductible) after the 2nd visit Participating/Non-participating: You pay all charges	Preferred Telehealth provider: Nothing for the first 2 visits per calendar year for any covered telehealth service $15 copayment per visit after the 2nd visit Participating/Non-participating: You pay all charges

Professional Services - continued on next page

Benefit Description	You Pay	
Professional Services (cont.)	**Standard Option**	**Basic Option**
• 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	**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 use disorder includes room and board and ancillary charges for confinements in a hospital/treatment facility for rehabilitative treatment of alcoholism or substance use disorder. Note: You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: 35% of the Plan allowance for unlimited days (no deductible), and any remaining balance after our payment	Preferred facilities: $175 per day copayment up to $875 per admission for unlimited days Member/Non-member facilities: You pay all charges
Residential Treatment Center	**Standard Option**	**Basic Option**
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.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible)	Preferred facilities: $175 per day copayment up to $875 per admission for unlimited days Member/Non-member facilities: You pay all charges

Residential Treatment Center - continued on next page

Benefit Description	You Pay	
Residential Treatment Center (cont.)	**Standard Option**	**Basic Option**
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 use disorder: • 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 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; biofeedback; Outward Bound programs; hippotherapy/equine therapy provided during the approved stay; personal comfort items, such as guest meals and beds, phone, television, beauty and barber services; custodial or long term care (see *Definitions*, page 153); and domiciliary care provided because care in the home is not available or is unsuitable. Note: For outpatient residential treatment center services, see the next Section.	Non-member facilities: 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.	See previous page
Outpatient Hospital or Other Covered Facility	**Standard Option**	**Basic Option**
Outpatient services provided and billed by a covered facility Note: We cover outpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers at the levels shown here. • 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 Hospital or Other Covered Facility - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Other Covered Facility (cont.)	**Standard Option**	**Basic Option**
Outpatient services provided and billed by a covered facility • Diagnostic tests • Psychological testing Note: A residential treatment center is a covered facility for outpatient care (see Section 10, Definitions, for more information). We cover inpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers, other than room and board and inpatient physician care, at the levels shown here.	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)	**Standard Option**	**Basic Option**
• *Marital, family, educational, or other counseling or training services* • *Services performed by a non-covered provider* • *Testing for and treatment of learning disabilities and intellectual disability* • *Inpatient services performed or billed by residential treatment centers, except as described on pages 87-88 and 100-101* • *Services performed or billed by schools, halfway houses, group homes or members of their staffs* *Note: We cover professional services as described on pages 99-100 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.)* • *Hippotherapy/equine therapy (exercise on horseback)* • *Light boxes* • *Custodial or long term care (see* Definitions*)* • *Costs associated with enabling or maintaining providers' telehealth (telemedicine) technologies, non-interactive telecommunication such as email communications, or store-and-forward telehealth services*	*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 108.
- If there is no generic drug available, you must pay the brand-name cost-sharing amount when you receive a brand-name drug.
- If there is a generic substitution available and you or your provider requests a brand-name drug, you will be responsible for the applicable tier cost-share plus the difference in the cost of the brand-name and generic drug. If the provider's prescription is for the brand-name drug and indicates "dispense as written," you are responsible only for the applicable tier cost-share.
- 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.
- Benefits for certain self-injectable (self-administered) drugs are provided only when they are dispensed by a pharmacy under the pharmacy benefit. See pages 114-115 for Tier 4 and Tier 5 specialty drug fills from a Preferred pharmacy.
- Benefits for certain auto-immune infusion medications (limited to Remicade, Renflexis and Inflectra) are covered only when they are obtained by a non-pharmacy provider, such as a physician or facility (hospital or ambulatory surgical center). See *Drugs From Other Sources* in this section, pages 119-120, for more 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.
- Medication prices vary among different retail pharmacies, the Mail Service Prescription Drug Program, and the Specialty Drug Pharmacy Program. **Review purchasing options for your prescriptions to get the best price.** A drug cost tool is available at www.fepblue.org or call:
  - **Retail Pharmacy Program: 800-624-5060, TTY: 800-624-5077**
  - **Mail Service Prescription Drug Program: 800-262-7890, TTY: 800-216-5343**
  - **Specialty Drug Pharmacy Program: 888-346-3731, TTY: 877-853-9549**
- **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 pages 106-107 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 or biosimilar becomes available or if new safety concerns arise. If your drug is moved to a higher tier, your cost-share will increase. See pages 114-116 for the amounts members pay for Preferred retail, mail service, and specialty drug purchases. If your drug is moved to non-covered, you pay the full cost of the medication. Tier reassignments during the year are not considered benefit changes.
- A pharmacy restriction may be applied for clinically inappropriate use of prescription drugs and supplies.
- The Standard Option and Basic Option formularies both contain a comprehensive list of drugs under all therapeutic categories with two exceptions: some drugs, nutritional supplements and supplies are not covered (see pages 118-119); we may also exclude certain U.S. FDA-approved drugs when multiple generic equivalents/alternative medications are available. See pages 104 and 105 for details.

- **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.
  - There is no calendar year deductible for 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 retail pharmacies or the Specialty Drug Pharmacy Program in order to receive benefits.** Our specialty drug pharmacy is a Preferred pharmacy.
  - The Mail Service Prescription Drug Program is available only to members with primary Medicare Part B coverage.
  - There is **no calendar year deductible.**
  - We use a managed formulary for certain drug classes.

We will send each new enrollee a Plan identification card, which covers pharmacy and medical benefits. 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 pre-addressed reply envelope.

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

- **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/certified provider with prescriptive authority prescribing within their scope of practice 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 159 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 159 for the definition of “specialty drugs.”

Under Standard Option and Basic Option

Note: The Mail Service Prescription Drug Program will not fill your prescription for a drug requiring prior approval 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 unable to be filled and a letter will be mailed to you explaining the prior approval procedures.

Note: The Specialty Drug Pharmacy Program will not fill your prescription for a drug requiring prior approval until you have obtained prior approval. AllianceRx Walgreens Prime, 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 unable to be filled and a letter will be mailed to you explaining the prior approval procedures.

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 pages 115-116.

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 pages 114-115 for information about your cost-share for specialty drugs purchased at a Preferred retail pharmacy that are affected by these restrictions.

- **What is covered.**

  Under Basic Option, we use a managed formulary for certain drug classes. 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.

  Under Standard Option and Basic Option

  Note: Both formularies include lists of preferred drugs that are safe, effective and appropriate for our members, and are available at lower costs than non-preferred drugs. If your physician prescribed a more expensive non-preferred drug for you, we may ask that he or she prescribe a preferred drug instead; we encourage you to do the same. If you purchase a drug that is not on our preferred drug list, your cost will be higher. Your cooperation with our cost-savings efforts helps keep your premium affordable.

  Note: Some drugs, nutritional supplements, and supplies are not covered (see pages 118-119); we may also exclude certain U.S. FDA-approved drugs when multiple generic equivalents/alternative medications are available. If you purchase a drug, nutritional supplement, or supply that is not covered, you will be responsible for the full cost of the item.

  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. Changes to the preferred drug list are not considered benefit changes.

  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. 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 call 800-624-5060, TTY: 800-624-5077, for assistance. Changes to the formulary are not considered benefit changes. 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 requests a brand-name drug and indicates "dispense as written." Keep in mind that **Basic Option members must use Preferred providers in order to receive benefits.** See Section 10, *Definitions*, page 154, 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. 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 unless otherwise noted. 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.

  Under Standard Option and Basic Option

  Benefits for Tier 4 and Tier 5 specialty drugs purchased at a 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. 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 of the specialty drug. See page 116 for more information.

  Note: Certain drugs such as narcotics may have additional limits or requirements as established by the U.S. FDA or by national scientific or medical practice guidelines (such as Centers for Disease Control and Prevention, American Medical Association, etc.) 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 22, 30, and 90-day supplies of those medications. **In most cases, refills cannot be obtained until 75% of the prescription has been used. Controlled substances cannot be refilled until 80% of the prescription has been used.** Controlled substances are medications that can cause physical and mental dependence, and have restrictions on how they can be filled and refilled. They are regulated and classified by the DEA (Drug Enforcement Administration) based on how likely they are to cause dependence. 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.

  Note: Benefits for certain self-injectable (self-administered) drugs are provided only when they are dispensed by a pharmacy under the pharmacy benefit. Medical benefits will be provided for a once-per-lifetime dose per therapeutic category of drugs dispensed by your provider or any non-pharmacy-benefit provider. This benefit limitation does not apply if you have primary Medicare Part B coverage. See pages 114-115 for Tier 4 and Tier 5 specialty drug fills from a Preferred pharmacy.

  Note: Benefits for certain auto-immune infusion medications (Remicade, Renflexis and Inflectra) are provided only when obtained by a non-pharmacy provider, such as a physician or facility (hospital or ambulatory surgical center). See *Drugs From Other Sources* in this Section, page 120, for more information.

- **Important contact information**

  Retail Pharmacy Program: 800-624-5060, TTY: 800-624-5077;
  Mail Service Prescription Drug Program: 800-262-7890, TTY: 800-216-5343;
  Specialty Drug Pharmacy Program: 888-346-3731, TTY: 877-853-9549; or www.fepblue.org.

Patient Safety and Quality Monitoring (PSQM)

We have a special program to promote patient safety and monitor healthcare 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 on page 107, 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 U.S. FDA-approved recommendations, national scientific and generally accepted standards of medical practice guidelines (such as Centers for Disease Control and Prevention, American Medical Association, etc.), 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 800-624-5060, TTY: 800-624-5077.

Prior Approval

As part of our Patient Safety and Quality Monitoring (PSQM) program (see page 106), **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 generally 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 800-624-5060, TTY: 800-624-5077. You can also obtain the list and forms 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.

Note: It is your responsibility to know the prior approval authorization expiration date for your medication. We encourage you to work with your physician to obtain prior approval renewal in advance of the expiration date.

Standard Option Generic Incentive Program

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

- If you switch from one generic drug to another, you will be responsible for your copayment.

Note: The list of eligible generic drug replacements may change and is not considered a benefit change. For the most up-to-date information, please visit www.fepblue.org/en/benefit-plans/coverage/pharmacy/generic-incentive-program or call:

Retail Pharmacy Program: 800-624-5060, TTY: 800-624-5077
Mail Service Prescription Drug Program: 800-262-7890, TTY: 800-216-5343
Specialty Drug Pharmacy Program: 888-346-3731, TTY: 877-853-9549

Benefits 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	**Standard Option**	**Basic Option**
Asthma Medications **Preferred Retail Pharmacies:** Note: See page 24 for information about drugs and supplies that require prior approval.	Tier 1 (generic drug): $5 copayment (no deductible) Tier 2 (preferred brand-name drug): 20% of the Plan allowance (no deductible)	Tier 1 (generic drug): $5 copayment for each purchase of up to a 90-day supply Tier 2 (preferred brand-name drug): $35 copayment for each purchase of up to a 30-day supply ($105 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment Tier 2 (preferred brand-name drug): $30 copayment for each purchase of up to a 30-day supply ($90 copayment for a 31 to 90-day supply)
Mail Service Prescription Drug Program: 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 107. Note: See pages 114-116 for Tier 3, 4 and 5 prescription drug benefits.	Tier 1 (generic drug): $5 copayment (no deductible) Tier 2 (preferred brand-name drug): $65 copayment (no deductible)	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment Tier 2 (preferred brand-name drug): $75 copayment
Anti-hypertensive Medications **Preferred Retail Pharmacies:** Note: See page 24 for information about drugs and supplies that require prior approval.	Tier 1 (generic drug): $3 copayment (no deductible)	Tier 1 (generic drug): $5 copayment for each purchase of up to a 90-day supply
Mail Service Prescription Drug Program: 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 107. Note: See pages 114-116 for Tier 2, 3, 4, and 5 prescription drug benefits.	Tier 1 (generic drug): $3 copayment (no deductible)	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**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 pages 112-113 for our coverage of medications to promote better health as recommended under the Affordable Care Act. • Medical foods, as defined by the U.S. Food and Drug Administration, that are consumed or administered enterally and are intended for the specific dietary management of a disease or condition for which there are distinctive nutritional requirements. The Plan covers medical food formulas and enteral nutrition products that are ordered by a healthcare provider, and are medically necessary to prevent clinical deterioration in members at nutritional risk. (See Coverage below) - Must meet the definition of medical food (see definition on page 155) - Must be receiving active, regular, and ongoing medical supervision and must be unable to manage the condition by modification of diet alone Coverage is provided as follows: - Inborn errors of amino acid metabolism up to age 22 - Food allergy with atopic dermatitis, gastrointestinal symptoms, IgE mediation, malabsorption disorder, seizure disorder, failure to thrive, or prematurity, when administered orally and is the sole source (100%) of nutrition. This once per lifetime benefit is limited to one year following the date of the initial prescription or physician order for the medical food (e.g., Neocate, in a formula form or powders mixed to become formulas) - Medical foods and nutritional supplements when administered by catheter or nasogastric tubes Note: A prescription and prior approval are required for medical foods provided under the pharmacy benefit. Renewals of the prior authorization are required every benefit year for inborn errors of metabolism and tube feeding.	See page 108 and pages 110-116	See page 108 and pages 110-116

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Note: See Section 5(a), page 58, for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube under the medical benefit. • Insulin, diabetic test strips, and lancets Note: See page 57 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	See previous page	See previous page
• 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 117. Note: You may be eligible to receive smoking and tobacco cessation medications at no charge. See page 117 for more information. • Drugs for the diagnosis and treatment of infertility, except as described on pages 118-119 • Drugs to treat gender dysphoria (gonadotropin-releasing hormone (GnRH) antagonists and testosterones) • 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 115 and 116 for details.	See below and pages 111-117	See below and pages 111-117
• Over-the-counter (OTC) contraceptive drugs and devices, for women only, limited to: - Emergency contraceptive pills - Female condoms - Spermicides	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

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
- Sponges Note: We provide benefits in full for OTC contraceptive drugs and devices for women only when the contraceptives meet U.S. FDA standards for OTC products. To receive benefits, you must use a retail pharmacy and present the pharmacist with a written prescription from your physician.	See previous page	See previous page
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. See pages 43 and 45 for specific coverage. Note: Our vaccine network is a network of Preferred retail pharmacies that have agreements with us to administer one or more routine immunizations. Check with your pharmacy or call our Retail Pharmacy Program at 800-624-5060, TTY: 800-624-5077, to find out 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 every 365 days at no cost through our Diabetic Meter Program. To use this program, you must call the phone 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 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. See page 112 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
Metformin and metformin extended release (excluding osmotic and modified release generic drugs) **Preferred Retail Pharmacies:** **Mail Service Prescription Drug Program:**	Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply (no deductible) Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply (no deductible)	Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Other Preferred Diabetic Medications, Test Strips, and Supplies **Preferred Retail Pharmacies:** **Mail Service Prescription Drug Program:** **Note: See pages 115-116 for Tier 2, 3, 4, and 5 prescription drug benefits.** Benefits will be provided for syringes, pens and pen needles and test strips at Tier 2 (diabetic medications and supplies) for Standard Option members, and Basic Option members with primary Medicare Part B, through the Mail Service Prescription Drug Program. See pages 115-116 for more information.	Tier 2 (preferred diabetic medications and supplies): 20% of the Plan allowance for each purchase of up to a 90-day supply (no deductible) Non-preferred retail pharmacies: You pay all charges Tier 2 (preferred brand-name drug): $40 copayment for each purchase of up to a 90-day supply (no deductible)	Tier 2 (preferred diabetic medications and supplies): $35 copayment for each purchase of up to a 30-day supply ($65 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 2 (preferred brand-name drugs): $30 copayment for each purchase of up to a 30-day supply ($60 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 2 (preferred brand-name drugs) $50 copayment for each purchase of up to a 90-day supply
Medications 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 • Low-dose aspirin (81 mg per day) for pregnant members at risk for preeclampsia • Aspirin for men age 45 through 79 and women age 50 through 79 • Generic cholesterol-lowering statin drugs Note: Benefits are not available for acetaminophen, ibuprofen, naproxen, etc.	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

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Note: Benefits for the medications listed on the previous page are subject to the dispensing limitations described on page 106 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/preventive-care-benefits. See pages 42-46 in Section 5(a) for information about other covered preventive care services. Note: See page 117 for our coverage of smoking and tobacco cessation medications.	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 medications 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 800-624-5060, TTY: 800-624-5077, to request this form. You can also obtain the Coverage Request Form through our website at www.fepblue.org.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges Mail Service Prescription Drug Program: Nothing (no deductible)	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
We cover the first prescription filled for certain bowel preparation medications for colorectal cancer screenings with no member cost-share. We also cover certain antiretroviral therapy medications for HIV for those at risk but who do not have HIV. You can view the list of covered medications on our website at www.fepblue.org or call 800-624-5060, TTY: 800-624-5077, for assistance.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges Mail Service Prescription Drug Program: Nothing (no deductible)	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
Opioid Reversal Agents: Tier 1 medications limited to Narcan nasal spray and naloxone generic injectable		
Preferred Retail Pharmacies	Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year (no deductible) Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost-share.	Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost-share.
Non-preferred Retail Pharmacies	You pay all charges	You pay all charges

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Opioid Reversal Agents (cont.) **Mail Service Prescription Drug Program**	Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year (no deductible) Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost-share.	**When Medicare Part B is primary, you pay the following:** Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost-share.
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 retail pharmacy to request your prescriptions online and delivery, if available. • For a listing of Preferred retail pharmacies, call the Retail Pharmacy Program at 800-624-5060, TTY: 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 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 116 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 Preferred 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 115.**	Tier 1 (generic drug): $7.50 copayment for each purchase of up to a 30-day supply ($22.50 copayment for a 31 to 90-day supply) (no deductible) Note: You pay a $5 copayment for each purchase of up to a 30-day supply ($15 copayment for a 31 to 90-day supply) 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 107 for information. Tier 2 (preferred brand-name drug): 30% of the Plan allowance for each purchase of up to a 90-day supply (no deductible) Tier 3 (non-preferred brand-name drug): 50% of the Plan allowance for each purchase of up to a 90-day supply (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 a 31 to 90-day supply) Tier 2 (preferred brand-name drug): $55 copayment for each purchase of up to a 30-day supply ($165 copayment for a 90-day supply) Tier 3 (non-preferred brand-name drug): 60% of the Plan allowance ($75 minimum) for each purchase of up to a 30-day supply ($210 minimum for a 31 to 90-day supply) Tier 4 (preferred specialty drug): $65 copayment limited to one purchase of up to a 30-day supply Tier 5 (non-preferred specialty drug): $90 copayment limited to one purchase of up to a 30-day supply **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): see above Tier 2 (preferred brand-name drug): $50 copayment for each purchase of up to a 30-day supply ($150 copayment for a 31 to 90-day supply) Tier 3 (non-preferred brand-name drug): 50% of the Plan allowance ($60 minimum) for each purchase of up to a 30-day supply ($175 minimum for a 31 to 90-day supply) Tier 4 (preferred specialty drug): $60 copayment limited to one purchase of up to a 30-day supply

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Note: For a list of the Preferred Network Long Term Care pharmacies, call 800-624-5060, TTY: 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 800-624-5060, TTY: 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.	See previous page	Continued from previous page: Tier 5 (non-preferred specialty drug): $80 copayment limited to one purchase of up to a 30-day supply
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 For Standard Option and Basic Option members when Medicare Part B is Primary, 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: 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 107. 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 116 for information about the Specialty Drug Pharmacy Program.	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 107 for information. Tier 2 (preferred brand-name drug): $90 copayment (no deductible) Tier 3 (non-preferred brand-name drug): $125 copayment (no deductible)	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $20 copayment Tier 2 (preferred brand-name drug): $100 copayment Tier 3 (non-preferred brand-name drug): $125 copayment **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 108 of this Section for our payment levels for drugs obtained through Preferred retail pharmacies.

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
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 800-262-7890, TTY: 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.	See previous page	See previous page
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 phone number below or visit our website, www.fepblue.org. (See page 159 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 are most convenient for you, as well as ask you about any side effects you may be experiencing. See page 138 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 31 to 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 888-346-3731, TTY: 877-853-9549.	Specialty Drug Pharmacy Program: Tier 4 (preferred specialty drug): $65 copayment for each purchase of up to a 30-day supply ($185 copayment for a 31 to 90-day supply) (no deductible) Tier 5 (non-preferred specialty drug): $85 copayment for each purchase of up to a 30-day supply ($240 copayment for a 31 to 90-day supply) (no deductible)	Specialty Drug Pharmacy Program: Tier 4 (preferred specialty drug): $85 copayment for each purchase of up to a 30-day supply ($235 copayment for a 31 to 90-day supply) Tier 5 (non-preferred specialty drug): $110 copayment for each purchase of up to a 30-day supply ($300 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 4 (preferred specialty drug): $80 copayment for each purchase of up to a 30-day supply ($210 copayment for a 31 to 90-day supply) Tier 5 (non-preferred specialty drug): $100 copayment for each purchase of up to a 30-day supply ($255 copayment for a 31 to 90-day supply)

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Smoking and Tobacco Cessation Medications If you are a covered member, 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, create a Tobacco Cessation Quit Plan using our Online Health Coach. For more information, see page 125. Note: There may be age-restrictions based on U.S. FDA guidelines for these medications. 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 continuing monthly pack - 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 61 for our coverage of smoking and tobacco cessation treatment, counseling, and classes.	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

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Remicade, Renflexis, and Inflectra are not covered for prescriptions obtained from a retail pharmacy, Mail Service Prescription or through the Specialty Drug Program* • *Medical foods administered orally are not covered if not obtained at a retail pharmacy or through the Mail Service Prescription Drug Program* • *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 58 and 110)* • *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* • *Products and foods other than liquid formulas or powders mixed to become formulas; foods and formulas readily available in a retail environment and marketed for persons without medical conditions; low-protein modified foods (e.g., pastas, breads, rice, sauces and baking mixes); nutritional supplements, energy products; and similar items* *Note: See page 112 for our coverage of medications recommended under the Affordable Care Act and page 117 for smoking and tobacco cessation medications.* *Note: See Section 5(a), page 58 for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube.* • *Infant formula other than described on pages 58 and 109* • *Drugs for which prior approval has been denied or not obtained* • *Drugs and supplies related to sexual dysfunction or sexual inadequacy*	*All charges*	*All charges*

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
• *Drugs and covered-drug-related supplies for the treatment of 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 110* • *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 110* • *Drugs used to terminate pregnancy* • *Sublingual allergy desensitization drugs, except as described on page 51*	*All charges*	*All charges*
Drugs From Other Sources	**Standard Option**	**Basic Option**
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. This includes drugs and supplies covered only under the medical benefit. 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 page 131 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 related to drugs obtained from other sources: - Physician's office – Section 5(a) - Facility (inpatient or outpatient) – Section 5(c) - Hospice agency – Section 5(c) • Please refer to page 114 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 professional provider: 35% of the Plan allowance (deductible applies) Non-participating professional provider: 35% of the Plan allowance (deductible applies) plus any difference between our allowance and the billed amount Member: 35% of the Plan allowance (deductible applies) 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 professional provider: You pay all charges Non-participating professional provider: You pay all charges Member or Non-member: You pay all charges

Drugs From Other Sources - continued on next page

Benefits Description	You Pay	
Drugs From Other Sources (cont.)	**Standard Option**	**Basic Option**
• Auto-immune infusion medications: Remicade, Renflexis and Inflectra Note: Benefits for certain auto-immune infusion medications (limited to Remicade, Renflexis and Inflectra) are covered only when they are obtained by a non-pharmacy provider, such as a physician or facility (hospital or ambulatory surgical center).	Preferred: 10% of the Plan allowance (deductible applies) Participating professional provider: 15% of the Plan allowance (deductible applies) Non-participating professional provider: 15% of the Plan allowance (deductible applies) plus any difference between our allowance and the billed amount Member: 15% of the Plan allowance (deductible applies) Non-member: 15% of the Plan allowance (deductible applies), plus any difference between our allowance and billed amount.	Preferred: 15% of the Plan allowance Participating professional provider: You pay all charges Non-participating professional provider: You pay all charges Member or Non-member: You pay 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.**

Benefit Description	You Pay	
Accidental Injury Benefit	**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.	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.

Accidental Injury Benefit - continued on next page

Benefit Description	You Pay	
Accidental Injury Benefit (cont.)	**Standard Option**	**Basic Option**
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.	See previous page	See previous page

Dental Benefits

What is Covered

Standard Option dental benefits are presented in the chart on the following page.

Basic Option dental benefits appear on page 124.

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 phone 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 phone 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 page. 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 page 122).

Standard Option Dental Benefits	Standard Option Only		
Covered Service	**We Pay to Age 13**	**We Pay Age 13 and Over**	**You Pay**
Clinical oral evaluations			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).
Periodic oral evaluation *(up to 2 per person per calendar year)*	$12	$8	
Limited oral evaluation	$14	$9	
Comprehensive oral evaluation	$14	$9	
Detailed and extensive oral evaluation	$14	$9	
Diagnostic imaging			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	
Palliative treatment			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).
Palliative treatment of dental pain – minor procedure	$24	$15	
Protective restoration	$24	$15	
Preventive			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).
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 (*up to 2 per person per calendar year*)	$13	$8	
Not covered: Any service not specifically listed above	*Nothing*	*Nothing*	*All charges*

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; see page 122). 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 phone 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*)	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
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)*	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
Not covered: Any service not specifically listed above	*Nothing*	*All charges*

Section 5(h). Wellness and Other 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 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 phone, secure email, or live chat. Ask questions and get medical advice. Please keep in mind that benefits for any healthcare 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 healthcare expenses. See below and page 126 for more information. • **Online Health Coach (OHC)** – Manage your health proactively by setting and managing health goals, create a plan of care, track your progress, and pursue healthy activities. The OHC offers members a combination of guidance, support, and resources. • **Tobacco Cessation Incentive Program** – If you would like to quit smoking, you can participate in this program and receive tobacco cessation products at no charge. 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 page 117 for more information. Note: There may be age-restrictions based on U.S. FDA guidelines for these medications. • **Health Topics and WebMD Videos** offer an extensive variety of educational tools using videos, recorded messages, and colorful online materials that provide up-to-date information about a wide range of health-related topics.
Services for the Deaf and Hearing Impaired	All Blue Cross and Blue Shield Plans provide TTY 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 well-being. For more information, go to www.fepblue.org.
Diabetes Management Program	The Diabetes Management Program is a program to help members with diabetes manage their condition. All members with type 1 and type 2 diabetes, including those for whom Medicare is primary, are eligible for this program. You will receive a free glucose meter and have unlimited test strips and lancets shipped directly to you. Automated reordering is based on your usage. Personalized coaching and support are also provided. The program offers live interventions triggered by acute alerts based on your glucose meter test results. Member support is offered 24/7/365. For more information go to www.fepblue.org/diabetes.
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.

Special features	Description
Blue Health Assessment (cont.)	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, both the contract holder and spouse 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, hypertension, 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, 2021**. 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 888-258-3432 toll-free.
Diabetes Management Incentive Program	The **Diabetes Management Incentive Program** is designed to encourage members to achieve and maintain control of their blood sugar and help manage or slow the progression of complications related to diabetes. Through this program you can earn a maximum of $100 toward a health account to be used for most qualified medical expenses. This incentive is in addition to other incentives described in this brochure and is available to all covered adult members, age 18 and over. To qualify for the Diabetes Management Incentive Program, each eligible member must have at least one medical claim that has been processed during the past 12 months with a reported diagnosis of diabetes and complete the following steps: • Provide us with lab test results for an HbA1c performed in the first 6 months of the calendar year (January 1 to June 30) to receive a $25 incentive reward. • Provide us with lab test results for an HbA1c performed in the last 6 months of the calendar year (July 1 to December 31) to receive a $75 incentive reward; the test results must show: - Your HbA1c result is less than 8 percent; or - If your HbA1c is greater than or equal to 8 percent, you will receive the incentive if we provided benefits for three nutritional counseling visits performed during the calendar year. Note: See pages 43 and 46 for information on nutritional counseling. Information on how to submit your HbA1c lab results can be found on our website, www.fepblue.org/diabetes. See page 111 for information about the Diabetic Meter Program.
Hypertension Management Program	The **Hypertension Management Program** gives members age 18 and older with hypertension (otherwise known as high blood pressure) 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 the contract holder and spouse who meet the following criteria. 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:

Special features	Description
Hypertension Management Program (cont.)	• 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, you will be sent a letter advising you of your eligibility for the free BPM. You are eligible to receive a free BPM every two calendar years. You must follow the directions in the letter, which include taking the letter to your healthcare 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 criteria or for those who obtain a BPM outside of this program. For more information, call us at the phone number on the back of your ID card. See page 108 for information on preferred generic anti-hypertensive medications.
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. 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. All covered adult members, age 18 and over may be eligible for this incentive. To qualify for the Pregnancy Care Box, you must be pregnant. Information on the program is available on our website, www.fepblue.org. To qualify for the $75 incentive, you must meet the criteria above for the Pregnancy Care Box and send us a copy of your healthcare provider's medical record that confirms you had a prenatal care visit during the first trimester of your pregnancy. Information that must be included when submitting your medical record can be found on our website, www.fepblue.org/maternity. To receive 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 are limited to two pregnancies per calendar year.
Annual Incentive Limitation	Financial incentives earned through participation in the Blue Health Assessment, personalized goals through the Online Health Coach, the Diabetes Management Incentive Program, and the Pregnancy Care Incentive Program are limited to a total of $250 per person per calendar year for the contract holder and spouse.
Reimbursement Account for Basic Option Members Enrolled in Medicare Part A and Part B	Basic Option members enrolled in Medicare Part A and Part B are eligible to be reimbursed up to $800 per calendar year for their Medicare Part B premium payments. The account is used to reimburse member-paid Medicare Part B premiums. For more information on how to obtain reimbursement, please visit www.fepblue.org/mra or call 888-706-2583.
MyBlue® Customer eService	Visit **MyBlue Customer eService** at www.fepblue.org/myblue or use the fepblue mobile app 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 "View My Claims"; from there you can search claims and select the "EOB" link next to each claim to access your EOB. You can also access EOBs via the fepblue mobile app. Simply link to MyBlue, and click on Claims.

Special features	Description
MyBlue® Customer eService (cont.)	• **Opt In or Out of Mailed Paper EOBs** – The Service Benefit Plan offers an environmentally friendly way of accessing your EOBs via www.fepblue.org/myblue. You can opt in or out of receiving mailed paper EOBs by following 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. • **Financial Dashboard** – Log in to MyBlue to access important information in real time, including deductibles, out-of-pocket costs, remaining covered provider visits, medical claims, and pharmacy claims. You also can review your year-to-date summary of completed claims, MyBlue Wellness Card balance, and pharmacy spending throughout the year.
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 healthcare needs, the Service Benefit Plan offers two types of Care Management Programs that provide assistance with the coordination of your care, provide member education and clinical support. • **Case Management** provides members who have acute or chronic complex healthcare needs with the services and assistance of a licensed health care professional with a nationally recognized case management certification. Case managers may be a registered nurse, licensed social worker, or other licensed healthcare professional practicing within the scope of their license, who may work with you and your providers to assess your health care needs, coordinate needed care and available resources, evaluate the outcomes of your care, and support and monitor the progress of the member's treatment plan and healthcare needs. Some members may receive guidance and clinical support for an acute healthcare need while others may benefit from a short-term case management enrollment. Enrollment in case management requires your consent. Members in case management are asked to provide verbal consent prior to enrollment in case management and must provide written consent for case management. Note: Benefits for care provided by residential treatment centers and for inpatient care provided by skilled nursing facilities for members enrolled in Standard Option who do not have Medicare Part A require written consent and participation in Case Management prior to admission; please see pages 87-88, 100 and 130 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, including if you are eligible for enrollment and assistance with enrollment, please contact us at the customer service phone 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 will review the member's healthcare needs and may at our sole discretion, identify a less costly alternative treatment plan for the member. The member (or their healthcare proxy) and provider (s) must cooperate in the process. Case Management Program enrollment is required for eligibility. Prior to the starting date of the alternative treatment plan, members who are eligible to receive services through the flexible benefits option are required to sign and return a written consent for case management and 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. **We must receive the consent for case management and the alternative benefits agreement signed by the member/ healthcare proxy before you receive any services included in the alternative benefits agreement.**

Special features	Description
Flexible Benefits Option (cont.)	• Alternative benefits will be made available for a limited period of time and are subject to our ongoing review. You must cooperate with and participate in the review process. Your provider(s) must submit the information necessary for our reviews. You and/or your healthcare proxy must participate in care conferences and caregiver training as requested by your provider(s) or by us. • We may revoke the alternative benefits agreement immediately at any time, if we discover we were misled by the information given to us by you, your provider, or anyone else involved in your care, or that you are not meeting the terms of the agreement. • If we approve alternative benefits, we do not guarantee that they will be extended beyond the limited time period and/or scope of the alternative benefits agreement 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 at our sole discretion, 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 alternative benefits for the stated time period, unless we are misled by the information given to us or circumstances change. Benefits as stated in this brochure will apply to all services and dates of care not included in the alternative benefits agreement. You or your provider may request an extension of the time period initially approved for alternative benefits, no later than five business days prior to the end of the alternative benefits agreement. We will review the request, including the services proposed as an alternative and the cost of those services, but benefits as stated in this brochure will apply if we do not approve your request. Note: If we deny a request for precertification or prior approval of regular contract benefits, as stated in this brochure, 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).
Telehealth Services	Go to www.fepblue.org/telehealth or call 855-636-1579, TTY: 855-636-1578, toll free to access on-demand, affordable, high-quality care for adults and children experiencing non-emergency medical issues, including treatment of minor acute conditions (see page 155 for definition), dermatology care, counseling for behavioral health and substance use disorder, and nutritional counseling. Note: This benefit is available only through the contracted telehealth provider network.
The fepblue Mobile Application	Blue Cross and Blue Shield's fepblue mobile application is available for download for both iOS and Android mobile phones. The application provides members with 24/7 access to helpful features, tools and information related to Blue Cross and Blue Shield Service Benefit Plan benefits. Members can log in with their MyBlue® username and password to access personal healthcare information such as benefits, out-of-pocket costs, deductibles (if applicable) and physician visit limits. They can also view claims and approval status, view/share Explanations of Benefits (EOBs), view/share member ID cards, locate in-network providers, and connect with our telehealth services.

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 131-132 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 healthcare 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, with the exception of admissions for gender reassignment surgery (see pages 22 and 64-65 for information) and admissions to residential treatment centers and skilled nursing facilities. Prior approval is required for all non-emergent air ambulance transport services for overseas members (refer to page 92 for more information).

Overseas 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 Overseas 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 Overseas 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 Overseas Assistance Center (provided by GMMI, Inc.), by calling the center collect at 804-673-1678. Members in the United States, Puerto Rico, or the U.S. Virgin Islands should call 800-699-4337 or email the Overseas Assistance Center at fepoverseas@gmmi.com. GMMI, Inc., 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.

Hospital and professional provider benefits

For **professional care** you receive overseas, we provide benefits at Preferred benefit levels using either our Overseas Fee Schedule, a customary percentage of the billed charge, 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. **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. You must also pay any charges for noncovered services.

For **inpatient facility care** you receive overseas, we provide benefits at the Preferred level **under both Standard and Basic Options. For Basic Option, there is no member cost-share** for admissions to a DoD facility, or when the Overseas Assistance Center (provided by GMMI, Inc.) has arranged direct billing or acceptance of a guarantee of benefits with the facility. Standard Option members have no cost-share for inpatient facility care.

For **outpatient 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 have no deductible for overseas services.

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.

Pharmacy benefits

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 119 in Section 5(f) for more information.

Overseas claims payment

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.

Filing overseas claims

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 260070, Pembroke Pines, FL 33026.
2. Fax: 001-954-308-3957. 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 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@gmmi.com, or from your Local Plan.

Filing a claim for 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. Timely filing for overseas pharmacy claims is limited to one year from the prescription fill date. 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 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

These benefits are not part of the FEHB contract or premium, and you cannot file an FEHB dispute regarding these benefits. Fees paid 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® – The Blue Cross and Blue Shield Service Benefit Plan presents Blue365, a program that offers exclusive health and wellness deals that will assist in your efforts to be healthy and happy, every day of the year. Blue365 delivers top discounts from national and local retailers such as hearing aids through TruHearing, healthy food delivery via Sun Basket, wearable devices from Fitbit, and genetic composition testing by Molecular Fitness, just to name a few. Each week, Blue365 members receive great health and wellness deals via email. With Blue365, there is no paperwork to fill out. Just 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 – Fitness Your Way by Tivity Health can help you meet your health and fitness goals, on your budget, and on your own time. Fitness Your Way by Tivity Health offers access to more than 10,000 different fitness locations for a discounted monthly rate. You'll have access to well-being support, health articles, and online health coaching, as well as exercise tracking and nutrition goals, social networking, rewards, and the Daily Challenge 24 hours a day, 7 days a week. For more information or to enroll, visit www.fepblue.org/healthclub or call customer service at 888-242-2060, Monday through Friday, 8 a.m. – 8 p.m., in all U.S. time zones.

Discount Drug Program – The Discount Drug Program is available to members 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 24%. The program permits you to obtain discounts on several drugs related to dental care, weight loss, hair removal and hair growth, and other miscellaneous health conditions. Please refer to www.fepblue.org/ddp for a full list of discounted drugs, including those that may be added to this list as they are approved by the U.S. Food and Drug Administration (U.S. FDA). To use the program, simply present a valid prescription and your Service Benefit Plan ID card at a Preferred 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 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 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.

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 155).
- Experimental or investigational procedures, treatments, drugs, or devices (see Section 5(b) 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 and gender reassignment surgeries specifically listed as covered).
- Travel expenses except as specifically provided for covered transplants performed in a Blue Distinction Center for Transplant (see page 76).
- 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 149), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge, see page 150), or state premium taxes however applied.
- Prescriptions, 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 provided 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, diagnostic tests, and procedures and services for the treatment of morbid obesity listed on page 65.
- 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 phone.
- 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 *Preventive Care, Child* in Sections 5(a) and 5(c), the preventive screenings specifically listed on pages 42-46 and page 85; and certain routine services associated with covered clinical trials (see page 144).
- Recreational or educational therapy, and any related diagnostic testing, except as provided by a hospital during a covered inpatient stay.
- Applied behavior analysis (ABA) and related services for any condition other than an autism spectrum disorder.
- Applied behavior analysis (ABA) services and related services performed as part of an educational program; or provided in or by a school/educational setting; or provided as a replacement for services that are the responsibility of the educational system.
- 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 118), meditation techniques, relaxation techniques, movement therapies, and energy therapies.
- Services, drugs, or supplies related to medical marijuana.
- Advanced care planning, except when provided as part of a covered hospice care treatment plan (see page 90).
- Membership or concierge service fees charged by a healthcare provider.
- Fees associated with copies, forwarding or mailing of records except as specifically described in Section 8.
- Services not specifically listed as covered.
- Services or supplies we are prohibited from covering under the Federal Law.

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 phone 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 provider 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, speech, or cognitive rehabilitation therapy, you must provide a written statement from the provider 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 provider's name, date, and charge. (See pages 137-138 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 (e.g., medical records) 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 retail 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 retail 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 paragraphs 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 800-624-5060 to request a retail prescription drug claim form to claim benefits. Hearing-impaired members with TTY equipment may call 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 800-262-7890, TTY: 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 phone 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 116 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 888-346-3731, TTY: 877-853-9549, or you may send your prescription to: Specialty Drug Pharmacy Program, AllianceRx Walgreens Prime, P.O. Box 692169, Orlando, FL 32869. 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 are most convenient for you. To order refills, call the same phone 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 888-346-3731, TTY: 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 (e.g., diagnosis codes, dates of service, etc.), you must resubmit it within 90 days, or before the timely filing period expires, whichever is later.

Note: Timely filing for overseas pharmacy claims is limited to one year from the prescription fill date.

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 131-132 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 healthcare 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 phone 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 healthcare 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 or to make an inquiry 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 call your Plan's customer service representative at the phone number found on your enrollment card, our brochure, or our website (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 phone 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 healthcare 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

Step	Description
2	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.
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, FEHB 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; • Your daytime phone number and the best time to call; and • 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 healthcare 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 phone 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 FEHB 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 healthcare 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 healthcare 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 on NAIC rules regarding the coordinating of benefits, visit our website at www.fepblue.org/coordinationofbenefits.

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 150). 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 healthcare 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 healthcare 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, 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 covered 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 69-76. **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 phone 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 (U.S. FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I enroll in Medicare?" please contact Medicare at 1-800-Medicare 800-663-4227, TTY: 877-486-2048, or at www.medicare.gov.

- **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 21 for exceptions).

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 phone 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 healthcare 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 (skilled) 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**

If you are enrolled in Medicare Part B, 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 healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227), TTY: 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 20 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 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:	
	Standard Option	**Basic Option**
Participates with Medicare or accepts Medicare assignment for the claim and is in our Preferred network	your deductibles, coinsurance, and copayments.	your copayments and coinsurance.
Participates with Medicare or accepts Medicare assignment and is not in our Preferred network	your deductibles, coinsurance, and copayments, and any balance up to the Medicare-approved amount.	all charges.
Does not participate with Medicare and is in our Preferred network 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.	your deductibles, coinsurance, and copayments, and any balance up to 115% of the Medicare-approved amount.	your copayments and coinsurance, and any balance up to 115% of the Medicare-approved amount.
Does not participate with Medicare and is not in our Preferred network	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare-approved amount.	all charges.
Opts-out of Medicare via private contract	your deductibles, coinsurance, copayments, and any balance your physician charges.	your deductibles, coinsurance, copayments, and any balance your physician 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.

Physicians Who Opt-Out of Medicare

A physician may have opted-out of Medicare and may or may not ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. This is different than a Non-participating doctor, and we recommend you ask your physician if he or she has opted-out of Medicare. Should you visit an opt-out physician, the physician will not be limited to 115% of the Medicare-approved amount. You may be responsible for paying the difference between the billed amount and our regular in-network/out-of-network benefits.

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, you pay nothing for covered charges (see note below for Basic Option).
- If your physician **does not accept** Medicare assignment, 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 20 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.

Please review the following table illustrating your cost-share liabilities when Medicare is your primary payor **and** your provider is in our network and participates with Medicare compared to what you pay without Medicare. Please do not rely on this chart alone but read all information in this section of the brochure. You can find more information about how our Plan coordinates with Medicare in our *Medicare and You Guide for Federal Employees* available online at www.fepblue.org.

Benefit Description	**Standard Option** You Pay **Without** Medicare	**Standard Option** You Pay **With** Medicare Parts A & B	**Basic Option** You Pay **Without** Medicare	**Basic OptionWith** Medicare Parts A & B
Deductible	$350-Self $750-Family	$0.00	N/A	$0.00
Catastrophic Protection Out-of-Pocket Maximum	$7,000-Self $14,000-Family	$7,000-Self $14,000-Family	$5,500-Self $11,000-Family	$5,500-Self $11,000-Family
Part B Premium Reimbursement	N/A	N/A	N/A	$800
Primary Care Physician	$25	$0.00	$30	$0.00
Specialist	$35	$0.00	$40	$0.00
Inpatient Hospital	$450	$0.00	$175/day up to $875	$0.00
Outpatient Hospital	15% or $25 copayment	$0.00	30% or $30-$500 copayment	$0.00
Incentives Offered	N/A	N/A	N/A	N/A

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.
Advanced care planning	Receiving information on the types of life-sustaining treatments that are available, completing advance directives and other standard forms, and/or if you are diagnosed with a terminal illness and making decisions about the care you would want to receive if you become unable to speak for yourself.
Agents	Medications 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 medications 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. Benefits provided under the contract are not assignable by the member to any person without express written approval of the Carrier, and in the absence of such approval, any such assignment shall be void. Please visit www.fepblue.org to obtain a valid authorization form.
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.
Biologic drug	A complex drug or product that is manufactured in a living organism, or its components, that is used as a diagnostic, preventive or therapeutic agent.
Biosimilar drug	A U.S. FDA-approved biologic drug, which is considered highly similar to an original brand-name biologic drug, with no clinically meaningful differences from the original biologic drug in terms of safety, purity and potency.
Biosimilar, interchangeable drug	A U.S. FDA-approved biosimilar drug that may be automatically substituted for the original brand-name biologic drug.
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.
Clinical trials	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 U.S. Food and Drug Administration (U.S. FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.
Coinsurance	See Section 4 page 29.
Concurrent care claims	A claim for continuing care or an ongoing course of treatment that is subject to prior approval. See page 26 in Section 3.
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; ambiguous genitalia; and webbed fingers and toes. Note: Congenital anomalies do not include conditions related to the teeth or intra-oral structures supporting the teeth.

Copayment See Section 4 page 28.

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 See Section 4 page 28.

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 healthcare 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.

Durable medical equipment Equipment and supplies that are:

1. Prescribed by your physician (i.e., the physician who is treating your illness or injury);
2. Medically necessary;
3. Primarily and customarily used only for a medical purpose;
4. Generally useful only to a person with an illness or injury;
5. Designed for prolonged use; and
6. Used to serve a specific therapeutic purpose in the treatment of an illness or injury.

Experimental or investigational services Experimental or investigational shall mean:

1. A drug, device, or biological product that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (U.S. FDA); and approval for marketing has not been given at the time it is furnished; or
2. Reliable evidence shows that the healthcare 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
3. Reliable evidence shows that the consensus of opinion among experts regarding the healthcare 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

4. Reliable evidence shows that the healthcare 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:

1. Published reports and articles in the authoritative medical and scientific literature;
2. 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
3. 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 a U.S. 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 U.S. FDA as interchangeable with your brand-name drug.

Group health coverage Healthcare 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).

Healthcare professional A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law. See page 17 for information about how we determine which healthcare 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 healthcare provider. For more information, visit our website, www.fepblue.org.

Inpatient You are an inpatient when you are formally admitted to a hospital with a doctor's order.

Note: Inpatient care requires precertification. For some services and procedures prior approval must also be obtained. See pages 21-26.

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 use disorders. 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 healthcare 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:

1. In accordance with generally accepted standards of medical practice in the United States; and
2. 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
3. Not primarily for the convenience of the patient, physician, or other healthcare 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
4. Not part of or associated with scholastic education or vocational training of the patient; and
5. In the case of inpatient care, able to be provided safely only in the inpatient 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.

Minor acute conditions

Under the telehealth benefit you have on-demand access to care for common, non-emergent conditions. Examples of common conditions include sinus problems, rashes, allergies, cold and flu symptoms, etc.

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. For more information, see pages 7-8.

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.

Outpatient

You are an outpatient if you are getting emergency department services, observation services, outpatient surgery, lab tests, X-rays, or any other hospital services, and the doctor has not written an order to admit you to a hospital as an inpatient. In these cases, you are an outpatient even if you are admitted to a room in the hospital for observation and spend the night at the hospital.

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 healthcare 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 123 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 healthcare 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 Local Plan Allowance. The Local Plan Allowance varies by region and is determined by each Plan. If you would like additional information, or to obtain the current allowed amount, please call the customer service phone number on the back of your ID card. For inpatient stays resulting from medical emergencies or accidental injuries, or for emergency deliveries, our allowance is the billed amount;
  - For outpatient, non-emergency 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 Local Plan Allowance. This allowance applies to all of the covered services billed by the hospital. If you plan on using a Non-member hospital, or other Non-member facility, for your outpatient procedure, please call us before you receive services at the customer service phone 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 to use our National Doctor and Hospital Finder, or call us at the customer service phone number on the back of your ID card;
  - For outpatient 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 healthcare 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 Local Plan Allowance. In the absence of a Medicare participating fee schedule amount or ASP for any service, drug, or supply, our allowance is the Local Plan Allowance. 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 healthcare 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 Local Plan Allowance 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 the Overseas Assistance Center (provided by GMMI, Inc.), 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, D.C., area, or a customary percent of billed charge, whichever is higher.

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 phone 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 94-97).

For more information, see *Differences between our allowance and the bill* in Section 4. For more information about how we pay providers overseas, see pages 32 and 130.

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, healthcare institutions, and other covered healthcare 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 healthcare 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)); EKG; general health panel; basic or comprehensive metabolic panel; fasting lipoprotein profile; urinalysis; CBC; screening for diabetes mellitus, hepatitis B and hepatitis C, and latent tuberculosis; screening for alcohol/substance use disorders; counseling on reducing health risks; screening for depression; screening for chlamydia, syphilis, gonorrhea, HPV, and HIV; screening for intimate partner violence for women of reproductive age; administration and interpretation of a Health Risk Assessment questionnaire; cancer screenings including low-dose CT screening for lung cancer; screening for abdominal aortic aneurysms; osteoporosis screening, as specifically stated in this brochure; and immunizations as licensed by the U.S. Food and Drug Administration (U.S. FDA).

Note: Anesthesia services and pathology services associated with preventive colorectal surgical screenings are also paid as preventive care.

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 21-24.

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 page 144).

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.

Telehealth dermatology — Under the telehealth benefit, dermatologic conditions seen and treated include but are not limited to acne, dermatitis, eczema, psoriasis, rosacea, seborrheic keratosis, fungal infections, scabies, suspicious moles, and warts. Members capture important digital images, combine those with the comprehensive questionnaire responses, and send those to the dermatology network without requiring a phone or video interaction.

Telehealth services — Non-emergency services provided by phone or secure online video/messaging for minor acute conditions (see page 155 for definition), dermatology care, behavioral health and substance use disorder counseling, and nutritional counseling. Go to www.fepblue.org/telehealth or call 855-636-1579, TTY: 855-636-1578, toll free to access this benefit. After your telehealth visit, please follow up with your primary care provider.

Telemedicine Services — Services provided by phone or secure online video/messaging for evaluation and management services. This does not include the use of fax machine or email; costs associated with enabling or maintaining providers' telehealth (telemedicine) technologies; or fees for medical information stored and forwarded to be reviewed at a later time by a physician or healthcare practitioner at a distant site without the patient being present. Providers must perform covered services acting within the scope of their license or certification under applicable state law. Please note, your healthcare provider must know when and where they can treat you. You, in turn, are responsible for accurately identifying to your provider where you are physically located for the service you received through telehealth (telemedicine) technologies. You and your physician must be in the same U.S. State, Territory, or foreign country as required by applicable legislation.

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 phone 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.

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Do not rely only 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.

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Summary of Benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2021

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a decision, please read this FEHB brochure.

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 healthcare professional, you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown below.

You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.fepblue.org/brochure.

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 healthcare professionals $35 per office visit for specialists Non-PPO: 35%* of our allowance	39-46
• Telehealth services	PPO: Nothing for the first 2 visits per calendar year after the 2nd visit: $10 copayment per visit Non-PPO: You pay all charges	39, 99
Services provided by a hospital:		
• Inpatient	PPO: $350 per admission Non-PPO: $450 per admission, plus 35% of our allowance	79-81
• Outpatient	PPO: 15%* of our allowance Non-PPO: 35%* of our allowance	81-85
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	95-96
• 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)	96-97

Standard Option Benefits	You pay	Page
Mental health and substance use disorder 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	98-102
Prescription drugs	**Retail Pharmacy Program:** • PPO: $7.50 for each purchase of up to a 30-day supply generic ($5.00 for a 30-day supply if you have Medicare Part B primary)/30% of our allowance Preferred brand-name/50% 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 Part B primary)/$90 Preferred brand-name/$125 non-preferred brand-name per prescription; up to a 90-day supply **Specialty Drug Pharmacy Program:** • $50 preferred specialty drug for a purchase of up to a 30-day supply; $70 non-preferred specialty drug for a purchase of up to a 30-day supply	108-120
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	123
Wellness and other special features: Health Tools; Blue Health Assessment; MyBlue® Customer eService; Diabetes Management Incentive Program; National Doctor and Hospital Finder; Healthy Families; travel benefit/services overseas; Care Management Programs; and Flexible benefits option		125-129
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 – 2021

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a decision, please read this FEHB brochure.

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 20. There is no deductible for Basic Option.

You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.fepblue.org/brochure.

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 healthcare professionals; $40 per office visit for specialists Non-PPO: You pay all charges	39-46
• Telehealth services	PPO: Nothing for the first 2 visits per calendar year after the 2nd visit: $15 copayment per visit Non-PPO: You pay all charges	39, 99
Services provided by a hospital:		
• Inpatient	PPO: $175 per day up to $875 per admission Non-PPO: You pay all charges	79-81
• Outpatient	PPO: $100 per day per facility Non-PPO: You pay all charges	81-85
Emergency benefits:		
• Accidental injury	PPO: $35 copayment for urgent care; $175 copayment for emergency room care Non-PPO: $175 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	95-96
• Medical emergency	Same as for accidental injury	96-97
Mental health and substance use disorder 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	98-102

Basic Option Benefits	You pay	Page
Prescription drugs	**Retail Pharmacy Program:** • PPO: $10 generic/$55 Preferred brand-name per prescription ($50 if you have primary Medicare Part B)/60% coinsurance ($75 minimum) for non-preferred brand-name drugs (50% ($60 minimum) if you have primary Medicare Part B) • Non-PPO: You pay all charges **Specialty Drug Pharmacy Program:** • $70 preferred specialty drug for a purchase of up to a 30-day supply; $95 non-preferred specialty drug for a purchase of up to a 30-day supply **Mail Service Prescription Drug Program** (for primary Medicare Part B members only): • $20 generic/$100 Preferred brand-name/$125 non-preferred brand-name per prescription; up to a 90-day supply	108-120
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	124
Wellness and other special features: Health Tools; Blue Health Assessment; MyBlue® Customer eService; Diabetes Management Incentive Program; National Doctor and Hospital Finder; Healthy Families; travel benefit/services overseas; Care Management Programs; and Flexible benefits option		125-129
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

Notes

Notes

Notes

2021 Rate Information for the Blue Cross and Blue Shield Service Benefit Plan

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

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 certain United States Postal Service employees as follows:

- **Postal Category 1** rates apply to career bargaining unit employees who are represented by the following agreement: NALC.
- **Postal Category 2** rates apply to career bargaining unit employees who are represented by the following agreement: PPOA.

Non-Postal rates apply to all career non-bargaining unit Postal Service employees and career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NPMHU, NPPN and NRLCA. Postal rates do not apply to non-career Postal employees, Postal retirees, and associate members of any Postal employee organization who are not career Postal employees.

If you are a Postal Service employee and have questions or require assistance, please contact:

USPS Human Resources Shared Service Center: 877-477-3273, option 5, Federal Relay Service 800-877-8339

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
Nationwide							
Standard Option Self Only	104	$241.58	$123.45	$523.42	$267.48	$120.09	$110.03
Standard Option Self Plus One	106	$517.46	$280.81	$1,121.16	$608.43	$273.62	$252.06
Standard Option Self and Family	105	$562.25	$300.12	$1,218.21	$650.26	$292.31	$268.89
Nationwide							
Basic Option Self Only	111	$235.82	$78.60	$510.93	$170.31	$75.46	$65.24
Basic Option Self Plus One	113	$517.46	$189.17	$1,121.16	$409.87	$181.98	$160.42
Basic Option Self and Family	112	$562.25	$201.27	$1,218.21	$436.08	$193.46	$170.04

EXHIBIT M

Blue Cross® and Blue Shield® Service Benefit Plan

www.fepblue.org

2022

A Fee-For-Service Plan (FEP Blue Standard and FEP Blue Basic Options) with a Preferred Provider Organization

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. This Plan is accredited. See page 13.

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

IMPORTANT

- Rates: Back Cover
- Changes for 2022: Page 15
- Summary of Benefits: Page 163

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

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

The Office of Personnel Management (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 is 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 800-772-1213, TTY: 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 800-MEDICARE 800-633-4227, TTY 877-486-2048.

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Introduction

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Standard and FEP Blue Basic Options** under contract (CS 1039) between the Blue Cross and Blue Shield Association and 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 phone number appearing on the back of your ID card.

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 healthcare benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2022, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2022, and changes are summarized on pages 15-16. Rates are shown on the back cover of this brochure.

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 and each covered 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 Healthcare Fraud!

Fraud increases the cost of healthcare 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 phone or to people you do not know, except for your healthcare provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare 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 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 800-FEP-8440 (800-337-8440) and explain the situation.
  - If we do not resolve the issue:

CALL – THE HEALTHCARE FRAUD HOTLINE
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)
  - Your child age 26 or over (unless they were disabled and incapable of self-support prior to age 26)
  - A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- 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 (TCC).
- 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.

Discrimination is Against the Law

The Blue Cross and Blue Shield Service Benefit Plan complies with all applicable Federal civil rights laws, including Title VII of the Civil Rights Act of 1964.

We:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator of your Local Plan by contacting your Local Plan at the phone number appearing on the back of your ID card.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator of your Local Plan. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, your Local Plan's Civil Rights Coordinator is available to help you.

Members may file a complaint with the HHS Office of Civil Rights, OPM, or FEHB Program Carriers.

You can also file a civil rights complaint with the Office of Personnel Management by mail at:

Office of Personnel Management
Healthcare and Insurance
Federal Employee Insurance Operations
Attention: Assistant Director, FEIO
1900 E Street NW, Suite 3400-S
Washington, D.C. 20415-3610

For further information about how to file a civil rights complaint, go to www.fepblue.org/en/rights-and-responsibilities/, or call the customer service phone number on the back of your member ID card. For TTY, dial 711.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. 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 take notes, ask questions and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medications or give your doctor and pharmacist a list of all the medications and dosages that you take, including non-prescription (over-the-counter) medications 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 medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Do not assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

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

For more information on patient safety, please visit:

- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. 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 healthcare providers and improve the quality of care you receive.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- 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 healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not 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, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

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. When such an event occurs, neither you nor your FEHB Plan will incur costs to correct the medical error.

You will not be billed for inpatient services when care is related to treatment of specific hospital-acquired conditions if you use Preferred or Member hospitals. This policy helps to protect you from having to pay for the cost of treating these conditions, and it encourages hospitals to improve the quality of care they provide.

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. 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.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for updates and questions about your benefit coverage.

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

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include 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 Plus One or Self and Family 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 are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your carrier to obtain a Certificate of Creditable Coverage (COCC) or to add a dependent when there is already family Coverage.

Contact your employing or retirement office if you are changing from Self to Self Plus One or Self and Family or to add a newborn if you currently have a Self Only plan.

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, you or they cannot be enrolled in or covered as a family member by another enrollee in 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 below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: 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
Coverage: 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
Coverage: 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
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

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 or children.

If this law applies to you, you must enroll in 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 lowest-cost nationwide Plan option as determined by OPM.
- 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 lowest-cost nationwide plan option as determined by OPM.

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 does not 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 does not 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 processed according to the 2022 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2021 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 family members 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 assistance with enrolling in a conversion policy (non-FEHB individual policy). FEP helps members with Temporary Continuation of Coverage (TCC) and with finding replacement coverage.

- **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 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. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- **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 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 coverage.

We also want to inform you that the Patient Protection and ACA did not eliminate TCC or change the TCC rules.

- **Finding replacement coverage**

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please refer to the next Section of this brochure. We will help you find replacement coverage inside or outside the Marketplace. For assistance, please contact your Local Plan at the phone 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 ACA's Health Insurance Marketplace. These rules are established by the Federal Government agencies that have responsibility for implementing the ACA and by the Marketplace.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA'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 healthcare 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.

OPM requires that FEHB plans be accredited to validate that Plan operations and/or care management meet nationally recognized standards. The local Plans and vendors that support the Blue Cross and Blue Shield Service Benefit Plan hold accreditation from National Committee for Quality Assurance (NCQA) and/or URAC. To learn more about this Plan's accreditations, please visit the following websites:

- National Committee for Quality Assurance (www.ncqa.org);
- URAC (www.URAC.org).

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 healthcare 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 Preferred 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. 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 20 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 phone 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 healthcare facilities, physicians, and other healthcare 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 156-157). 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 20 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.

- **Pilot Programs.** We may implement pilot programs in one or more Local Plan areas and overseas to test the feasibility and examine the impact of various initiatives. The pilot programs do not affect all Plan areas. Information on specific pilots is not published in this brochure; it is communicated to members and network providers in accordance with our agreement with OPM. Certain pilot programs may incorporate benefits that are different from those described in this brochure. For example, certain pilot programs may revise the Plan Allowance for Non-participating providers described in Section 10 of this brochure.

Your rights and responsibilities

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/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence
- Profit status
- Care management, including case management and disease management programs
- How we determine if procedures are experimental or investigational

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, at www.fepblue.org/en/rights-and-responsibilities.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.fepblue.org/en/terms-and-privacy/notice-of-privacy-practices/ to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

If you want more information about us, call or write to us. Our phone 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 2022

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.

Changes to our Standard Option only

- The member cost-share associated with care you receive from Non-participating providers who cannot balance bill you under the No Surprises Act (NSA), will now be applied to your Preferred Provider catastrophic out-of-pocket maximum. Previously, these amounts only counted toward the Non-preferred Provider out-of-pocket maximum. (See page 33.)
- For Self Only contracts, your Preferred Provider catastrophic out-of-pocket maximum is now $6,000. For Self Plus One and Self and Family contracts, your Preferred Provider catastrophic out-of-pocket maximum is now $12,000. Previously, the Preferred Provider out-of-pocket maximum for Self Only contracts was $5,000; for Self Plus One and Self and Family Contracts, the Preferred Provider out-of-pocket maximum was $10,000. (See page 33.)
- For Self Only contracts, your Non-preferred Provider catastrophic out-of-pocket maximum is now $8,000. For Self Plus One and Self and Family contracts, your Non-preferred Provider catastrophic out-of-pocket maximum is now $16,000. Previously, the Non-preferred Provider out-of-pocket maximum for Self Only contracts was $7,000; for Self Plus One and Self and Family Contracts, the Non-preferred Provider out-of-pocket maximum was $14,000. (See page 33.)
- We now provide only medical benefits for EKGs. Previously, one EKG per calendar year was covered under the preventive care adult benefit with no member cost-share. (See page 40.)
- If you are admitted to a Member or Non-member facility due to a medical emergency or accidental injury, you now will pay a $350 per admission copayment for unlimited days and we will then provide benefits at 100% of the Plan allowance. Previously, you paid a $450 per admission copayment. (See page 79.)

Changes to our Basic Option only

- For Self Only contracts, your Preferred Provider catastrophic out-of-pocket maximum is now $6,500. For Self Plus One and Self and Family contracts, your Preferred Provider catastrophic out-of-pocket maximum is now $13,000. Previously, the Preferred Provider out-of-pocket maximum for Self Only contracts was $5,500; for Self Plus One and Self and Family Contracts, the Preferred Provider out-of-pocket maximum was $11,000. (See page 33.)
- We now provide only medical benefits for EKGs. Previously, one EKG per calendar year was covered under the preventive care adult benefit with no member cost-share. (See page 40.)
- The member cost-share for a Tier 4 preferred specialty drug is now an $85 copayment, limited to one purchase of up to a 30-day supply when obtained at a Preferred retail pharmacy. The member cost-share for a Tier 5 non-preferred specialty drug is now a $110 copayment, limited to one purchase of up to a 30-day supply when obtained at a Preferred retail pharmacy. Previously, the member cost-share for a Tier 4 preferred specialty drug was a $65 copayment and the member cost-share for a Tier 5 non-preferred specialty drug was $90; each was also limited to one purchase of up to a 30-day supply at a Preferred retail pharmacy. (See page 114.)
- For members with Medicare Part B primary, the member cost-share for a Tier 4 preferred specialty drug is now an $80 copayment, limited to one purchase of up to a 30-day supply when obtained at a Preferred retail pharmacy. The member cost-share for a Tier 5 non-preferred specialty drug is now a $100 copayment, limited to one purchase of up to a 30-day supply when obtained at a Preferred retail pharmacy. Previously, the member cost-share for a Tier 4 preferred specialty drug was a $60 copayment and the member cost-share for a Tier 5 non-preferred specialty drug was $80; each was also limited to one purchase of up to a 30-day supply at a Preferred retail pharmacy. (See page 115.)
- Your member cost-share for some services to treat a covered accidental dental injury is now subject to a 30% coinsurance. Previously, you paid a $30 copayment per visit to treat an accidental dental injury. (See page 121.)

Changes to both our Standard and Basic Options

- You will no longer need to obtain prior approval for surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth, for care provided within 72 hours of the accidental injury. Previously, prior approval was required for all surgeries needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth regardless of when the care was performed. (See pages 22, 62, 68 and 78.)
- You are no longer responsible for the difference between our allowance and a Non-participating provider's billed charges in certain situations described under the No Surprises ACT (NSA) federal legislation. Previously, you were responsible for these differences. (See page 32.)
- We now cover group counseling on prevention and reducing health risks, and group nutritional counseling under the preventive benefit. Previously, only individual counseling was covered. (See pages 42, 46 and 61.)
- Under our maternity benefit, we now offer a breast pump and milk storage bags for members who are pregnant and/or nursing when ordered through our fulfillment vendor. Previously, these items were covered when ordered through CVS Caremark. (See page 48.)
- We now offer kidney transplants as part of the Blue Distinction Centers for Transplants® Program. Previously, kidney transplants were not a part of this program. (See page 76.)
- Kidney transplants will now require prior approval. Previously, kidney transplants did not require prior approval. (See pages 62, 69 and 76.)
- We now cover nipple reconstruction after a mastectomy for female to male gender reassignment surgery. Previously, there was no benefit for this procedure. (See page 66.)
- We no longer offer pancreas transplants as part of the Blue Distinction Centers for Transplants® Program. (See page 76.)
- We now provide coverage for tubeless insulin delivery systems under the Tier 2 and Tier 3 pharmacy benefit. Previously, all types of insulin delivery systems were covered only under the durable medical equipment benefit. (See pages 110 and 114.)
- For inpatient stays at Non-member facilities resulting from medical emergencies or accidental injuries, or for emergency deliveries, our allowance is now the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations. Previously, our allowance for these services was the billed amount. (See page 156.)
- For outpatient services resulting from a medical emergency or accidental injury and billed by a Non-member facility, our allowance is now the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations. Previously, our allowance for these services was the billed amount. (See page 157.)
- For non-emergency medical services performed in Preferred hospitals provided by physicians and other covered healthcare professionals identified under the NSA that do not contract with your local Blue Cross and Blue Shield Plans and cannot balance bill you under this regulation, our allowance is now equal to the lesser of the billed amount or the qualifying payment amount (QPA). Previously, our allowance was equal to the greater of the Medicare participating fee schedule amount or 100% of the local Plan allowance. (See page 157.)
- For emergency medical services performed in the emergency department of a hospital provided by physicians and other covered healthcare professionals that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is now equal to the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations. Previously, the Plan allowance was 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 Local Plan Allowance 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. (See page 157.)
- We no longer limit the difference between the Non-participating Provider Allowance (NPA) and the amount billed to $5,000 when care is received in a Preferred facility from certain non-participating professional providers. Federal regulations now limit what you can be billed in these situations. (See pages 32 and 157.)

Section 3. How You Get Care

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 20 for the exceptions to this requirement. Refer to page 13 for more information about Preferred providers.

Under both Standard and Basic Option, you can also get care for the treatment of minor acute conditions (see page 155 for definition), dermatology care (see page 39), counseling for behavioral health and substance use disorder (see page 99), and nutritional counseling (see pages 42 and 46), using teleconsultation services delivered via phone by calling 855-636-1579, TTY: 855-636-1578, or via secure online video/messaging at www.fepblue.org/telehealth.

The term "primary care provider" includes family practitioners, general practitioners, medical internists, pediatricians, obstetricians/gynecologists, and physician assistants. Physician assistants working for a specialist may also be considered specialists.

Balance Billing Protection

FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or in some cases for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

- **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. Covered professional providers within the United States, Puerto Rico, and the U.S. Virgin Islands are healthcare 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 healthcare services in the normal course of business. Covered services must be provided in the state in which the provider is licensed or certified. **If the state has no applicable licensing or certification requirement, the provider must meet the requirements of the Local Plan.** 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.

This plan recognizes that transsexual, transgender, and gender-nonconforming members require healthcare delivered by healthcare providers experienced in transgender health. While gender reassignment surgeons (benefit details found in Section 5(b)) and hormone therapy providers (benefit details found in Section 5(f)) play important roles in preventive care, you should see a primary care provider familiar with your overall healthcare needs. Benefits described in this brochure are available to all members meeting medical necessity guidelines.

If you have questions about covered providers or would like the names of PPO (Preferred) providers, please contact the Local Plan where services will be performed.

- **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-Preferred (Member/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 surgicenter, 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 use disorder. Accredited healthcare 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 use disorder 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 87-88 and 100-101. If you have questions about treatment at an RTC, please contact us at the customer service phone number listed on the back of your ID card.

Blue Distinction® Specialty Care

Blue Distinction Specialty Care, our centers of excellence program, focuses on effective treatment for specialty procedures, such as: Bariatric Surgery, Cardiac Care, Knee and Hip Replacement, Spine Surgery, Transplants, Cancer Care, Cellular Immunotherapy (CAR-T), Gene Therapy, Maternity Care, and Substance Use Treatment and Recovery. Using national evaluation criteria developed with input from medical experts, the Blue Distinction Centers offer comprehensive care delivered by multidisciplinary teams with subspecialty training and distinguished clinical expertise. Providers demonstrate quality care, treatment expertise and better overall patient results.

We cover specialty care at designated Blue Distinction Centers at Preferred benefit levels. See pages 86-87 for information regarding enhanced inpatient and outpatient benefits for bariatric, spine, knee and hip surgeries performed at a Blue Distinction Center. We also provide enhanced benefits for covered transplant services performed at the Blue Distinction Centers for Transplant designated centers as described on page 76.

For listings of Blue Distinction Centers, visit https://www.bcbs.com/blue-distinction-center/facility; access our National Doctor & Hospital Finder via www.fepblue.org/provider/; or call us at the customer service phone number listed on the back of your ID card.

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 phone 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 70).

Skilled Nursing Facility (SNF)

A SNF is a freestanding institution or a distinct part of a hospital which customarily bills insurance as a skilled nursing facility and meets the following criteria:

- Is Medicare-certified as a skilled nursing facility;
- Is licensed in accordance with state or local law or is approved by the state or local licensing agency as meeting the licensing standards (where state or local law provides for the licensing of such facilities);
- Has a transfer agreement in effect with one or more Preferred hospitals; and
- Is primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care; or rehabilitation services for the rehabilitation of injured, disabled or sick persons.

To be covered, skilled nursing facility care cannot be maintenance or custodial care. The term skilled nursing facility does not include any institution that is primarily for the care and treatment of mental diseases.

Note: Additional criteria apply when Medicare Part A is not the primary payor (see page 88).

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.

Exceptions:

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 phone number listed in your local phone directory. If you already have your new Service Benefit Plan ID card, call us at the phone 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 may require precertification and prior approval. If you do not obtain precertification, there may be a reduction or denial of benefits. Be sure to read all of the precertification and prior approval information below and on pages 22-26. Our FEP medical policies may be found by visiting www.fepblue.org/policies.

- **Inpatient hospital admission, inpatient residential treatment center admission, or skilled nursing facility admission**

Precertification is the process by which – prior to your inpatient 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, inpatient residential treatment center, or skilled nursing facility whether or not they have contacted us and provided all necessary information. You may contact us at the phone number on the back of your ID card to ask if we have received the request for precertification. You are also responsible for enrolling in case management and working with your case manager if your care involves residential treatment or a skilled nursing facility. For information about precertification of an emergency inpatient hospital admission, please see page 26.

Warning: We will reduce our benefits for the inpatient hospital stay by $500, even if you have obtained prior approval for the service or procedure being performed during the stay, 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: If precertification was not obtained prior to admission, inpatient benefits (such as room and board) are not available for inpatient care at a residential treatment center, or, when Medicare Part A is not the primary payor, at a skilled nursing facility. 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; with the exception of admissions for gender reassignment surgery and admissions to residential treatment centers, and skilled nursing facilities.
- You have another group health insurance policy that is the primary payor for the hospital stay; with the exception of admissions for gender reassignment surgery. (See page 76 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)
- Medicare Part A is the primary payor for the hospital or skilled nursing facility stay; with the exception of admissions for gender reassignment surgery. (See page 76 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 64-65 in order for benefits to be provided for the admission and surgical procedure.

- **Other services**

You must obtain prior approval for these services under both Standard and Basic Option in all outpatient and inpatient settings unless otherwise noted. Precertification is also required if the service or procedure requires an inpatient hospital admission. Contact us using the customer service phone 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:

- **Gene therapy and cellular immunotherapy, for example CAR-T and T-Cell receptor therapy**
- **Air Ambulance Transport (non-emergent)** – Air ambulance transport related to immediate care of a medical emergency or accidental injury does not require prior approval; see Section 5 (c), page 92, for more information.
- **Outpatient facility-based sleep studies** – Prior approval is required for sleep studies performed in a provider's office, sleep center, clinic, any type of outpatient center, or any location other than your home.
- **Applied behavior analysis (ABA)** – Prior approval is required for ABA and all related services, including assessments, evaluations, and treatments.
- **Gender reassignment surgery –** Prior to surgical treatment of gender dysphoria, your provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and your provider later modifies the plan.
- **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.
  Note: You must receive genetic counseling and evaluation services before preventive BRCA testing is performed. See page 44.
- **Surgical services** – The surgical services on the following list require prior approval for care performed by Preferred, Participating/Member, and Non-participating/Non-member professional and facility providers:
  - 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 page 64-65.
  - Surgical correction of congenital anomalies (see definition on page 152);
  - Surgery needed to correct accidental injuries (see definition on page 152) to jaws, cheeks, lips, tongue, roof and floor of mouth except when care is provided within 72 hours of the accidental injury; and
  - Gender reassignment surgery.
- **Intensity-modulated radiation therapy (IMRT)** – Prior approval is required for all 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 page 69 for the list of covered organ/tissue transplants. **Prior approval is required** for both the procedure and the facility. Contact us at the customer service phone 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 pages 70-71 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. Contact your local Plan for Medicare's approved transplant programs.

  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 phone number listed on the back of your ID card.

  The blood or marrow stem cell transplants listed on pages 71-73 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 74** must be performed at a FACT-accredited facility. See page 19 for more information about these types of facilities.

  Not every transplant program 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 phone number listed 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 73-74 for the list of conditions covered **only** in clinical trials. Contact us at the customer service phone 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.

  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 Blue Distinction Center for Transplants to treat your condition. If your physician has recommended you receive a transplant or that you participate in a transplant clinical trial, we encourage you to contact the Case Management Department at your Local Plan.

  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 73) where the procedure is to be performed.
- **Transplant travel –** 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 companions. If the transplant recipient is age 21 or younger, we pay up to $10,000 for eligible travel costs for the member and companions. Reimbursement is subject to IRS regulations.

- **Prescription drugs and supplies – Certain prescription drugs and supplies require prior approval.** Contact CVS Caremark, our Pharmacy Program administrator, at 800-624-5060, TTY: 800-624-5077, 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 pages 106-107 for more information 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 for a drug requiring prior approval 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 unable to be filled and a letter will be mailed to you explaining the prior approval procedures.

  Note: The Specialty Drug Pharmacy Program will not fill your prescription for a drug requiring prior approval 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 unable to be filled and a letter will be mailed to you explaining the prior approval procedures.
- **Medical foods covered under the pharmacy benefit require prior approval.** See Section 5 (f), page 109, for more information.

- **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 phone 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 70-74) – 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 phone 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 87-88 and 100-101 for additional information.

Note: If we approve the request for prior approval or precertification, you will be provided with a notice that identifies the approved services and the authorization period. You must contact us with a request for a new approval five (5) business days prior to a change to the approved original request, and for requests for an extension beyond the approved authorization period in the notice you received. We will advise you of the information needed to review the request for change and/or extension.

- **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 27.) If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not 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 phone number listed on the back of your Service Benefit Plan ID card. You may also call OPM's FEHB 1 at 202-606-0727 between 8 a.m. and 5 p. m. Eastern Time (excluding holidays) 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 phone 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, 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 phone 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 phone 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* below.

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, your physician or the hospital must contact us for precertification of additional days. Further, if your newborn stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your newborn.

Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **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, 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 on the next page. Note that these procedures apply to requests for reconsideration of concurrent care claims as well (see page 152 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 verbal or written requests for appeals and the exchange of information by phone, 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.

- **The Federal Flexible Spending Account Program – FSAFEDS**

Healthcare FSA (HCFSA) – Reimburses you for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, 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).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 4. Your Costs for Covered Services

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

Cost-share/Cost-sharing

Cost-share or 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 81). 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 83).

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 prior 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. See Section 5(i) for information about the deductible and overseas benefits.

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 or not 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 phone 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 the 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 the bill.

  Remember, under Basic Option, you must use Preferred providers in order to receive benefits. See page 20 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 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 the bill.

  Under Basic Option, there are no benefits for care performed by Participating providers; you pay all charges. See page 20 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 phone 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 156-158). 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 the 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 20 for the exceptions to this requirement.

The following tables 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 39; see page 81 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
Physician's charge: $250
Our allowance: We set it at: 100
We pay: 85% of our allowance: 85
You owe: Coinsurance: 15% of our allowance: 15
You owe: Copayment: Not applicable
+Difference up to charge?: No: 0
TOTAL YOU PAY: $15

Participating Physician Standard Option
Physician's charge: $250
Our allowance: We set it at: 100
We pay: 65% of our allowance: 65
You owe: Coinsurance: 35% of our allowance: 35
You owe: Copayment: Not applicable
+Difference up to charge?: No: 0
TOTAL YOU PAY: $35

Non-participating Physician Standard Option
Physician's charge: $250
Our allowance: We set it at: 100
We pay: 65% of our allowance: 65
You owe: Coinsurance: 35% of our allowance: 35
You owe: Copayment: Not applicable
+Difference up to charge?: Yes: 150
TOTAL YOU PAY: $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.

You should also see section *Important Notice About Surprise Billing – Know Your Rights* on page 32 that describes your protections against surprise billing under the No Surprises Act.

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
Facility's charge: $5,000
Our allowance: We set it at: 2,900
We pay: 85% of our allowance: 2,465
You owe: Coinsurance: 15% of our allowance: 435
You owe: Copayment: Not applicable
+Difference up to charge?: No: 0
TOTAL YOU PAY: $435

Member Ambulatory Surgical Facility Standard Option
Facility's charge: $5,000
Our allowance: We set it at: 2,900
We pay: 65% of our allowance: 1,885
You owe: Coinsurance: 35% of our allowance: 1,015
You owe: Copayment: Not applicable
+Difference up to charge?: No: 0
TOTAL YOU PAY: $1,015

Non-member Ambulatory Surgical Facility* Standard Option
Facility's charge: $5,000
Our allowance: We set it at: 2,500
We pay: 65% of our allowance: 1,625
You owe: Coinsurance: 35% of our allowance: 875
You owe: Copayment: Not applicable
+Difference up to charge?: Yes: 2,500
TOTAL YOU PAY: $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 Surprise Billing — Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" under certain circumstances. A surprise bill is an unexpected bill you receive from a Non-participating healthcare provider, facility, or air ambulance service for healthcare. Surprise bills can happen when you receive emergency care – when you have little or no say in the facility or provider from whom you receive care. They can also happen when you received non-emergency services at participating facilities, but you receive some care from Non-participating providers.

Balance billing happens when you receive a bill from the non-participating provider, facility, or air ambulance service for the difference between the Non-participating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from unexpected bills.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.fepblue.org/NSA or contact the customer service phone number on the back of your ID card.

Your costs for other care

Overseas care. Services provided outside the United States, Puerto Rico, and the U.S. Virgin Islands are considered overseas care. **Under Standard and Basic Options**, we pay overseas claims at Preferred benefit levels. Therefore, the Basic Option requirement to use Preferred providers in order to receive benefits does not apply. See Section 5(i) for specific 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 20 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 healthcare 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 $6,000 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 $12,000 for Preferred provider services. Only eligible expenses for Preferred provider services, and the cost-shares associated with care from Non-participating providers under the NSA (see page 32), 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 $8,000 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 $16,000 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 $6,500 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 $13,000 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 29-30;
- 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 facility;
- 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 20 for the exceptions to the requirement to use Preferred providers.

If your provider's prescription allows for generic substitution and you select a brand-name drug, your expenses for the difference in cost-share do not count toward your catastrophic protection out-of-pocket maximum (see page 103 for additional information).

Carryover

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 above) from that point until the effective date of your new plan.

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

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 prior 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.

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.

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 contract holder.

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. Benefits

See page 15 for how our benefits changed this year. Pages 163-166 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.

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Section 5. Standard and Basic Option Overview

The benefit package for Standard and Basic Options are described in Section 5, which is divided into subsections 5(a) through 5(i). Make sure that you review the benefits that are available under the option in which you are enrolled.

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 phone number on the back of your Service Benefit Plan ID card or on our website at www.fepblue.org. Each option offers unique features. Members do not need to have referrals to see specialists.

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 Retail Pharmacy Program, a Mail Service Prescription Drug Program, and a 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). 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 Retail Pharmacy Program and a 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 Healthcare 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 Get Care*, for information on covered professional providers and other healthcare 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 healthcare 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 or facility bills for the service.
- The services listed in this Section are for the charges billed by a physician or other healthcare 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.
- You should be aware that some Non-preferred (non-PPO) professional providers may provide services in Preferred (PPO) facilities.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 114 for information about Tier 4 and Tier 5 specialty drug fills from Preferred providers and Preferred pharmacies. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731. Basic Option members must use Preferred providers and Preferred pharmacies (see page 104).
- We waive the cost-share for the first 2 visits for telehealth per calendar year. This applies to a combined total for treatment of minor acute conditions, dermatology care, and mental health and substance use disorder conditions. (See pages 39 and 99.)
- **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 may be responsible for any difference between our payment and the billed amount. See page 32, NSA, for information on when you are not responsible for this difference.
- **Under Basic Option,**
  - There is **no calendar year deductible**.
  - **You must use Preferred providers in order to receive benefits. See below and page 20 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 may be responsible for any difference between our payment and the billed amount. See page 32, NSA, for information on when you are not responsible for this difference.

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 healthcare professionals: • Consultations • Genetic counseling • 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) • Phone consultations and online medical evaluation and management services (telemedicine) Note: Please refer to pages 40-42 for our coverage of laboratory, X-ray, and other diagnostic tests billed for by a healthcare professional, and to page 83 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 healthcare 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 healthcare 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 152 for more information about "agents.") Participating/Non-participating: You pay all charges
Telehealth professional services for: • Minor acute conditions (see page 155 for definition) • Dermatology care (see page 159 for definition) Note: Refer to Section 5(h), *Wellness and Other Special Features*, for information on telehealth services and how to access a provider. Note: Benefits are combined with telehealth services listed in Section 5(e), see page 99. Note: Copayments are waived for members with Medicare Part B primary.	Preferred Telehealth Provider: Nothing (no deductible) for the first 2 visits per calendar year for any covered telehealth service $10 copayment per visit (no deductible) after the 2nd visit Participating/Non-participating: You pay all charges	Preferred Telehealth Provider: Nothing for the first 2 visits per calendar year for any covered telehealth service $15 copayment per visit after the 2nd visit 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	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

Benefit Description	You Pay	
Diagnostic and Treatment Services (cont.)	**Standard Option**	**Basic Option**
• 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
Not covered: • *Routine services except for those Preventive care services described on pages 42-46* • *Costs associated with enabling or maintaining providers' telehealth (telemedicine) technologies, non-interactive telecommunication such as email communications, or asynchronous store-and-forward telehealth 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	**Standard Option**	**Basic Option**
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	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 152 for more information about "agents.")

Lab, X-ray and Other Diagnostic Tests - continued on next page

Benefit Description	You Pay	
Lab, X-ray and Other Diagnostic Tests (cont.)	**Standard Option**	**Basic Option**
	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.	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.
Diagnostic tests including but not limited to: • Cardiovascular monitoring • EEGs • Home-based/unattended sleep studies • 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 152 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 • Nuclear medicine • Facility-based sleep studies (prior approval required) • 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.	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 152 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.

Lab, X-ray and Other Diagnostic Tests - continued on next page

Benefit Description	You Pay	
Lab, X-ray and Other Diagnostic Tests (cont.)	**Standard Option**	**Basic Option**
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 page 44). 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 152 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	**Standard Option**	**Basic Option**
Benefits are provided for preventive care services for adults age 22 and over. Covered services include: • Counseling on prevention and reducing health risks • Nutritional counseling Note: When nutritional counseling is via the contracted telehealth provider network, we provide benefits as shown here for Preferred providers. Refer to Section 5(h), *Wellness and Other Special Features*, for information on how to access a telehealth provider. • Visits/exams for preventive care Note: See the definition of Preventive Care, Adult, on page 158 for included health screening services. Preventive care benefits for each of the services listed below are limited to one per calendar year. • 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. See Section 5(h) for complete information. • Basic or comprehensive metabolic panel test • CBC • Cervical cancer screening tests - Human papillomavirus (HPV) tests of cervix - Pap tests of the cervix • Colorectal cancer tests, including:	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.

Preventive Care, Adult - continued on next page

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
- Colonoscopy, with or without biopsy (see page 63 for our payment levels for diagnostic colonoscopies) - DNA analysis of stool samples - Double contrast barium enema - Fecal occult blood test - Sigmoidoscopy	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. 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.	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

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
• Fasting lipoprotein profile (total cholesterol, LDL, HDL, and/or triglycerides) • General health panel • Prostate cancer test – Prostate Specific Antigen (PSA) • Screening for chlamydial infection • Screening for diabetes mellitus • Screening for gonorrhea infection • Screening for human immunodeficiency virus (HIV) • Screening mammograms, including mammography using digital technology • Ultrasound for abdominal aortic aneurysm for adults, ages 65 to 75, limited to one screening per lifetime • Urinalysis The following preventive services are covered at the time intervals recommended at each of the links below as adopted by December 31, 2020. • Immunizations such as COVID-19, Pneumococcal, influenza, shingles, tetanus/DTaP) and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules. 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. • USPSTF A and B recommended screenings such as cancer, osteoporosis, depression, and high blood pressure. For a complete list of covered A and B recommendation screenings and age and frequency limitations go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org • Well woman care such as gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of Well Women preventive care services go to the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/ • To build your personalized list of preventive services go to https://health.gov/myhealthfinder	Continued from previous page: Note: Many Preferred retail pharmacies participate in our vaccine network. See page 111 for our coverage of these vaccines when provided by pharmacies in the vaccine network.	Continued from previous page: 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: Many Preferred retail pharmacies participate in our vaccine network. See page 111 for our coverage of these vaccines when provided by pharmacies in the vaccine network.

Preventive Care, Adult - continued on next page

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
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. If you receive both preventive and diagnostic services from your Provider on the same day, you are responsible for paying you cost-share for the diagnostic services. Note: See page 112 for our payment levels for medications to promote better health as recommended under the Affordable Care Act. Note: See page 113 for our payment levels for certain bowel preparation medications, and antiretroviral medications for the prevention of HIV. Note: Unless otherwise noted, the benefits listed above and on pages 42-43 do not apply to children up to age 22. (See benefits under *Preventive Care, Child*, this Section.)	See previous page	See previous page
Hereditary Breast and Ovarian Cancer Screening Benefits are available for screening members, age 18 and over (including children ages 18 – 21) limited to one of each type of test per lifetime, 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 and additional BRCA coverage or call the phone number on the back of your ID card for additional policy information. Note: See page 63 for the benefits available for the surgical removal of breast, ovaries, or prostate cancer when screening reveals a BRCA mutation: preventive care benefits are not available.	See page 42	See page 42

Preventive Care, Adult - continued on next page

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance and deductible.	See page 42	See page 42
Not covered: • *Genetic testing related to family history of cancer or other disease, except as described on page 44* *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* • *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* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure. Medical benefits may be available for these services.* • *Phone consultations and online medical evaluation and management services (telemedicine) for preventive services, except as noted on page 42 for nutritional counseling.*	*All charges*	*All charges*
Preventive Care, Child	**Standard Option**	**Basic Option**
Benefits are provided for preventive care services for children up to age 22. This includes: • Well-child visits, examinations, and other preventive services as adopted by December 31, 2020, and described in the Bright Future Guidelines as provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Future Guidelines go to https://brightfutures.aap.org • Immunizations such as DTaP, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html Note: U.S. FDA licensure may restrict the use of the immunizations and vaccines listed above to specific age ranges, frequencies, and/or other patient-specific indications, including gender. • To build your personalized list of preventive services go to https://health.gov/myhealthfinder	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: 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.

Preventive Care, Child - continued on next page

Benefit Description	You Pay	
Preventive Care, Child (cont.)	**Standard Option**	**Basic Option**
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 • Cervical cancer screening tests - Pap tests of the cervix - Human papillomavirus (HPV) tests of the cervix Note: See page 44 for covered BRCA testing. • Screening for human immunodeficiency virus (HIV) infection • Screening for syphilis infection • Screening for latent tuberculosis infection for children ages 18 through 21 • Nutritional counseling 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. Note: When nutritional counseling is via the contracted telehealth provider network, we provide benefits as shown here for Preferred providers. Refer to Section 5(h), *Wellness and Other Special Features*, for information on how to access a telehealth provider. Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: See page 112 for our payment levels for medications to promote better health as recommended under the Affordable Care Act.	Continued from previous page: 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.	Continued from previous page: 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.
Not covered: • *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* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel* • *Immunizations, boosters, and medications for travel or work-related exposure. Medical benefits may be available for these services.*	*All charges*	*All charges*

Preventive Care, Child - continued on next page

Benefit Description	You Pay	
Preventive Care, Child (cont.)	**Standard Option**	**Basic Option**
• *Phone consultations and online medical evaluation and management services (telemedicine) for preventive services, except as noted above for nutritional counseling.*	*All charges*	*All charges*
Maternity Care	**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 or during a covered observation stay • Breastfeeding education and individual coaching on breastfeeding by healthcare providers such as physicians, physician assistants, midwives, nurse practitioners/clinical specialists, and lactation consultants Note: See page 48 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 42 for our coverage of nutritional counseling. Note: Benefits for home nursing visits (skilled) related to covered maternity care are subject to the visit limitations described on page 59. Note: Maternity care benefits are not provided for prescription drugs required during pregnancy, except as recommended under the Affordable Care Act. See page 112 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 phone 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 the notes on pages 82-85. 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

Benefit Description	You Pay	
Maternity Care (cont.)	**Standard Option**	**Basic Option**
Note: Here are some things to keep in mind: • You do not need to precertify your delivery; see page 26 for other circumstances, such as extended stays for you or your newborn. • You may remain in the hospital up to 48 hours after a vaginal 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 when performed during the covered portion of the mother's maternity stay and billed by the facility. We cover other care of a newborn who requires professional services or non-routine treatment, only if we cover the newborn under a Self Plus One or Self and Family enrollment. Surgical benefits apply to circumcision when billed by a professional provider for a male newborn. • Hospital services are listed in Section 5(c) and Surgical benefits are in Section 5(b). Note: See page 156 for our payment for inpatient stays resulting from an emergency delivery at a hospital or other facility not contracted with your Local Plan. Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in their own right. Regular medical or surgical benefits apply rather than maternity benefits. Note: See page 63 for our payment levels for circumcision.	See previous page	See previous page
• Breast pump, limited to one per calendar year for members who are pregnant and/or nursing Note: Milk storage bags will be included with your breast pump. Note: Benefits for the breast pump and milk storage bags are only available when you order them through our fulfillment vendor by visiting www.fepblue.org/maternity or calling 1-800-411-2583.	Nothing (no deductible)	Nothing
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 above on this page*	*All charges*	*All charges*

Maternity Care - continued on next page

Benefit Description	You Pay	
Maternity Care (cont.)	**Standard Option**	**Basic Option**
• *Breastfeeding supplies other than those contained in the breast pump kit described on the previous page including clothing (e.g., nursing bras), baby bottles, or items for personal comfort or convenience (e.g., nursing pads)* • *Tocolytic therapy and related services except as described on page 47* • *Maternity care for members not enrolled in the Service Benefit Plan*	*All charges*	*All charges*
Family Planning	**Standard Option**	**Basic Option**
A range of voluntary family planning services for women, limited to: • Contraceptive counseling • Diaphragms and contraceptive rings • Injectable contraceptives • Intrauterine devices (IUDs) • Implantable contraceptives • Tubal ligation or tubal occlusion/tubal blocking procedures only Family planning services for men, limited to: • Vasectomy Note: We also provide benefits for professional services associated with tubal ligation/occlusion/blocking procedures, vasectomy, 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
• 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 110 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*

Benefit Description	You Pay	
Reproductive Services	**Standard Option**	**Basic Option**
Diagnosis and treatment of infertility including covered: • Diagnostic and treatment services • Laboratory tests • Diagnostic tests • Surgical procedures • Prescription drugs Note: See Section 5(a) for covered labs, diagnostic tests, and X-rays. Note: See Section 5(b) for covered surgical services. Note: See Section 5(f) for covered prescription drugs. Note: See below for a list of services not covered as treatments for infertility or as alternatives to conventional conception.	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 healthcare 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 152 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.
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) and 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*

Benefit Description	You Pay	
Allergy Care	**Standard Option**	**Basic Option**
• Allergy testing • Allergy treatment • Sublingual allergy desensitization drugs as licensed by the U.S. FDA 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 healthcare 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 152 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 healthcare 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*

Benefit Description	You Pay	
Treatment Therapies	**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 21-24). • Intensity-modulated radiation therapy (IMRT) Note: **You must get prior approval for IMRT related to cancers, except head, neck, breast, prostate, or anal cancer.** Please refer to page 22 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 59. • Outpatient cardiac rehabilitation • Pulmonary rehabilitation therapy • Applied behavior analysis (ABA) for the treatment of an autism spectrum disorder (see prior approval requirements on page 22) Note: See Section 5(c) for our payment levels for treatment therapies billed for by the outpatient department of a hospital. Note: See page 60 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 healthcare 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 152 for more information about “agents.”) Participating/Non-participating: You pay all charges
• Auto-immune infusion medications: Remicade, Renflexis and Inflectra Note: See above for your costs for intravenous (IV)/ infusion therapy - Home IV or infusion therapy.	Preferred: 10% 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 billed amount	Preferred: 15% of the Plan allowance Participating/Non-participating: You pay all charges

Treatment Therapies - continued on next page

Benefit Description	You Pay	
Treatment Therapies (cont.)	**Standard Option**	**Basic Option**
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 21-24). • 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.) • Applied behavior analysis (ABA) for the treatment of an autism spectrum disorder (see prior approval requirements on page 22)	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 Rehabilitation Therapy	**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 healthcare 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.	Preferred primary care provider or other healthcare 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 152 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.

Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Rehabilitation Therapy - continued on next page

Benefit Description	You Pay	
Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Rehabilitation Therapy (cont.)	**Standard Option**	**Basic Option**
	Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown on page 53, according to the contracting status of the facility.	
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* • *Equine therapy and hippotherapy (exercise on horseback)* • *Massage therapy*	*All charges*	*All charges*
Hearing Services (Testing, Treatment, and Supplies)	**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 57.	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 healthcare 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 152 for more information about “agents.”) Participating/Non-participating: You pay all charges
Not covered: • *Routine hearing tests (except as indicated on page 45)* • *Hearing aids (except as described on page 57)*	*All charges*	*All charges*
Vision Services (Testing, Treatment, and Supplies)	**Standard Option**	**Basic Option**
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;	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies)	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges

Vision Services (Testing, Treatment, and Supplies) - continued on next page

Benefit Description	You Pay	
Vision Services (Testing, Treatment, and Supplies) (cont.)	**Standard Option**	**Basic Option**
• For the nonsurgical treatment for amblyopia and strabismus, for children from birth through age 21 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 and on page 54.	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
• Eye examinations related to a specific medical condition • Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 21 Note: See above and on page 54 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 40-42 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 above.	Preferred primary care provider or other healthcare 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 healthcare 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 152 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 above and on page 54* • *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 above*	*All charges*	*All charges*

Benefit Description	You Pay	
Foot Care	**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 healthcare 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 healthcare 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 152 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	**Standard Option**	**Basic Option**
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 limited to treatment of erectile dysfunction or as part of an approved plan for gender reassignment surgery • Surgical implants 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

Benefit Description	You Pay	
Orthopedic and Prosthetic Devices (cont.)	**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 5 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, 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* • *Over the counter hearing aids, enhancement devices, accessories or supplies (including remote controls and warranty packages)*	*All charges*	*All charges*
Durable Medical Equipment (DME)	**Standard Option**	**Basic Option**
Durable medical equipment (DME) is equipment and supplies that are: 1. Prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Medically necessary; 3. Primarily and customarily used only for a medical purpose; 4. Generally useful only to a person with an illness or injury; 5. Designed for prolonged use; and 6. Used to 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	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.

Durable Medical Equipment (DME) - continued on next page

Benefit Description	You Pay	
Durable Medical Equipment (DME) (cont.)	**Standard Option**	**Basic Option**
• 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
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 48* • *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 above)* • *Equipment for cosmetic purposes* • *Topical Hyperbaric Oxygen Therapy (THBO)* • *Charges associated with separate or extended warranties*	*All charges*	*All charges*
Medical Supplies	**Standard Option**	**Basic Option**
• Medical foods and nutritional supplements when administered by catheter or nasogastric tubes Note: See Section 10, *Definitions*, for more information about medical foods. • Ostomy and catheter supplies	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

Medical Supplies - continued on next page

Benefit Description	You Pay	
Medical Supplies (cont.)	**Standard Option**	**Basic Option**
• 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* • *Medical foods administered orally, except as described in Section 5(f)*	*All charges*	*All charges*
Home Health Services	**Standard Option**	**Basic Option**
Home nursing care (skilled) 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 152 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*	*All charges*	*All charges*

Home Health Services - continued on next page

Benefit Description	You Pay	
Home Health Services (cont.)	**Standard Option**	**Basic Option**
• *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 pages 88-89.* • *Private duty nursing*	*All charges*	*All charges*
Manipulative Treatment	**Standard Option**	**Basic Option**
Manipulative treatment performed by a professional provider, 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. 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: $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	**Standard Option**	**Basic Option**
Acupuncture Note: Acupuncture must be performed and billed by a healthcare 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 17 for more information. Note: When billed by a facility such as the outpatient department of a hospital, you are limited to the number of visits per calendar year listed on this page. See Section 5(c) for your cost-share. Note: See page 77 for our coverage of acupuncture when provided as anesthesia for covered surgery. Note: See page 47 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 healthcare 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

Alternative Treatments - continued on next page

Benefit Description	You Pay	
Alternative Treatments (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Biofeedback* • *Self-care or self-help training*	*All charges*	*All charges*
Educational Classes and Programs	**Standard Option**	**Basic Option**
• Smoking and tobacco cessation treatment - Counseling for smoking and tobacco cessation - 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 40, 42 and 46 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 healthcare 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, or applied behavior analysis (ABA), when performed as part of an educational class or program* • *Premenstrual syndrome (PMS), lactation (except as described on page 47), headache, eating disorder (except as described on pages 40 and 42), 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*	*All charges*	*All charges*

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare 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 healthcare 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 healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e., hospital, surgical center, etc.).
- **YOU MUST GET PRIOR APPROVAL for the following surgical services: surgery for morbid obesity; surgical correction of congenital anomalies; and surgery needed to correct accidental injuries (see *Definitions*, page 152) to jaws, cheeks, lips, tongue, roof and floor of mouth, except when care is provided within 72 hours of the accidental injury. Please refer to page 22 for more information.**
- **YOU MUST GET PRIOR APPROVAL for all organ transplant surgical procedures (except corneal 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.**
- **YOU MUST GET PRIOR APPROVAL for gender reassignment surgery. Prior to any gender reassignment surgery, your provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and your provider later modifies the plan (including changes to the procedures to be performed or the anticipated dates for the procedures). See page 22 and page 66 for additional information. If your surgical procedure requires an inpatient admission, YOU MUST ALSO GET PRECERTIFICATION of the inpatient care.**
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 114 for information about Tier 4 and Tier 5 specialty drug fills from Preferred providers and Preferred pharmacies. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731. Basic Option members must use Preferred providers and Preferred pharmacies (see page 104).
- **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 may be responsible for any difference between our payment and the billed amount. See page 32, NSA, for information on when you are not responsible for this difference.
  - 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 20 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 may be responsible for any difference between our payment and the billed amount. See page 32, NSA, for information on when you are not responsible for this difference.

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 • Assistant surgeons/surgical assistance if required because of the complexity of the surgical 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 42). 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 66) • 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.	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 152 for more information about "agents.") Participating/Non-participating: You pay all charges

Surgical Procedures - continued on next page

Benefit Description	You Pay	
Surgical Procedures (cont.)	**Standard Option**	**Basic Option**
• **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. Benefits are available only for the following procedures: - Roux-en-Y - Gastric bypass - Laparoscopic adjustable gastric banding - Sleeve gastrectomy - Biliopancreatic bypass with duodenal switch **Note: Benefits for the surgical treatment of morbid obesity are subject to the requirements listed on pages 64-65.** 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 86-87 for information. Note: **Prior approval is required for 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 above) for a period of 1 year 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 pages 42 and 46 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 use disorder for 1 year prior to surgery and there is no evidence of substance use disorder during the 1-year period prior to surgery	See page 63	See page 63

Surgical Procedures - continued on next page

Benefit Description	You Pay	
Surgical Procedures (cont.)	**Standard Option**	**Basic Option**
• 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, except when the subsequent surgery is necessary to treat a complication from the prior morbid obesity surgery. - 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 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.	See page 63	See page 63
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 sexual inadequacy (except surgical placement of penile prostheses to treat erectile dysfunction and gender reassignment surgeries specifically listed as covered)* • *Reversal of gender reassignment surgery*	*All charges*	*All charges*

Benefit Description	You Pay	
Reconstructive Surgery	**Standard Option**	**Basic Option**
• Surgery to correct a functional defect • Surgery to correct a congenital anomaly (See Section 10, page 152, for definition.) • 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 152 for more information about "agents.") Participating/Non-participating: You pay all charges
• **Gender reassignment surgical benefits** are limited to the following: - For female to male surgery: mastectomy (including nipple reconstruction), hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty, electrolysis (hair removal at the covered operative site), and placement of testicular and erectile prosthesis - For male to female surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, labiaplasty, and electrolysis (hair removal at the covered operative site) **Note: Prior approval is required for gender reassignment surgery.** For more information about prior approval, please refer to page 22.	See above	See above

Reconstructive Surgery - continued on next page

Benefit Description	You Pay	
Reconstructive Surgery (cont.)	**Standard Option**	**Basic Option**
Note: Benefits for gender reassignment surgery are limited to once per covered procedure, per lifetime. Benefits are not available for repeat or revision procedures when benefits were provided for the initial procedure. Benefits are not available for gender reassignment surgery for any condition other than gender dysphoria. • Gender reassignment surgery on an inpatient or outpatient basis is subject to the pre-surgical requirements listed below. **The member must meet all requirements**. - **Prior approval is obtained** - **Member must be at least 18 years of age at the time prior approval is requested and the treatment plan is submitted** - Diagnosis of gender dysphoria by a qualified healthcare professional • New gender identity has been present for at least 24 continuous months • Member has a strong desire to be rid of primary and/or secondary sex characteristics because of a marked incongruence with the member's identified gender • Member's gender dysphoria is not a symptom of another mental disorder or chromosomal abnormality • Gender dysphoria causes clinical distress or impairment in social, occupational, or other important areas of functioning - Member must meet the following criteria: • Living 12 months of continuous, full-time, real-life experience in the desired gender (including place of employment, family, social and community activities) • 12 months of continuous hormone therapy appropriate to the member's gender identity (not required for mastectomy) • Two referral letters from qualified mental health professionals – one must be from a psychotherapist who has treated the member for a minimum of 12 months. Letters must document: diagnosis of persistent and chronic gender dysphoria; any existing co-morbid conditions are stable; member is prepared to undergo surgery and understands all practical aspects of the planned surgery (one referral letter required for mastectomy) • If medical or mental health concerns are present, they are being optimally managed and are reasonably well-controlled	See page 66	See page 66

Reconstructive Surgery - continued on next page

Benefit Description	You Pay	
Reconstructive Surgery (cont.)	**Standard Option**	**Basic Option**
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 sexual dysfunction or sexual inadequacy (except surgical placement of penile prostheses to treat erectile dysfunction and gender reassignment surgeries specifically listed as covered)* • *Reversal of gender reassignment surgery*	*All charges*	*All charges*
Oral and Maxillofacial Surgery	**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: **Prior approval is required for oral/maxillofacial surgery needed to correct accidental injuries as described above, except when care is provided within 72 hours of the accidental injury.** 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 phone 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 152 for more information about “agents.”) Participating/Non-participating: You pay all charges

Oral and Maxillofacial Surgery - continued on next page

Benefit Description	You Pay	
Oral and Maxillofacial Surgery (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Oral implants and transplants except for those required to treat accidental injuries as specifically described on page 68 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 on page 68 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 on page 68 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 on page 68 and in Section 5(g)*	*All charges*	*All charges*

Organ/Tissue Transplants

Prior approval requirements:

You must obtain prior approval (see page 23) from the Local Plan, for both the procedure and the facility, for the transplant procedures listed below. Prior approval is not required for transplants of corneal tissue.

- Blood or marrow stem cell transplant procedures (Note: Pages 73-74 have **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)
- Kidney
- Liver transplant
- Lung (single, double, or lobar) transplant
- Pancreas transplant

Note: Refer to pages 21-22 for information about precertification of inpatient care.

Covered organ/tissue transplants are listed on pages 70-71. 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. Contact your local Plan for Medicare's approved transplant programs.

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 phone number on the back of your ID card.

Blood or marrow stem cell transplants are covered as shown on pages 71-75. 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 71-75, the medical necessity limitation is considered satisfied if the patient meets the staging description.

The blood or marrow stem cell transplants listed on pages 71-73 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 74** must be performed at a FACT-accredited facility. See page 19 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 phone number listed 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 71-72 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 73-74 for information about **blood or marrow stem cell transplants covered only in clinical trials** and the **additional requirements** that apply.

Note: See pages 144-145 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 76 for more information).

Benefit Description	You Pay	
Organ/Tissue Transplants	**Standard Option**	**Basic Option**
• Transplants of corneal tissue • Heart transplant • Heart-lung transplant • Kidney transplant • Liver transplant • Pancreas transplant • Combination liver-kidney transplant • Combination pancreas-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	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 corneal 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.

Organ/Tissue Transplants - continued on next page

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
• 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 pages 69-70 for the prior approval and facility requirements that apply to **organ/tissue transplants**.	See previous page	Continued from previous page: 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 for the diagnoses as indicated below: • 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, Hurler's syndrome and Maroteaux-Lamy syndrome variants) • 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)	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

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
• Primary immunodeficiencies (e.g., severe combined immunodeficiency, Wiskott-Aldrich syndrome, hemophagocytic lymphohistiocytosis, X-linked lymphoproliferative syndrome, Kostmann's syndrome, leukocyte adhesion deficiencies) Note: See pages 69-70 for the prior approval and facility requirements that apply to **blood or marrow stem cell transplants**. Note: Refer to pages 73-75 for information about **blood or marrow stem cell transplants covered only in clinical trials**.	See previous page	See previous page
Autologous blood or marrow stem cell transplants for the diagnoses as indicated below: • 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) • Scleroderma Note: See pages 69-70 for the prior approval and facility requirements that apply to **blood or marrow stem cell transplants.** Note: Refer to pages 73-75 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

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
Blood or marrow stem cell transplants for the diagnoses as indicated below, **only** when performed as part of a clinical trial that meets the facility criteria described on page 69 and the **requirements** listed on page 74: • Allogeneic blood or marrow stem cell transplants for: - Breast cancer - Colon cancer - Epidermolysis bullosa - Glial tumors (e.g., anaplastic astrocytoma, choroid plexus tumors, ependymoma, glioblastoma multiforme) - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Retinoblastoma - Rhabdomyosarcoma - Sarcoma - Wilm's tumor • Autologous blood or marrow stem cell transplants for: - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - 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 74 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

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
Blood or marrow stem cell transplants for the diagnoses as indicated below, **only** when performed at a FACT-accredited facility (see page 19) as part of a **clinical trial** that meets the **requirements** listed below: • Allogeneic blood or marrow stem cell transplants for: - Autoimmune disease (limited to: multiple sclerosis, scleroderma, systemic lupus erythematosus and chronic inflammatory demyelinating polyneuropathy) • Autologous blood or marrow stem cell transplants for: - Autoimmune disease (limited to: multiple sclerosis, systemic lupus erythematosus and 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 phone 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 73, 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.	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

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
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 pages 144-145 for our coverage of other costs associated with clinical trials.	See previous page	See previous page
Related transplant services: • Extraction or reinfusion of blood or marrow stem cells as part of a covered allogeneic or autologous 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 71-74 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 71-74 • Covered medical and hospital expenses of the donor, when we cover the recipient • Covered 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 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 159 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 phone 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)
- Kidney (adult and pediatric)
- Liver (adult and pediatric liver alone; adult only for combination liver-kidney)
- Single or double lung (adult only)
- Blood or marrow stem cell transplants (adult and pediatric) listed on pages 71-74
- Related transplant services listed on page 75

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 companions. If the transplant recipient is age 21 or younger, we pay up to $10,000 for eligible travel costs for the member and companions. Reimbursement is subject to IRS regulations.

Note: You must obtain prior approval for travel benefits (see page 23).

Note: Benefits for cornea, intestinal, pancreas, pediatric lung, and heart-lung transplants are not available through Blue Distinction Centers for Transplants. See pages 70-71 for benefit information for these transplants.

Note: See Section 5(c) for our benefits for facility care.

Note: See pages 70-76 for requirements related to blood or marrow stem cell transplant coverage.

Benefit Description	You Pay	
Organ/Tissue Transplants	**Standard Option**	**Basic Option**
Not covered: • *Any transplant not listed as covered and transplants for any diagnosis not listed as covered* • *Donor screening tests and donor search expenses, including associated travel expenses, except as defined on page 75* • *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 pages 70-71* • *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*

Benefit Description	You Pay	
Anesthesia	**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: Anesthesia acupuncture services do not accumulate toward the member's annual maximum. 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
Not covered: • *Anesthesia related to noncovered surgeries or procedures*	*All charges*	*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 AND SKILLED NURSING FACILITY 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 82. See page 155 for more information about these types of services.
- **YOU MUST GET PRIOR APPROVAL for the following services: facility-based sleep studies; surgery for morbid obesity; surgical correction of congenital anomalies; and surgery needed to correct accidental injuries (see *Definitions*, page 152) to jaws, cheeks, lips, tongue, roof and floor of mouth, except when care is provided within 72 hours of the accidental injury. Please refer to page 22 for more information.**
- **YOU MUST GET PRIOR APPROVAL for gender reassignment surgery. See page 22 for prior approval and pages 66-67 for the surgical benefit.**
- You should be aware that some Non-preferred (non-PPO) professional providers may provide services in Preferred (PPO) facilities.
- We base payment on whether a facility or a healthcare 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 or facility bills for the service.
- 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.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 114 for information about Tier 4 and Tier 5 specialty drug fills from Preferred providers and Preferred pharmacies. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731. Basic Option members must use Preferred providers and Preferred pharmacies (see page 104).
- **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 20 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 pages 155-157 for more information. See pages 87-88 and 100-101 for inpatient residential treatment center. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • 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	Preferred facilities: $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 facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: $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 $350 per admission copayment for unlimited days and we then provide benefits at 100% of the Plan allowance.	Preferred facilities: $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 facilities: You pay all charges

Inpatient Hospital - continued on next page

Benefit Description	You Pay	
Inpatient Hospital (cont.)	**Standard Option**	**Basic Option**
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 82. See page 155 for more information about these types of services. Note: Here are some things to keep in mind: • You do not need to precertify your delivery; see page 26 for other circumstances, such as extended stays for you or your newborn. • 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 page 26 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 47-48 for other covered maternity services. Note: See page 59 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 pages 86-87 for information.	See previous page	See previous page
Not covered: • *Admission to noncovered facilities, such as nursing homes, extended care facilities, schools, or residential treatment centers (except as described on pages 87-88 and 100-101)* • *Personal comfort items, such as guest meals and beds, phone, television, beauty and barber services* • *Private duty nursing* • *Facility room and board expenses when, in our judgment, an 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*	*All charges*	*All charges*

Inpatient Hospital - continued on next page

Benefit Description	You Pay	
Inpatient Hospital (cont.)	**Standard Option**	**Basic Option**
• *Care that is 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.* - *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 an inpatient 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 18-19).*	*All charges*	*All charges*
Outpatient Hospital or Ambulatory Surgical Center	**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 • Acupuncture • 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 42). 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	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 facilities: $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 152 for more information about "agents.") Member/Non-member facilities: You pay all charges

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**Standard Option**	**Basic Option**
• 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 Notes: • See pages 95-97 for our payment levels for care related to a medical emergency or accidental injury. • See page 49 for our coverage of family planning services. • For our coverage of hospital-based clinic visits, please refer to the professional benefits described on pages 39-40 and page 55 for vision services. • 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 86-87 for information. • 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 47-49 for other included maternity services. • See page 85 for outpatient drugs, medical devices, and durable medical equipment billed for by a facility. • 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.	See previous page	See previous page
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.	Preferred facilities: $350 copayment for the duration of services (no deductible) Member facilities: $450 copayment for the duration of services, plus 35% of the Plan allowance (no deductible)	Preferred facilities: $175 per day copayment up to $875 Member/Non-member facilities: You pay all charges

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**Standard Option**	**Basic Option**
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.	Continued from previous page: Non-member facilities: $450 copayment for the duration of services, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	See previous page
Outpatient **diagnostic testing and treatment services** performed and billed by a facility, limited to: • Angiographies • Bone density tests • CT scans/MRIs/PET scans • Nuclear medicine • Facility-based sleep studies (prior approval is required) • 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.	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 facilities: $150 copayment per day per facility Member facilities: $150 copayment per day per facility Non-member facilities: $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 152 for more information about “agents.”)
Outpatient **diagnostic testing services** performed and billed by a facility, such as: • Cardiovascular monitoring • EEGs • Home-based/unattended sleep studies • 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 facilities: $40 copayment per day per facility Member facilities: $40 copayment per day per facility Non-member facilities: $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 152 for more information about “agents.”)

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**Standard Option**	**Basic Option**
Outpatient **treatment and therapy services** performed and billed by a facility, limited to: • Cognitive rehabilitation therapy • Physical, occupational, and speech therapy - Standard Option benefits are limited to a combined total of 75 visits per person per calendar year - Basic Option benefits are limited to a combined total of 50 visits per person per calendar year • Manipulative treatment services - Standard Option benefits are limited to a combined total of 12 visits per person per calendar year - Basic Option benefits are limited to a combined total of 20 visits per person per calendar year	Preferred facilities: $25 copayment per day per facility (no deductible) 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 facilities: $30 copayment per day per facility Member/Non-member facilities: You pay all charges Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 152 for more information about “agents.”)
Outpatient **treatment services** performed and billed by a facility, limited to: • Cardiac rehabilitation • Pulmonary rehabilitation • Applied behavior analysis (ABA) for an autism spectrum disorder (see prior approval requirements on page 22)	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 facilities: $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 152 for more information about “agents.”) Member/Non-member facilities: You pay all charges

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**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 facilities: Nothing Member facilities: Nothing Non-member facilities: 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 152 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 42-45 • Cancer screenings listed on pages 42-43 and ultrasound screening for abdominal aortic aneurysm Note: See page 44 for our coverage requirements for preventive BRCA testing. Note: See pages 45-46 for our payment levels for covered preventive care services for children billed for by facilities and performed on an outpatient basis.	See page 42 for our payment levels for covered preventive care services for adults	Preferred facilities: Nothing Member/Non-member facilities: 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 • Surgical implants 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. Note: Certain self-injectable drugs are covered only when dispensed by a pharmacy under the pharmacy benefit. These drugs will be covered once per lifetime per therapeutic category of drugs when dispensed by a non-pharmacy-benefit provider. This benefit limitation does not apply if you have primary Medicare Part B coverage.	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 facilities: 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 81-84 for specific coverage information. Member/Non-member facilities: You pay all charges

Benefit Description	You Pay	
Blue Distinction® Specialty Care	**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 Knee and Hip Replacement, Blue Distinction Center for Spine Surgery, or Blue Distinction Center for Comprehensive Bariatric Surgery. • Bariatric surgeries covered are: - Roux-en-Y - Gastric bypass - Laparoscopic adjustable gastric banding - Sleeve gastrectomy - Biliopancreatic bypass with duodenal switch • 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 phone 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 78-80 for regular inpatient hospital benefits and pages 81-85 for outpatient facility benefit levels. Note: See pages 18-19 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 specific covered bariatric surgical procedures, when the surgery is performed at a designated Blue Distinction Center for Bariatric Surgery. Outpatient facility services related to specific covered hip and knee replacement or revision surgeries and certain spine surgery procedures, when performed at a designated Blue Distinction Center for hip/knee/spine surgery.	Blue Distinction Center: $100 per day per facility (no deductible)	Blue Distinction Center: $25 per day per facility

Blue Distinction® Specialty Care - continued on next page

Benefit Description	You Pay	
Blue Distinction® Specialty Care (cont.)	**Standard Option**	**Basic Option**
Note: You must meet the pre-surgical requirements listed on pages 64-65 for bariatric surgeries. Note: 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 phone 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 benefits do not apply to other types of outpatient surgical services, even when performed at a Blue Distinction Center. See pages 81-82 for the benefits we provide. Note: See pages 18-19 for more information about Blue Distinction Centers.	Blue Distinction Center: $100 per day per facility (no deductible)	Blue Distinction Center: $25 per day per facility
Residential Treatment Center	**Standard Option**	**Basic Option**
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 use disorder: • 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.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: 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 facilities: $175 per day copayment up to $875 per admission for unlimited days Member/Non-member facilities: You pay all charges

Residential Treatment Center - continued on next page

Benefit Description	You Pay	
Residential Treatment Center (cont.)	**Standard Option**	**Basic Option**
Note: Benefits are not available for noncovered services, including: respite care; outdoor residential programs; services provided outside of the provider's scope of licensure; recreational therapy; educational therapy; educational classes; biofeedback; Outward Bound programs; equine/hippotherapy provided during the approved stay; personal comfort items, such as guest meals and beds, phone, 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. Note: For outpatient residential treatment center services, see page 101.	See previous page	See previous page
Extended Care Benefits/Skilled Nursing Care Facility Benefits	**Standard Option**	**Basic Option**
When Medicare Part A is not your primary payor: For members who do not have Medicare Part A, we cover skilled nursing facility (SNF) inpatient care for a maximum of 30 days annually, when the member can be expected to benefit from short-term SNF services with a goal of returning home. The following criteria must also be met: • Member is enrolled in case management prior to admission to the SNF (signed consent required), and actively participates in case management both prior to and during admission to the SNF. • Precertification is obtained prior to admission (including overseas care). • We approve the preliminary treatment plan prior to admission (plan must include proposed therapies and document the need for inpatient care). • Member participates in all treatment and care planning activities, including discharge planning/transition to home. Benefits are not available for inpatient SNF care solely for management of tube feedings, for home level dialysis treatment, as an interim transition to long term care placement, or for any other noncovered services. Note: No inpatient benefits (such as room and board) will be provided if precertification is not obtained prior to admission (see page 21). Members are responsible for enrolling in case management (see page 21).	Preferred facilities: $175 (no deductible) per admission Member facilities: $275 plus 35% of the Plan allowance (no deductible) per admission Non-member facilities: $275 plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment, per admission	All charges

Extended Care Benefits/Skilled Nursing Care Facility Benefits - continued on next page

Benefit Description	You Pay	
Extended Care Benefits/Skilled Nursing Care Facility Benefits (cont.)	**Standard Option**	**Basic Option**
When Medicare Part A is your primary payor: When Medicare Part A is the primary payor (meaning it pays first) and has made a 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. Note: See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c03.pdf for complete Medicare benefit period definition. 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 84 for benefits provided for outpatient physical, occupational, speech, and cognitive rehabilitation therapy, and manipulative treatment services when billed by a skilled nursing facility. See Section 5(f) for benefits for prescription drugs. ***Note: If Medicare Part A is your primary payor, we will only provide benefits if Medicare provided benefits for the admission.***	Preferred facilities: Nothing (no deductible) Member facilities: Nothing (no deductible) Non-member facilities: Nothing (no deductible) Note: You pay all charges not paid by Medicare after the 30th day.	All charges
Not covered: *Phone, television, personal comfort items, such as guest meals and beds, beauty and barber services, recreational outings/trips, stretcher or wheelchair transportation, non-emergent 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, custodial or long term care (see* Definitions*), and domiciliary care provided because care in the home is not available or is unsuitable*	*All charges*	*All charges*
Hospice Care	**Standard Option**	**Basic Option**
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 pages 90-92.	See pages 90-92.

Hospice Care - continued on next page

Benefit Description	You Pay	
Hospice Care (cont.)	**Standard Option**	**Basic Option**
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 **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 page 22 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 on this page and on pages 91-92. **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.**	Nothing (no deductible)	Nothing
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: • Advanced care planning (see Section 10, page 152) • Dietary counseling • Durable medical equipment rental • Medical social services • Medical supplies • Nursing care	See next page	See next page

Hospice Care - continued on next page

Benefit Description	You Pay	
Hospice Care (cont.)	**Standard Option**	**Basic Option**
• Oxygen therapy • Periodic physician visits • Physical therapy, occupational therapy, and speech therapy related to the terminal medical condition • Prescription drugs and medications • Services of home health aides (certified or licensed, if the state requires it, and provided by the home hospice agency)	See below	See below
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. An episode of care is one home hospice treatment plan per calendar year. See page 90 for prior approval requirements.	Preferred facilities: Nothing (no deductible) Member/Non-member facilities: $450 copayment per episode (no deductible)	Preferred facilities: Nothing Member/Non-member facilities: You pay all charges
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. The member must be enrolled in a home hospice program in order to receive benefits for subsequent continuous home hospice care, and the services must be provided by the home hospice program in which the member is enrolled.	Preferred facilities: Nothing (no deductible) Member facilities: $450 per episode copayment (no deductible) Non-member facilities: $450 per episode copayment, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred facilities: Nothing Member/Non-member facilities: 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 30 consecutive days in a facility licensed as an inpatient hospice facility. 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 facilities: Nothing (no deductible) Member facilities: $450 per admission copayment, plus 35% of the Plan allowance (no deductible) Non-member facilities: $450 per admission copayment, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred facilities: Nothing Member/Non-member facilities: You pay all charges

Hospice Care - continued on next page

Benefit Description	You Pay	
Hospice Care (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Advanced care planning, except when provided as part of a covered hospice care treatment plan (see page 90)* • *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	**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. Note: Prior approval is required for all non-emergent air ambulance transport.	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 the Overseas Assistance Center (provided by GMMI) by calling 804-673-1678. See page 130 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 $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*	*All charges*	*All charges*

Ambulance - continued on next page

Benefit Description	You Pay	
Ambulance (cont.)	**Standard Option**	**Basic Option**
• *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 Non-preferred (non-PPO) professional providers may provide services in Preferred (PPO) facilities.
- 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. For more information, see page 32, NSA.
- 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 member, the health of the member and their 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, 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: Nothing (no deductible)	Preferred: Nothing Participating: Nothing Non-participating: Nothing
• **Professional provider services** in the providers office, including, 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)	Regular benefit levels apply to covered services provided in this setting. See Sections 5(a) and 5(b).
• 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: Nothing (no deductible)	Preferred emergency room: $175 copayment per day per facility Member emergency room: $175 copayment per day per facility Non-member emergency room: $175 copayment per day per facility Note: If you are admitted directly to the hospital from the emergency room, you do not have to pay the $175 emergency room copayment. However, the $175 per day copayment for Preferred inpatient care still applies.
• Urgent care centers, licensed as and permitted to provide emergency services and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider Note: The urgent care center must be licensed as and permitted to provide emergency services in order to receive protections under the NSA. See page 32 for more information.	Preferred urgent care center: Nothing (no deductible) Participating urgent care center: Nothing (no deductible) Non-participating urgent care center: Nothing (no deductible)	Preferred urgent care center: $35 copayment per visit Participating/Non-participating urgent care center: $35 copayment per visit
• Urgent care centers, not licensed as or permitted to provide emergency services and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider	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

Benefit Description	You Pay	
Accidental Injury (cont.)	**Standard Option**	**Basic Option**
Note: If you are treated by a non-PPO professional provider in a PPO facility, you will only be responsible for your cost-share and will not owe any difference between our allowance and the billed amount. (See page 32.) 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 on page 95 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	**Standard Option**	**Basic Option**
• **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)	Preferred: Nothing Participating: Nothing Non-participating: Nothing
• 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).	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)	Preferred emergency room: $175 copayment per day per facility Member emergency room: $175 copayment per day per facility Non-member emergency room: $175 copayment per day per facility Note: If you are admitted directly to the hospital from the emergency room, you do not have to pay the $175 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

Benefit Description	You Pay	
Medical Emergency (cont.)	**Standard Option**	**Basic Option**
• Urgent care centers, licensed as and permitted to provide emergency services and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider Note: The urgent care center must be licensed as and permitted to provide emergency services in order to receive protections under the NSA. See page 32 for more information. Note: Benefits for crutches, splints, braces, etc. when billed by a provider other than the urgent care center are stated in Section 5(a), pages 57-58.	Preferred urgent care center: $30 copayment per visit (no deductible) Participating urgent care center: $30 copayment per visit (no deductible) Non-participating urgent care center: $30 copayment per visit (no deductible)	Preferred urgent care center: $35 copayment per visit Participating/Non-participating urgent care center: $35 copayment per visit
• Urgent care centers, not licensed as or permitted to provide emergency services and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider Note: Benefits for crutches, splints, braces, etc. when billed by a provider other than the urgent care center are stated in Section 5(a), pages 57-58.	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
Not covered: Emergency room professional charges for shift differentials	*All charges*	*All charges*
Ambulance	**Standard Option**	**Basic Option**
See pages 92-93 for complete ambulance benefit and coverage information.	See pages 92-93	See pages 92-93

Section 5(e). Mental Health and Substance Use Disorder 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 an acute 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 page 128. Contact us at the phone number listed on the back of your Service Benefit Plan ID card if you have any questions or would like to discuss your healthcare 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.
- Every year, we conduct an analysis of the financial requirements and treatment limitations which apply to this Plan's mental health and substance use disorder benefits in compliance with the federal Mental Health Parity and Addiction Equity Act (the Act), and the Act's implementing regulations. Based on the results of this analysis, we may suggest changes to program benefits to OPM. More information on the Act is available on the following Federal Government websites:
  https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html
  https://www.dol.gov/ebsa/
  www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL OR RESIDENTIAL TREATMENT CENTER STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY**. 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 use disorder 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 20 for the exceptions to this requirement.**
  - There is **no calendar year deductible.**
- You should be aware that some Non-preferred (non-PPO) professional providers may provide services in Preferred (PPO) facilities.

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 use disorder 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 use disorder practitioners when acting within the scope of their license • Individual psychotherapy • Group psychotherapy • Pharmacologic (medication) management • Psychological testing • Office visits • Clinic visits • Home visits • Phone consultations and online medical evaluation and management services (telemedicine) 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 use disorder phone number on the back of your ID card. Note: See pages 61 and 117 for our coverage of smoking and tobacco cessation treatment. Note: See page 47 for our coverage of mental health visits to treat postpartum depression and depression during pregnancy. Note: We cover outpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers at the levels shown here.	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
Telehealth professional services for: • Behavioral health counseling • Substance use disorder counseling Note: Refer to Section 5(h), *Wellness and Other Special Features*, for information on telehealth services and how to access our telehealth provider network. Note: Benefits are combined with telehealth services listed in Section 5(a), page 39. Note: Copayments are waived for members with Medicare Part B primary.	Preferred Telehealth provider: Nothing (no deductible) for the first 2 visits per calendar year for any covered telehealth service $10 copayment per visit (no deductible) after the 2nd visit Participating/Non-participating: You pay all charges	Preferred Telehealth provider: Nothing for the first 2 visits per calendar year for any covered telehealth service $15 copayment per visit after the 2nd visit Participating/Non-participating: You pay all charges

Professional Services - continued on next page

Benefit Description	You Pay	
Professional Services (cont.)	**Standard Option**	**Basic Option**
• 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	**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 use disorder includes room and board and ancillary charges for confinements in a hospital/treatment facility for rehabilitative treatment of alcoholism or substance use disorder. Note: You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: 35% of the Plan allowance for unlimited days (no deductible), and any remaining balance after our payment	Preferred facilities: $175 per day copayment up to $875 per admission for unlimited days Member/Non-member facilities: You pay all charges
Residential Treatment Center	**Standard Option**	**Basic Option**
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.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible)	Preferred facilities: $175 per day copayment up to $875 per admission for unlimited days Member/Non-member facilities: You pay all charges

Residential Treatment Center - continued on next page

Benefit Description	You Pay	
Residential Treatment Center (cont.)	**Standard Option**	**Basic Option**
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 use disorder: • 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 licensed as a skilled nursing facility, group home, halfway house, or similar type facility. Note: Benefits are not available for noncovered services, including: respite care; outdoor residential programs; services provided outside of the provider's scope of practice; recreational therapy; educational therapy; educational classes; biofeedback; Outward Bound programs; hippotherapy/equine therapy provided during the approved stay; personal comfort items, such as guest meals and beds, phone, television, beauty and barber services; custodial or long term care (see *Definitions*, page 153); and domiciliary care provided because care in the home is not available or is unsuitable. Note: For outpatient residential treatment center services, see the next Section.	Non-member facilities: 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.	See previous page
Outpatient Hospital or Other Covered Facility	**Standard Option**	**Basic Option**
Outpatient services provided and billed by a covered facility Note: We cover outpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers at the levels shown here. • 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 Hospital or Other Covered Facility - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Other Covered Facility (cont.)	**Standard Option**	**Basic Option**
Outpatient services provided and billed by a covered facility • Diagnostic tests • Psychological testing Note: A residential treatment center is a covered facility for outpatient care (see Section 10, Definitions, for more information). We cover inpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers, other than room and board and inpatient physician care, at the levels shown here.	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)	**Standard Option**	**Basic Option**
• *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* • *Inpatient services performed or billed by residential treatment centers, except as described on pages 87-88 and 100-101* • *Services performed or billed by schools, halfway houses, group homes or members of their staffs* *Note: We cover professional services as described on pages 99-100 when they are provided and billed by a covered professional provider acting within the scope of their 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.)* • *Hippotherapy/equine therapy (exercise on horseback)* • *Light boxes* • *Custodial or long term care (see* Definitions*)* • *Costs associated with enabling or maintaining providers' telehealth (telemedicine) technologies, non-interactive telecommunication such as email communications, or asynchronous store-and-forward telehealth services*	*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 108.
- If there is no generic drug available, you must pay the brand-name cost-sharing amount when you receive a brand-name drug.
- If there is a generic substitution available and you or your provider requests a brand-name drug, you will be responsible for the applicable tier cost-share plus the difference in the cost of the brand-name and generic drug. If the provider's prescription is for the brand-name drug and indicates "dispense as written," you are responsible only for the applicable tier cost-share.
- 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.
- Benefits for certain self-injectable (self-administered) drugs are provided only when they are dispensed by a pharmacy under the pharmacy benefit. See pages 114-115 for Tier 4 and Tier 5 specialty drug fills from a Preferred pharmacy.
- Benefits for certain auto-immune infusion medications (limited to Remicade, Renflexis and Inflectra) are covered only when they are obtained by a non-pharmacy provider, such as a physician or facility (hospital or ambulatory surgical center). See *Drugs From Other Sources* in this section, pages 119-120, for more 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.
- Medication prices vary among different retail pharmacies, the Mail Service Prescription Drug Program, and the Specialty Drug Pharmacy Program. **Review purchasing options for your prescriptions to get the best price.** A drug cost tool is available at www.fepblue.org or call:
  - **Retail Pharmacy Program: 800-624-5060, TTY: 800-624-5077**
  - **Mail Service Prescription Drug Program: 800-262-7890, TTY: 800-216-5343**
  - **Specialty Drug Pharmacy Program: 888-346-3731, TTY: 877-853-9549**
- **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 pages 106-107 for more information about the PSQM program and to Section 3 for more information about prior approval. Our prior approval process may include step therapy, which requires you to use a generic and/or preferred medication(s) before a non-preferred medication is covered.
- 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 or biosimilar becomes available or if new safety concerns arise. If your drug is moved to a higher tier, your cost-share will increase. See pages 114-116 for the amounts members pay for Preferred retail, mail service, and specialty drug purchases. If your drug is moved to noncovered, you pay the full cost of the medication. Tier reassignments during the year are not considered benefit changes.
- A pharmacy restriction may be applied for clinically inappropriate use of prescription drugs and supplies.
- The Standard Option and Basic Option formularies both contain a comprehensive list of drugs under all therapeutic categories with two exceptions: some drugs, nutritional supplements and supplies are not covered (see pages 118-119); we may also exclude certain U.S. FDA-approved drugs when multiple generic equivalents/alternative medications are available. See pages 104 and 105 for details.

- **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.
  - There is no calendar year deductible for 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 retail pharmacies or the Specialty Drug Pharmacy Program in order to receive benefits.** Our specialty drug pharmacy is a Preferred pharmacy.
  - The Mail Service Prescription Drug Program is available only to members with primary Medicare Part B coverage.
  - There is **no calendar year deductible.**
  - We use a managed formulary for certain drug classes.

We will send each new enrollee a Plan identification card, which covers pharmacy and medical benefits. 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 pre-addressed reply envelope.

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

- **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/certified provider with prescriptive authority prescribing within their scope of practice 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 159 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 159 for the definition of “specialty drugs.”

Under Standard Option and Basic Option

Note: The Mail Service Prescription Drug Program will not fill your prescription for a drug requiring prior approval 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 unable to be filled and a letter will be mailed to you explaining the prior approval procedures.

Note: The Specialty Drug Pharmacy Program will not fill your prescription for a drug requiring prior approval 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 unable to be filled and a letter will be mailed to you explaining the prior approval procedures.

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 pages 115-116.

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 pages 114-115 for information about your cost-share for specialty drugs purchased at a Preferred retail pharmacy that are affected by these restrictions.

- **What is covered.**

  Under Basic Option, we use a managed formulary for certain drug classes. 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.

  Under Standard Option and Basic Option

  Note: Both formularies include lists of preferred drugs that are safe, effective and appropriate for our members, and are available at lower costs than non-preferred drugs. If your physician prescribed a more expensive non-preferred drug for you, we may ask that he or she prescribe a preferred drug instead; we encourage you to do the same. If you purchase a drug that is not on our preferred drug list, your cost will be higher. Your cooperation with our cost-savings efforts helps keep your premium affordable.

  Note: Some drugs, nutritional supplements, and supplies are not covered (see pages 118-119); we may also exclude certain U.S. FDA-approved drugs when multiple generic equivalents/alternative medications are available. If you purchase a drug, nutritional supplement, or supply that is not covered, you will be responsible for the full cost of the item.

  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. Changes to the preferred drug list are not considered benefit changes.

  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. 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 call 800-624-5060, TTY: 800-624-5077, for assistance. Changes to the formulary are not considered benefit changes. 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 requests a brand-name drug and indicates "dispense as written." Keep in mind that **Basic Option members must use Preferred providers in order to receive benefits.** See Section 10, *Definitions*, page 154, 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. 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 unless otherwise noted. 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.

  Under Standard Option and Basic Option

  Benefits for Tier 4 and Tier 5 specialty drugs purchased at a 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. 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 of the specialty drug. See page 116 for more information.

  Note: Certain drugs such as narcotics may have additional limits or requirements as established by the U.S. FDA or by national scientific or medical practice guidelines (such as Centers for Disease Control and Prevention, American Medical Association, etc.) 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 22, 30, and 90-day supplies of those medications. **In most cases, refills cannot be obtained until 75% of the prescription has been used. Controlled substances cannot be refilled until 80% of the prescription has been used.** Controlled substances are medications that can cause physical and mental dependence, and have restrictions on how they can be filled and refilled. They are regulated and classified by the DEA (Drug Enforcement Administration) based on how likely they are to cause dependence. 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.

  Note: Benefits for certain self-injectable (self-administered) drugs are provided only when they are dispensed by a pharmacy under the pharmacy benefit. Medical benefits will be provided for a once-per-lifetime dose per therapeutic category of drugs dispensed by your provider or any non-pharmacy-benefit provider. This benefit limitation does not apply if you have primary Medicare Part B coverage. See pages 114-115 for Tier 4 and Tier 5 specialty drug fills from a Preferred pharmacy.

  Note: Benefits for certain auto-immune infusion medications (Remicade, Renflexis and Inflectra) are provided only when obtained by a non-pharmacy provider, such as a physician or facility (hospital or ambulatory surgical center). See *Drugs From Other Sources* in this Section, page 120, for more information.

- **Important contact information**

  Retail Pharmacy Program: 800-624-5060, TTY: 800-624-5077;
  Mail Service Prescription Drug Program: 800-262-7890, TTY: 800-216-5343;
  Specialty Drug Pharmacy Program: 888-346-3731, TTY: 877-853-9549; or www.fepblue.org.

Patient Safety and Quality Monitoring (PSQM)

We have a special program to promote patient safety and monitor healthcare 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 on page 107, 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 U.S. FDA-approved recommendations, national scientific and generally accepted standards of medical practice guidelines (such as Centers for Disease Control and Prevention, American Medical Association, etc.), 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 800-624-5060, TTY: 800-624-5077.

Prior Approval

As part of our Patient Safety and Quality Monitoring (PSQM) program (see page 106), **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 generally accepted standards of medical, dental, or psychiatric practice in the United States. Our prior approval process may include step therapy, which requires you to use a generic and/or preferred medication(s) before a non-preferred medication is covered. **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 800-624-5060, TTY: 800-624-5077. You can also obtain the list and forms 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.

Note: It is your responsibility to know the prior approval authorization expiration date for your medication. We encourage you to work with your physician to obtain prior approval renewal in advance of the expiration date.

Standard Option Generic Incentive Program

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

- If you switch from one generic drug to another, you will be responsible for your copayment.

Note: The list of eligible generic drug replacements may change and is not considered a benefit change. For the most up-to-date information, please visit www.fepblue.org/en/benefit-plans/coverage/pharmacy/generic-incentive-program or call:

Retail Pharmacy Program: 800-624-5060, TTY: 800-624-5077
Mail Service Prescription Drug Program: 800-262-7890, TTY: 800-216-5343
Specialty Drug Pharmacy Program: 888-346-3731, TTY: 877-853-9549

Benefits 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	**Standard Option**	**Basic Option**
Asthma Medications **Preferred Retail Pharmacies:** Note: See page 24 for information about drugs and supplies that require prior approval.	Tier 1 (generic drug): $5 copayment (no deductible) Tier 2 (preferred brand-name drug): 20% of the Plan allowance (no deductible)	Tier 1 (generic drug): $5 copayment for each purchase of up to a 90-day supply Tier 2 (preferred brand-name drug): $35 copayment for each purchase of up to a 30-day supply ($105 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment Tier 2 (preferred brand-name drug): $30 copayment for each purchase of up to a 30-day supply ($90 copayment for a 31 to 90-day supply)
Mail Service Prescription Drug Program: 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 107. Note: See pages 114-116 for Tier 3, 4 and 5 prescription drug benefits.	Tier 1 (generic drug): $5 copayment (no deductible) Tier 2 (preferred brand-name drug): $65 copayment (no deductible)	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment Tier 2 (preferred brand-name drug): $75 copayment
Anti-hypertensive Medications **Preferred Retail Pharmacies:** Note: See page 24 for information about drugs and supplies that require prior approval.	Tier 1 (generic drug): $3 copayment (no deductible)	Tier 1 (generic drug): $5 copayment for each purchase of up to a 90-day supply
Mail Service Prescription Drug Program: 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 107. Note: See pages 114-116 for Tier 2, 3, 4, and 5 prescription drug benefits.	Tier 1 (generic drug): $3 copayment (no deductible)	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**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 pages 112-113 for our coverage of medications to promote better health as recommended under the Affordable Care Act. • Medical foods, as defined by the U.S. Food and Drug Administration, that are consumed or administered enterally and are intended for the specific dietary management of a disease or condition for which there are distinctive nutritional requirements. The Plan covers medical food formulas and enteral nutrition products that are ordered by a healthcare provider, and are medically necessary to prevent clinical deterioration in members at nutritional risk. (See Coverage below) - Must meet the definition of medical food (see definition on page 155) - Must be receiving active, regular, and ongoing medical supervision and must be unable to manage the condition by modification of diet alone Coverage is provided as follows: - Inborn errors of amino acid metabolism up to age 22 - Food allergy with atopic dermatitis, gastrointestinal symptoms, IgE mediation, malabsorption disorder, seizure disorder, failure to thrive, or prematurity, when administered orally and is the sole source (100%) of nutrition. This once per lifetime benefit is limited to one year following the date of the initial prescription or physician order for the medical food (e.g., Neocate, in a formula form or powders mixed to become formulas) - Medical foods and nutritional supplements when administered by catheter or nasogastric tubes Note: A prescription and prior approval are required for medical foods provided under the pharmacy benefit. Renewals of the prior authorization are required every benefit year for inborn errors of metabolism and tube feeding. Note: See Section 5(a), page 58, for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube under the medical benefit.	See page 108 and pages 110-116	See page 108 and pages 110-116

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
• Insulin, diabetic test strips, lancets, and tubeless insulin delivery systems Note: See page 58 for our coverage of insulin pumps with tubes. • Needles and disposable syringes for the administration of covered medications • Clotting factors and anti-inhibitor complexes for the treatment of hemophilia	See page 108 and pages 110-116	See page 108 and pages 110-116
• 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 117. Note: You may be eligible to receive smoking and tobacco cessation medications at no charge. See page 117 for more information. • Drugs for the diagnosis and treatment of infertility, except as described on pages 118-119 • Drugs to treat gender dysphoria (gonadotropin-releasing hormone (GnRH) antagonists and testosterones) • 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 115 and 116 for details.	See below and pages 111-117	See below and pages 111-117
• Over-the-counter (OTC) contraceptive drugs and devices, for women only, limited to: - Emergency contraceptive pills - Female condoms - Spermicides - Sponges	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

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Note: We provide benefits in full for OTC contraceptive drugs and devices for women only when the contraceptives meet U.S. FDA standards for OTC products. To receive benefits, you must use a retail pharmacy and present the pharmacist with a written prescription from your physician.	See previous page	See previous page
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. See pages 43 and 45 for specific coverage. Note: Our vaccine network is a network of Preferred retail pharmacies that have agreements with us to administer one or more routine immunizations. Check with your pharmacy or call our Retail Pharmacy Program at 800-624-5060, TTY: 800-624-5077, to find out 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 every 365 days at no cost through our Diabetic Meter Program. To use this program, you must call the phone 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 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. See page 112 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
Metformin and metformin extended release (excluding osmotic and modified release generic drugs) **Preferred Retail Pharmacies:** **Mail Service Prescription Drug Program:**	Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply (no deductible) Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply (no deductible)	Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Other Preferred Diabetic Medications, Test Strips, and Supplies **Preferred Retail Pharmacies:** **Mail Service Prescription Drug Program:** **Note: See pages 115-116 for Tier 2, 3, 4, and 5 prescription drug benefits.** Benefits will be provided for syringes, pens and pen needles and test strips at Tier 2 (diabetic medications and supplies) for Standard Option members, and Basic Option members with primary Medicare Part B, through the Mail Service Prescription Drug Program. See pages 115-116 for more information.	Tier 2 (preferred diabetic medications and supplies): 20% of the Plan allowance for each purchase of up to a 90-day supply (no deductible) Non-preferred retail pharmacies: You pay all charges Tier 2 (preferred brand-name drug): $40 copayment for each purchase of up to a 90-day supply (no deductible)	Tier 2 (preferred diabetic medications and supplies): $35 copayment for each purchase of up to a 30-day supply ($65 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 2 (preferred brand-name drugs): $30 copayment for each purchase of up to a 30-day supply ($60 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 2 (preferred brand-name drugs) $50 copayment for each purchase of up to a 90-day supply
Medications 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 • Low-dose aspirin (81 mg per day) for pregnant members at risk for preeclampsia • Aspirin for men age 45 through 79 and women age 50 through 79 • Generic cholesterol-lowering statin drugs Note: Benefits are not available for acetaminophen, ibuprofen, naproxen, etc.	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

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Note: Benefits for the medications listed on the previous page are subject to the dispensing limitations described on page 106 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/preventive-care-benefits. See pages 42-46 in Section 5(a) for information about other covered preventive care services. Note: See page 117 for our coverage of smoking and tobacco cessation medications.	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 medications 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 800-624-5060, TTY: 800-624-5077, to request this form. You can also obtain the Coverage Request Form through our website at www.fepblue.org.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges Mail Service Prescription Drug Program: Nothing (no deductible)	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
We cover the first prescription filled for certain **bowel preparation** medications for colorectal cancer screenings with no member cost-share. We also cover certain **antiretroviral therapy** medications for HIV for those at risk but who do not have HIV. You can view the list of covered medications on our website at www.fepblue.org or call 800-624-5060, TTY: 800-624-5077, for assistance.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges Mail Service Prescription Drug Program: Nothing (no deductible)	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
Opioid Reversal Agents: Tier 1 medications limited to Narcan nasal spray and naloxone generic injectable		
Preferred Retail Pharmacies	Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year (no deductible) Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost-share.	Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost-share.
Non-preferred Retail Pharmacies	You pay all charges	You pay all charges

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Opioid Reversal Agents (cont.) **Mail Service Prescription Drug Program**	Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year (no deductible) Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost-share.	**When Medicare Part B is primary, you pay the following:** Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost-share.
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 retail pharmacy to request your prescriptions online and delivery, if available. • For a listing of Preferred retail pharmacies, call the Retail Pharmacy Program at 800-624-5060, TTY: 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 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 116 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 Preferred 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 115.**	Tier 1 (generic drug): $7.50 copayment for each purchase of up to a 30-day supply ($22.50 copayment for a 31 to 90-day supply) (no deductible) Note: You pay a $5 copayment for each purchase of up to a 30-day supply ($15 copayment for a 31 to 90-day supply) 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 107 for information. Tier 2 (preferred brand-name drug): 30% of the Plan allowance for each purchase of up to a 90-day supply (no deductible) Tier 3 (non-preferred brand-name drug): 50% of the Plan allowance for each purchase of up to a 90-day supply (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 a 31 to 90-day supply) Tier 2 (preferred brand-name drug): $55 copayment for each purchase of up to a 30-day supply ($165 copayment for a 90-day supply) Tier 3 (non-preferred brand-name drug): 60% of the Plan allowance ($75 minimum) for each purchase of up to a 30-day supply ($210 minimum for a 31 to 90-day supply) Tier 4 (preferred specialty drug): $85 copayment limited to one purchase of up to a 30-day supply Tier 5 (non-preferred specialty drug): $110 copayment limited to one purchase of up to a 30-day supply **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): see above Tier 2 (preferred brand-name drug): $50 copayment for each purchase of up to a 30-day supply ($150 copayment for a 31 to 90-day supply) Tier 3 (non-preferred brand-name drug): 50% of the Plan allowance ($60 minimum) for each purchase of up to a 30-day supply ($175 minimum for a 31 to 90-day supply)

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Note: For a list of the Preferred Network Long Term Care pharmacies, call 800-624-5060, TTY: 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 800-624-5060, TTY: 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.	See previous page	Continued from previous page: Tier 4 (preferred specialty drug): $80 copayment limited to one purchase of up to a 30-day supply Tier 5 (non-preferred specialty drug): $100 copayment limited to one purchase of up to a 30-day supply
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 For Standard Option and Basic Option members when Medicare Part B is Primary, 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: 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 107. 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 116 for information about the Specialty Drug Pharmacy Program.	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 107 for information. Tier 2 (preferred brand-name drug): $90 copayment (no deductible) Tier 3 (non-preferred brand-name drug): $125 copayment (no deductible)	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $20 copayment Tier 2 (preferred brand-name drug): $100 copayment Tier 3 (non-preferred brand-name drug): $125 copayment **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 108 of this Section for our payment levels for drugs obtained through Preferred retail pharmacies.

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
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 800-262-7890, TTY: 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.	See previous page	See previous page
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 phone number below or visit our website, www.fepblue.org. (See page 159 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 are most convenient for you, as well as ask you about any side effects you may be experiencing. See page 138 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 31 to 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 888-346-3731, TTY: 877-853-9549.	Tier 4 (preferred specialty drug): $65 copayment for each purchase of up to a 30-day supply ($185 copayment for a 31 to 90-day supply) (no deductible) Tier 5 (non-preferred specialty drug): $85 copayment for each purchase of up to a 30-day supply ($240 copayment for a 31 to 90-day supply) (no deductible)	Tier 4 (preferred specialty drug): $85 copayment for each purchase of up to a 30-day supply ($235 copayment for a 31 to 90-day supply) Tier 5 (non-preferred specialty drug): $110 copayment for each purchase of up to a 30-day supply ($300 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 4 (preferred specialty drug): $80 copayment for each purchase of up to a 30-day supply ($210 copayment for a 31 to 90-day supply) Tier 5 (non-preferred specialty drug): $100 copayment for each purchase of up to a 30-day supply ($255 copayment for a 31 to 90-day supply)

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Smoking and Tobacco Cessation Medications If you are a covered member, 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, create a Tobacco Cessation Quit Plan using our Online Health Coach. For more information, see page 125. Note: There may be age-restrictions based on U.S. FDA guidelines for these medications. 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 continuing monthly pack - 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 61 for our coverage of smoking and tobacco cessation treatment, counseling, and classes.	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

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Remicade, Renflexis, and Inflectra are not covered for prescriptions obtained from a retail pharmacy, Mail Service Prescription or through the Specialty Drug Program* • *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 58 and 110)* • *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 112 for our coverage of medications recommended under the Affordable Care Act and page 117 for smoking and tobacco cessation medications.* • *Medical foods administered orally are not covered if not obtained at a retail pharmacy or through the Mail Service Prescription Drug Program* *Note: See Section 5(a), page 58, for our coverage of medical foods when administered by catheter or nasogastric tube.* • *Products and foods other than liquid formulas or powders mixed to become formulas; foods and formulas readily available in a retail environment and marketed for persons without medical conditions; low-protein modified foods (e.g., pastas, breads, rice, sauces and baking mixes); nutritional supplements, energy products; and similar items* *Note: See Section 5(a), page 58 for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube.* • *Infant formula other than described on pages 58 and 109*	*All charges*	*All charges*

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
• *Drugs for which prior approval has been denied or not obtained* • *Drugs and supplies related to sexual dysfunction or sexual inadequacy* • *Drugs and covered-drug-related supplies for the treatment of 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 110* • *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 110* • *Drugs used to terminate pregnancy* • *Sublingual allergy desensitization drugs, except as described on page 51*	*All charges*	*All charges*
Drugs From Other Sources	**Standard Option**	**Basic Option**
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. This includes drugs and supplies covered only under the medical benefit. 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 page 131 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 related to drugs obtained from other sources: - Physician's office – Section 5(a) - Facility (inpatient or outpatient) – Section 5(c) - Hospice agency – Section 5(c) • Please refer to page 114 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 professional provider: 35% of the Plan allowance (deductible applies) Non-participating professional provider: 35% of the Plan allowance (deductible applies) plus any difference between our allowance and the billed amount Member facilities: 35% of the Plan allowance (deductible applies) Non-member facilities: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating professional provider: You pay all charges Non-participating professional provider: You pay all charges Member/Non-member facilities: You pay all charges

Drugs From Other Sources - continued on next page

Benefits Description	You Pay	
Drugs From Other Sources (cont.)	**Standard Option**	**Basic Option**
• Auto-immune infusion medications: Remicade, Renflexis and Inflectra Note: Benefits for certain auto-immune infusion medications (limited to Remicade, Renflexis and Inflectra) are covered only when they are obtained by a non-pharmacy provider, such as a physician or facility (hospital or ambulatory surgical center).	Preferred: 10% of the Plan allowance (deductible applies) Participating professional provider: 15% of the Plan allowance (deductible applies) Non-participating professional provider: 15% of the Plan allowance (deductible applies) plus any difference between our allowance and the billed amount Member facilities: 15% of the Plan allowance (deductible applies) Non-member facilities: 15% of the Plan allowance (deductible applies), plus any difference between our allowance and billed amount.	Preferred: 15% of the Plan allowance Participating professional provider: You pay all charges Non-participating professional provider: You pay all charges Member/Non-member facilities: You pay 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.**

Benefit Description	You Pay	
Accidental Injury Benefit	**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.	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 for associated oral evaluations 30% of the Plan allowance for all other care 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 cost-share amounts 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.

Accidental Injury Benefit - continued on next page

Benefit Description	You Pay	
Accidental Injury Benefit (cont.)	**Standard Option**	**Basic Option**
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.	See previous page	See previous page

Dental Benefits

What is Covered

Standard Option dental benefits are presented in the chart on the following page.

Basic Option dental benefits appear on page 124.

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 phone 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 phone 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 page. 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 page 122).

Standard Option Dental Benefits	Standard Option Only		
Covered Service	**We Pay to Age 13**	**We Pay Age 13 and Over**	**You Pay**
Clinical oral evaluations			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).
Periodic oral evaluation *(up to 2 per person per calendar year)*	$12	$8	
Limited oral evaluation	$14	$9	
Comprehensive oral evaluation	$14	$9	
Detailed and extensive oral evaluation	$14	$9	
Diagnostic imaging			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	
Palliative treatment			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).
Palliative treatment of dental pain – minor procedure	$24	$15	
Protective restoration	$24	$15	
Preventive			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).
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 (*up to 2 per person per calendar year*)	$13	$8	
Not covered: Any service not specifically listed above	*Nothing*	*Nothing*	*All charges*

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; see page 122). 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 phone 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*)	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
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)*	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
Not covered: Any service not specifically listed above	*Nothing*	*All charges*

Section 5(h). Wellness and Other 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 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 phone, secure email, or live chat. Ask questions and get medical advice. Please keep in mind that benefits for any healthcare 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 healthcare expenses. See below and page 126 for more information. • **Online Health Coach (OHC)** – Manage your health proactively by setting and managing health goals, create a plan of care, track your progress, and pursue healthy activities. The OHC offers members a combination of guidance, support, and resources. • **Tobacco Cessation Incentive Program** – If you would like to quit smoking, you can participate in this program and receive tobacco cessation products at no charge. 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 page 117 for more information. Note: There may be age-restrictions based on U.S. FDA guidelines for these medications. • **Health Topics and WebMD Videos** offer an extensive variety of educational tools using videos, recorded messages, and colorful online materials that provide up-to-date information about a wide range of health-related topics.
Services for the Deaf and Hearing Impaired	All Blue Cross and Blue Shield Plans provide TTY 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 well-being. For more information, go to www.fepblue.org.
Diabetes Management Program	The Diabetes Management Program is a program to help members with diabetes manage their condition. All members with type 1 and type 2 diabetes, including those for whom Medicare is primary, are eligible for this program. You will receive a free glucose meter and have unlimited test strips and lancets shipped directly to you. Automated reordering is based on your usage. Personalized coaching and support are also provided. The program offers live interventions triggered by acute alerts based on your glucose meter test results. Member support is offered 24/7/365. For more information go to www.fepblue.org/diabetes.
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, both the contract holder and spouse are eligible for the $50 health account. We will send each eligible member a debit card to access their 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, hypertension, 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, 2021**. 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 888-258-3432 toll-free.
Diabetes Management Incentive Program	The **Diabetes Management Incentive Program** is designed to encourage members to achieve and maintain control of their blood sugar and help manage or slow the progression of complications related to diabetes. Through this program you can earn a maximum of $100 toward a health account to be used for most qualified medical expenses. This incentive is in addition to other incentives described in this brochure and is available to all covered adult members, age 18 and over. To qualify for the Diabetes Management Incentive Program, each eligible member must have at least one medical claim that has been processed during the past 12 months with a reported diagnosis of diabetes and complete the following steps: • Provide us with lab test results for an HbA1c performed in the first 6 months of the calendar year (January 1 to June 30) to receive a $25 incentive reward. • Provide us with lab test results for an HbA1c performed in the last 6 months of the calendar year (July 1 to December 31) to receive a $75 incentive reward; the test results must show: - Your HbA1c result is less than 8 percent; or - If your HbA1c is greater than or equal to 8 percent, you will receive the incentive if we provided benefits for three nutritional counseling visits performed during the calendar year. Note: See pages 43 and 46 for information on nutritional counseling. Information on how to submit your HbA1c lab results can be found on our website, www.fepblue.org/diabetes. See page 111 for information about the Diabetic Meter Program.
Hypertension Management Program	The **Hypertension Management Program** gives members age 18 and older with hypertension (otherwise known as high blood pressure) 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 the contract holder and spouse who meet the following criteria. 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, you will be sent a letter advising you of your eligibility for the free BPM. You are eligible to receive a free BPM every two calendar years. You must follow the directions in the letter, which include taking the letter to your healthcare 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 criteria or for those who obtain a BPM outside of this program. For more information, call us at the phone number on the back of your ID card. See page 108 for information on preferred generic anti-hypertensive medications.
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. 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. All covered adult members, age 18 and over may be eligible for this incentive. To qualify for the Pregnancy Care Box, you must be pregnant. Information on the program is available on our website, www.fepblue.org. To qualify for the $75 incentive, you must meet the criteria above for the Pregnancy Care Box and send us a copy of your healthcare provider's medical record that confirms you had a prenatal care visit during the first trimester of your pregnancy. Information that must be included when submitting your medical record can be found on our website, www.fepblue.org/maternity. To receive 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 are limited to two pregnancies per calendar year.
Annual Incentive Limitation	Financial incentives earned through participation in the Blue Health Assessment, personalized goals through the Online Health Coach, the Diabetes Management Incentive Program, and the Pregnancy Care Incentive Program are limited to a total of $420 per person per calendar year for the contract holder and spouse.
Reimbursement Account for Basic Option Members Enrolled in Medicare Part A and Part B	Basic Option members enrolled in Medicare Part A and Part B are eligible to be reimbursed up to $800 per calendar year for their Medicare Part B premium payments. The account is used to reimburse member-paid Medicare Part B premiums. For more information on how to obtain reimbursement, please visit www.fepblue.org/mra or call 888-706-2583.
MyBlue® Customer eService	Visit **MyBlue Customer eService** at www.fepblue.org/myblue or use the fepblue mobile app 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 "View My Claims"; from there you can search claims and select the "EOB" link next to each claim to access your EOB. You can also access EOBs via the fepblue mobile app. Simply link to MyBlue, and click on Claims.

	• **Opt In or Out of Mailed Paper EOBs** – The Service Benefit Plan offers an environmentally friendly way of accessing your EOBs via www.fepblue.org/myblue. You can opt in or out of receiving mailed paper EOBs by following 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. • **Financial Dashboard** – Log in to MyBlue to access important information in real time, including deductibles, out-of-pocket costs, remaining covered provider visits, medical claims, and pharmacy claims. You also can review your year-to-date summary of completed claims, MyBlue Wellness Card balance, and pharmacy spending throughout the year.
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 healthcare needs, the Service Benefit Plan offers two types of Care Management Programs that provide assistance with the coordination of your care, provide member education and clinical support. • **Case Management** provides members who have acute or chronic complex healthcare needs with the services and assistance of a licensed healthcare professional with a nationally recognized case management certification. Case managers may be a registered nurse, licensed social worker, or other licensed healthcare professional practicing within the scope of their license, who may work with you and your providers to assess your healthcare needs, coordinate needed care and available resources, evaluate the outcomes of your care, and support and monitor the progress of the member's treatment plan and healthcare needs. Some members may receive guidance and clinical support for an acute healthcare need while others may benefit from a short-term case management enrollment. Enrollment in case management requires your consent. Members in case management are asked to provide verbal consent prior to enrollment in case management and must provide written consent for case management. Note: Benefits for care provided by residential treatment centers and for inpatient care provided by skilled nursing facilities for members enrolled in Standard Option who do not have Medicare Part A require written consent and participation in Case Management prior to admission; please see pages 87-88, 100 and 130 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, including if you are eligible for enrollment and assistance with enrollment, please contact us at the customer service phone 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 will review the member's healthcare needs and may at our sole discretion, identify a less costly alternative treatment plan for the member. The member (or their healthcare proxy) and provider (s) must cooperate in the process. Case Management Program enrollment is required for eligibility. Prior to the starting date of the alternative treatment plan, members who are eligible to receive services through the flexible benefits option are required to sign and return a written consent for case management and 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. **We must receive the consent for case management and the alternative benefits agreement signed by the member/ healthcare proxy before you receive any services included in the alternative benefits agreement.**

	• Alternative benefits will be made available for a limited period of time and are subject to our ongoing review. You must cooperate with and participate in the review process. Your provider(s) must submit the information necessary for our reviews. You and/or your healthcare proxy must participate in care conferences and caregiver training as requested by your provider(s) or by us. • We may revoke the alternative benefits agreement immediately at any time, if we discover we were misled by the information given to us by you, your provider, or anyone else involved in your care, or that you are not meeting the terms of the agreement. • If we approve alternative benefits, we do not guarantee that they will be extended beyond the limited time period and/or scope of the alternative benefits agreement 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 at our sole discretion, 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 alternative benefits for the stated time period, unless we are misled by the information given to us or circumstances change. Benefits as stated in this brochure will apply to all services and dates of care not included in the alternative benefits agreement. You or your provider may request an extension of the time period initially approved for alternative benefits, no later than five business days prior to the end of the alternative benefits agreement. We will review the request, including the services proposed as an alternative and the cost of those services, but benefits as stated in this brochure will apply if we do not approve your request. Note: If we deny a request for precertification or prior approval of regular contract benefits, as stated in this brochure, 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).
Telehealth Services	Go to www.fepblue.org/telehealth or call 855-636-1579, TTY: 855-636-1578, toll free to access on-demand, affordable, high-quality care for adults and children experiencing non-emergency medical issues, including treatment of minor acute conditions (see page 155 for definition), dermatology care, counseling for behavioral health and substance use disorder, and nutritional counseling. Note: This benefit is available only through the contracted telehealth provider network.
The fepblue Mobile Application	Blue Cross and Blue Shield's fepblue mobile application is available for download for both iOS and Android mobile phones. The application provides members with 24/7 access to helpful features, tools and information related to Blue Cross and Blue Shield Service Benefit Plan benefits. Members can log in with their MyBlue® username and password to access personal healthcare information such as benefits, out-of-pocket costs, deductibles (if applicable) and physician visit limits. They can also view claims and approval status, view/share Explanations of Benefits (EOBs), view/share member ID cards, locate in-network providers, and connect with our telehealth services.

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 131-132 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 healthcare 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 overseas, with the exception of admissions for gender reassignment surgery (see pages 22 and 66-67 for information) and admissions to residential treatment centers and skilled nursing facilities. Prior approval is required for all non-emergent air ambulance transport services for overseas members (refer to page 92 for more information). Protections offered under the NSA (see page 32) do not apply to overseas claims.

Overseas 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 Overseas 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 Overseas 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 Overseas Assistance Center (provided by GMMI), by calling 804-673-1678. Members in the United States, Puerto Rico, or the U.S. Virgin Islands should call 800-699-4337 or email the Overseas Assistance Center at fepoverseas@gmmi.com. GMMI 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.

Hospital and professional provider benefits

For **professional care** you receive overseas, we provide benefits at Preferred benefit levels using either our Overseas Fee Schedule, a customary percentage of the billed charge, or a provider-negotiated discount as our Plan allowance. **The Basic Option requirement to use Preferred providers in order to receive benefits does not apply when you receive overseas care. Standard Option members have no deductible for overseas services.**

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. When the Plan allowance is a provider-negotiated discount, you are only responsible for your coinsurance and/or copayment amounts. You must also pay any charges for noncovered services.

For **inpatient facility care** you receive overseas, we provide benefits at the Preferred level **under both Standard and Basic Options. For Basic Option, there is no member cost-share** for admissions to a DoD facility, or when the Overseas Assistance Center (provided by GMMI) has arranged direct billing or acceptance of a guarantee of benefits with the facility. For all other inpatient facility care, Basic Option members are responsible for the per admission copayment. Standard Option members have no cost-share for inpatient facility care.

For **outpatient 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 have no deductible for overseas services.

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.

Pharmacy benefits

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 119 in Section 5(f) for more information.

Overseas claims payment

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.

Filing overseas claims

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 260070, Pembroke Pines, FL 33026.
2. Fax: 001-954-308-3957. 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 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@gmmi.com, or from your Local Plan.

Filing a claim for 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. Timely filing for overseas pharmacy claims is limited to one year from the prescription fill date. 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 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

These benefits are not part of the FEHB contract or premium, and you cannot file an FEHB dispute regarding these benefits. Fees paid 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® – The Blue Cross and Blue Shield Service Benefit Plan presents Blue365, a program that offers exclusive health and wellness deals that will assist in your efforts to be healthy and happy, every day of the year. Blue365 delivers top discounts from national and local retailers such as hearing aids through TruHearing, healthy food delivery via Sun Basket, wearable devices from Fitbit, and genetic composition testing by Molecular Fitness, just to name a few. Each week, Blue365 members receive great health and wellness deals via email. With Blue365, there is no paperwork to fill out. Just 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 – Fitness Your Way by Tivity Health can help you meet your health and fitness goals, on your budget, and on your own time. Fitness Your Way by Tivity Health offers access to more than 10,000 different fitness locations for a discounted monthly rate. You'll have access to well-being support, health articles, and online health coaching, as well as exercise tracking and nutrition goals, social networking, rewards, and the Daily Challenge 24 hours a day, 7 days a week. For more information or to enroll, visit www.fepblue.org/healthclub or call customer service at 888-242-2060, Monday through Friday, 8 a.m. – 8 p.m., in all U.S. time zones.

Discount Drug Program – The Discount Drug Program is available to members 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 24%. The program permits you to obtain discounts on several drugs related to dental care, weight loss, hair removal and hair growth, and other miscellaneous health conditions. Please refer to www.fepblue.org/ddp for a full list of discounted drugs, including those that may be added to this list as they are approved by the U.S. Food and Drug Administration (U.S. FDA). To use the program, simply present a valid prescription and your Service Benefit Plan ID card at a Preferred 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 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 888-897-9350 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.

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 155).
- Experimental or investigational procedures, treatments, drugs, or devices (see Section 5(b) 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 and gender reassignment surgeries specifically listed as covered).
- Travel expenses except as specifically provided for covered transplants performed in a Blue Distinction Center for Transplant (see page 76).
- 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 149), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge, see page 150), or state premium taxes however applied.
- Prescriptions, 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 provided 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, diagnostic tests, and procedures and services for the treatment of morbid obesity listed on page 65.
- 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 phone.
- 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 *Preventive Care, Child* in Sections 5(a) and 5(c), the preventive screenings specifically listed on pages 42-46 and page 85; and certain routine services associated with covered clinical trials (see page 144).
- Recreational or educational therapy, and any related diagnostic testing, except as provided by a hospital during a covered inpatient stay.
- Applied behavior analysis (ABA) and related services for any condition other than an autism spectrum disorder.
- Applied behavior analysis (ABA) services and related services performed as part of an educational program; or provided in or by a school/educational setting; or provided as a replacement for services that are the responsibility of the educational system.
- 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 118), meditation techniques, relaxation techniques, movement therapies, and energy therapies.
- Services, drugs, or supplies related to medical marijuana.
- Advanced care planning, except when provided as part of a covered hospice care treatment plan (see page 90).
- Membership or concierge service fees charged by a healthcare provider.
- Fees associated with copies, forwarding or mailing of records except as specifically described in Section 8.
- Services not specifically listed as covered.
- Services or supplies we are prohibited from covering under the Federal Law.

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 phone 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 provider 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, speech, or cognitive rehabilitation therapy, you must provide a written statement from the provider 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 provider's name, date, and charge. (See pages 137-138 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 (e.g., medical records) 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 retail 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 retail 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 paragraphs 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 800-624-5060 to request a retail prescription drug claim form to claim benefits. Hearing-impaired members with TTY equipment may call 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 800-262-7890, TTY: 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 phone 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 116 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 888-346-3731, TTY: 877-853-9549, or you may send your prescription to: BCBS FEP Specialty Drug Pharmacy Program, CVS Specialty, 9310 Southpark Center Loop, Orlando, FL 32819. 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 are most convenient for you. To order refills, call the same phone 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 888-346-3731, TTY: 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 (e.g., diagnosis codes, dates of service, etc.), you must resubmit it within 90 days, or before the timely filing period expires, whichever is later.

Note: Timely filing for overseas pharmacy claims is limited to one year from the prescription fill date.

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 131-132 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 healthcare 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 phone 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 healthcare 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 or to make an inquiry 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 call your Plan's customer service representative at the phone number found on your enrollment card, our brochure, or our website (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 phone 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 healthcare 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 their 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.

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, FEHB 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;
- Your daytime phone number and the best time to call; and
- 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 healthcare 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 phone 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 FEHB 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 healthcare 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 healthcare 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 on NAIC rules regarding the coordinating of benefits, visit our website at www.fepblue.org/coordinationofbenefits.

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 150). 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 healthcare 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 healthcare 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, 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 covered 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 69-76. **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 phone 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 (U.S. FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I enroll in Medicare?" please contact Medicare at 1-800-Medicare 800-633-4227, TTY: 877-486-2048, or at www.medicare.gov.

- **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 21 for exceptions).

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 phone 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 healthcare 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 (skilled) 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**

If you are enrolled in Medicare Part B, 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 healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227), TTY: 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 20 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		✓*
9) Are a Federal employee receiving 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 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:	
	Standard Option	**Basic Option**
Participates with Medicare or accepts Medicare assignment for the claim and is in our Preferred network	your deductibles, coinsurance, and copayments.	your copayments and coinsurance.
Participates with Medicare or accepts Medicare assignment and is not in our Preferred network	your deductibles, coinsurance, and copayments, and any balance up to the Medicare-approved amount.	all charges.
Does not participate with Medicare and is in our Preferred network 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.	your deductibles, coinsurance, and copayments, and any balance up to 115% of the Medicare-approved amount.	your copayments and coinsurance, and any balance up to 115% of the Medicare-approved amount.
Does not participate with Medicare and is not in our Preferred network	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare-approved amount.	all charges.
Opts-out of Medicare via private contract	your deductibles, coinsurance, copayments, and any balance your physician charges.	your deductibles, coinsurance, copayments, and any balance your physician 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.

Physicians Who Opt-Out of Medicare

A physician may have opted-out of Medicare and may or may not ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. This is different than a Non-participating doctor, and we recommend you ask your physician if they have opted-out of Medicare. Should you visit an opt-out physician, the physician will not be limited to 115% of the Medicare-approved amount. You may be responsible for paying the difference between the billed amount and our regular in-network/out-of-network benefits.

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, you pay nothing for covered charges (see note below for Basic Option).
- If your physician **does not accept** Medicare assignment, 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 20 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.

Please review the following table illustrating your cost-share liabilities when Medicare is your primary payor **and** your provider is in our network and participates with Medicare compared to what you pay without Medicare. Please do not rely on this chart alone but read all information in this section of the brochure. You can find more information about how our Plan coordinates with Medicare in our *Medicare and You Guide for Federal Employees* available online at www.fepblue.org.

Benefit Description: Deductible
Standard Option You Pay **Without** Medicare: $350-Self, $700-Family
Standard Option You Pay **With** Medicare Parts A & B: $0.00
Basic Option You Pay **Without** Medicare: N/A
Basic Option **With** Medicare Parts A & B: $0.00

Benefit Description: Catastrophic Protection Out-of-Pocket Maximum
Standard Option You Pay **Without** Medicare: $8,000-Self, $16,000-Family
Standard Option You Pay **With** Medicare Parts A & B: $8,000-Self, $16,000-Family
Basic Option You Pay **Without** Medicare: $6,500-Self, $13,000-Family
Basic Option **With** Medicare Parts A & B: $6,500-Self, $13,000-Family

Benefit Description: Part B Premium Reimbursement
Standard Option You Pay **Without** Medicare: N/A
Standard Option You Pay **With** Medicare Parts A & B: N/A
Basic Option You Pay **Without** Medicare: N/A
Basic Option **With** Medicare Parts A & B: $800

Benefit Description: Primary Care Physician
Standard Option You Pay **Without** Medicare: $25
Standard Option You Pay **With** Medicare Parts A & B: $0.00
Basic Option You Pay **Without** Medicare: $30
Basic Option **With** Medicare Parts A & B: $0.00

Benefit Description: Specialist
Standard Option You Pay **Without** Medicare: $35
Standard Option You Pay **With** Medicare Parts A & B: $0.00
Basic Option You Pay **Without** Medicare: $40
Basic Option **With** Medicare Parts A & B: $0.00

Benefit Description: Inpatient Hospital
Standard Option You Pay **Without** Medicare: $450
Standard Option You Pay **With** Medicare Parts A & B: $0.00
Basic Option You Pay **Without** Medicare: $175/day up to $875
Basic Option **With** Medicare Parts A & B: $0.00

Benefit Description: Outpatient Hospital
Standard Option You Pay **Without** Medicare: 15% or $25 copayment
Standard Option You Pay **With** Medicare Parts A & B: $0.00
Basic Option You Pay **Without** Medicare: 30% or $30-$500 copayment
Basic Option **With** Medicare Parts A & B: $0.00

Benefit Description: Incentives Offered
Standard Option You Pay **Without** Medicare: N/A
Standard Option You Pay **With** Medicare Parts A & B: N/A
Basic Option You Pay **Without** Medicare: N/A
Basic Option **With** Medicare Parts A & B: N/A

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.
Advanced care planning	Receiving information on the types of life-sustaining treatments that are available, completing advance directives and other standard forms, and/or if you are diagnosed with a terminal illness and making decisions about the care you would want to receive if you become unable to speak for yourself.
Agents	Medications 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 medications 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. Benefits provided under the contract are not assignable by the member to any person without express written approval of the Carrier, and in the absence of such approval, any such assignment shall be void. Please visit www.fepblue.org to obtain a valid authorization form.
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.
Biologic drug	A complex drug or product that is manufactured in a living organism, or its components, that is used as a diagnostic, preventive or therapeutic agent.
Biosimilar drug	A U.S. FDA-approved biologic drug, which is considered highly similar to an original brand-name biologic drug, with no clinically meaningful differences from the original biologic drug in terms of safety, purity and potency.
Biosimilar, interchangeable drug	A U.S. FDA-approved biosimilar drug that may be automatically substituted for the original brand-name biologic drug.
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.
Clinical trials	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 U.S. Food and Drug Administration (U.S. FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.
Coinsurance	See Section 4 page 29.
Concurrent care claims	A claim for continuing care or an ongoing course of treatment that is subject to prior approval. See page 26 in Section 3.
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; ambiguous genitalia; and webbed fingers and toes. Note: Congenital anomalies do not include conditions related to the teeth or intra-oral structures supporting the teeth.

Copayment See Section 4 page 28.

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 See Section 4 page 28.

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 healthcare 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.

Durable medical equipment Equipment and supplies that are:

1. Prescribed by your physician (i.e., the physician who is treating your illness or injury);
2. Medically necessary;
3. Primarily and customarily used only for a medical purpose;
4. Generally useful only to a person with an illness or injury;
5. Designed for prolonged use; and
6. Used to serve a specific therapeutic purpose in the treatment of an illness or injury.

Experimental or investigational services Experimental or investigational shall mean:

1. A drug, device, or biological product that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (U.S. FDA); and approval for marketing has not been given at the time it is furnished; or
2. Reliable evidence shows that the healthcare 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
3. Reliable evidence shows that the consensus of opinion among experts regarding the healthcare 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

4. Reliable evidence shows that the healthcare 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:

1. Published reports and articles in the authoritative medical and scientific literature;
2. 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
3. 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 a U.S. 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 U.S. FDA as interchangeable with your brand-name drug.

Group health coverage Healthcare 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).

Healthcare professional A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law. See page 17 for information about how we determine which healthcare 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 healthcare provider. For more information, visit our website, www.fepblue.org.

Inpatient You are an inpatient when you are formally admitted to a hospital with a doctor's order.

Note: Inpatient care requires precertification. For some services and procedures prior approval must also be obtained. See pages 21-26.

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 use disorders. 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 healthcare 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:

1. In accordance with generally accepted standards of medical practice in the United States; and
2. 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
3. Not primarily for the convenience of the patient, physician, or other healthcare 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
4. Not part of or associated with scholastic education or vocational training of the patient; and
5. In the case of inpatient care, able to be provided safely only in the inpatient 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.

Minor acute conditions

Under the telehealth benefit you have on-demand access to care for common, non-emergent conditions. Examples of common conditions include sinus problems, rashes, allergies, cold and flu symptoms, etc.

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. For more information, see pages 7-8.

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.

Outpatient

You are an outpatient if you are getting emergency department services, observation services, outpatient surgery, lab tests, X-rays, or any other hospital services, and the doctor has not written an order to admit you to a hospital as an inpatient. In these cases, you are an outpatient even if you are admitted to a room in the hospital for observation and spend the night at the hospital.

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 healthcare 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 123 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 healthcare 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 Local Plan Allowance. The Local Plan Allowance varies by region and is determined by each Plan. If you would like additional information, or to obtain the current allowed amount, please call the customer service phone number on the back of your ID card. For inpatient stays resulting from medical emergencies or accidental injuries, or for emergency deliveries, our allowance is the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations;
  - For outpatient, non-emergency 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 Local Plan Allowance. This allowance applies to all of the covered services billed by the hospital. If you plan on using a Non-member hospital, or other Non-member facility, for your outpatient procedure, please call us before you receive services at the customer service phone 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 to use our National Doctor and Hospital Finder, or call us at the customer service phone number on the back of your ID card;

- For outpatient services resulting from a medical emergency or accidental injury that are billed by Non-member facilities, our allowance is the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations (minus any amount for noncovered services);
- For non-emergency medical services performed in Preferred hospitals provided by physicians and other covered healthcare professionals identified under the NSA (see page 32) that do not contract with your local Blue Cross and Blue Shield Plan and cannot balance bill you under this regulation, our allowance is equal to the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations;
- For physicians and other covered healthcare 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 Local Plan Allowance. In the absence of a Medicare participating fee schedule amount or ASP for any service, drug, or supply, our allowance is the Local Plan Allowance. 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 healthcare professionals, and air ambulance providers that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations;
- 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 the Overseas Assistance Center (provided by GMMI), 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, D.C., area, or a customary percent of billed charge, whichever is higher.

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 phone 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. See page 32.

For more information, see *Differences between our allowance and the bill* in Section 4. For more information about how we pay providers overseas, see pages 32 and 130.

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, healthcare institutions, and other covered healthcare 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 healthcare 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)); general health panel; basic or comprehensive metabolic panel; fasting lipoprotein profile; urinalysis; CBC; screening for diabetes mellitus, hepatitis B and hepatitis C, and latent tuberculosis; screening for alcohol/substance use disorders; counseling on reducing health risks; screening for depression; screening for chlamydia, syphilis, gonorrhea, HPV, and HIV; screening for intimate partner violence for women of reproductive age; administration and interpretation of a Health Risk Assessment questionnaire; cancer screenings including low-dose CT screening for lung cancer; screening for abdominal aortic aneurysms; osteoporosis screening, as specifically stated in this brochure; and immunizations as licensed by the U.S. Food and Drug Administration (U.S. FDA).

Note: Anesthesia services and pathology services associated with preventive colorectal surgical screenings are also paid as preventive care.

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 21-24.

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 page 144).

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.

Telehealth dermatology Under the telehealth benefit, dermatologic conditions seen and treated include but are not limited to acne, dermatitis, eczema, psoriasis, rosacea, seborrheic keratosis, fungal infections, scabies, suspicious moles, and warts. Members capture important digital images, combine those with the comprehensive questionnaire responses, and send those to the dermatology network without requiring a phone or video interaction.

Telehealth services Non-emergency services provided by phone or secure online video/messaging for minor acute conditions (see page 155 for definition), dermatology care, behavioral health and substance use disorder counseling, and nutritional counseling. Go to www.fepblue.org/telehealth or call 855-636-1579, TTY: 855-636-1578, toll free to access this benefit. After your telehealth visit, please follow up with your primary care provider.

Telemedicine Services Services provided by phone or secure online video/messaging for evaluation and management services. This does not include the use of fax machine or email; costs associated with enabling or maintaining providers' telehealth (telemedicine) technologies; or fees for asynchronous services—medical information stored and forwarded to be reviewed at a later time by a physician or healthcare practitioner at a distant site without the patient being present. Providers must perform covered services acting within the scope of their license or certification under applicable state law. Please note, your healthcare provider must know when and where they can treat you. You, in turn, are responsible for accurately identifying to your provider where you are physically located for the service you received through telehealth (telemedicine) technologies. You and your physician must be in the same U.S. State, Territory, or foreign country as required by applicable legislation.

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 phone 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.

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Do not rely only 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.

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Summary of Benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2022

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a decision, please read this FEHB brochure.

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 healthcare professional, you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown below.

You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.fepblue.org/brochure.

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 healthcare professionals $35 per office visit for specialists Non-PPO: 35%* of our allowance	39-46
Medical services provided by physicians: Telehealth services	PPO: Nothing for the first 2 visits per calendar year after the 2nd visit: $10 copayment per visit Non-PPO: You pay all charges	39, 99
Services provided by a hospital: Inpatient	PPO: $350 per admission Non-PPO: $450 per admission, plus 35% of our allowance	79-81
Services provided by a hospital: Outpatient	PPO: 15%* of our allowance Non-PPO: 35%* of our allowance	81-85
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	95-96
Emergency benefits: 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)	96-97

Standard Option Benefits	You pay	Page
Mental health and substance use disorder 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	98-102
Prescription drugs	**Retail Pharmacy Program:** • PPO: $7.50 for each purchase of up to a 30-day supply generic ($5.00 for a 30-day supply if you have Medicare Part B primary)/30% of our allowance Preferred brand-name/50% 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 Part B primary)/$90 Preferred brand-name/$125 non-preferred brand-name per prescription; up to a 90-day supply **Specialty Drug Pharmacy Program:** • $65 preferred specialty drug for a purchase of up to a 30-day supply; $85 non-preferred specialty drug for a purchase of up to a 30-day supply	108-120
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	123
Wellness and other special features: Health Tools; Blue Health Assessment; MyBlue® Customer eService; Diabetes Management Incentive Program; National Doctor and Hospital Finder; Healthy Families; travel benefit/services overseas; Care Management Programs; and Flexible benefits option	See Section 5(h).	125-129
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	• Self Only: Nothing after $6,000 (PPO) or $8,000 (PPO/Non-PPO) per contract per year • Self Plus One: Nothing after $12,000 (PPO) or $16,000 (PPO/Non-PPO) per contract per year • Self and Family: Nothing after $12,000 (PPO) or $16,000 (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 – 2022

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a decision, please read this FEHB brochure.

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 20. There is no deductible for Basic Option.

You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.fepblue.org/brochure.

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 healthcare professionals; $40 per office visit for specialists Non-PPO: You pay all charges	39-46
Medical services provided by physicians: Telehealth services	PPO: Nothing for the first 2 visits per calendar year after the 2nd visit: $15 copayment per visit Non-PPO: You pay all charges	39, 99
Services provided by a hospital: Inpatient	PPO: $175 per day up to $875 per admission Non-PPO: You pay all charges	79-81
Services provided by a hospital: Outpatient	PPO: $100 per day per facility Non-PPO: You pay all charges	81-85
Emergency benefits: Accidental injury	PPO: $35 copayment for urgent care; $175 copayment for emergency room care Non-PPO: $175 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	95-96
Emergency benefits: Medical emergency	Same as for accidental injury	96-97
Mental health and substance use disorder 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	98-102

Basic Option Benefits	You pay	Page
Prescription drugs	**Retail Pharmacy Program:** • PPO: $10 generic/$55 Preferred brand-name per prescription ($50 if you have primary Medicare Part B)/60% coinsurance ($75 minimum) for non-preferred brand-name drugs (50% ($60 minimum) if you have primary Medicare Part B) • Non-PPO: You pay all charges **Specialty Drug Pharmacy Program:** • $85 preferred specialty drug for a purchase of up to a 30-day supply; $110 non-preferred specialty drug for a purchase of up to a 30-day supply **Mail Service Prescription Drug Program** (for primary Medicare Part B members only): • $20 generic/$100 Preferred brand-name/$125 non-preferred brand-name per prescription; up to a 90-day supply	108-120
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 associated oral evaluations required due to accidental injury; regular benefits for covered oral and maxillofacial surgery Non-PPO: You pay all charges	124
Wellness and other special features: Health Tools; Blue Health Assessment; MyBlue® Customer eService; Diabetes Management Incentive Program; National Doctor and Hospital Finder; Healthy Families; travel benefit/services overseas; Care Management Programs; and Flexible benefits option	See Section 5(h).	125-129
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	• Self Only: Nothing after $6,500 (PPO) per contract per year • Self Plus One: Nothing after $13,000 (PPO) per contract per year • Self and Family: Nothing after $13,000 (PPO) per contract per year; nothing after $6,500 (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

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2022 Rate Information for the Blue Cross and Blue Shield Service Benefit Plan

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

Premiums for Tribal employees are shown under the Monthly Premium Rate 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	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Nationwide Standard Option					
Standard Option Self Only	104	$244.86	$127.47	$530.53	$276.19
Standard Option Self Plus One	106	$524.63	$289.61	$1,136.70	$627.49
Standard Option Self and Family	105	$574.13	$314.11	$1,243.95	$680.57
Nationwide Basic Option					
Basic Option Self Only	111	$240.56	$80.18	$521.21	$173.73
Basic Option Self Plus One	113	$524.63	$196.13	$1,136.70	$424.95
Basic Option Self and Family	112	$574.13	$212.29	$1,243.95	$459.96

EXHIBIT N

Blue Cross® and Blue Shield® Service Benefit Plan

www.fepblue.org

2023

A Fee-For-Service Plan (FEP Blue Standard and FEP Blue Basic Options) with a Preferred Provider Organization

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. This Plan is accredited. See page 13.

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

IMPORTANT
- Rates: Back Cover
- Changes for 2023: Page 15
- Summary of Benefits: Page 162

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

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:
United States Office of Personnel Management
Healthcare and Insurance
http://www.opm.gov/insure

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

The Office of Personnel Management (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 is 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% 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 800-772-1213, TTY: 711.

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 800-MEDICARE 800-633-4227, TTY 711.

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Introduction

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Standard and FEP Blue Basic Options** under contract (CS 1039) between the Blue Cross and Blue Shield Association and 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 phone number appearing on the back of your ID card.

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 healthcare benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2023, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2023, and changes are summarized on pages 15-16. Rates are shown on the back cover of this brochure.

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 and each covered 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 Healthcare Fraud!

Fraud increases the cost of healthcare 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 phone or to people you do not know, except for your healthcare provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare 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 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 800-FEP-8440 (800-337-8440) and explain the situation.
  - If we do not resolve the issue:

CALL THE HEALTHCARE FRAUD HOTLINE
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)
  - Your child age 26 or over (unless they were disabled and incapable of self-support prior to age 26)
- A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- 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 (TCC).
- 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.

Discrimination is Against the Law

The Blue Cross and Blue Shield Service Benefit Plan complies with all applicable Federal civil rights laws, including Title VII of the Civil Rights Act of 1964.

We:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator of your Local Plan by contacting your Local Plan at the phone number appearing on the back of your ID card.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator of your Local Plan. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, your Local Plan's Civil Rights Coordinator is available to help you.

Members may file a complaint with the HHS Office of Civil Rights, OPM, or FEHB Program Carriers.

You can also file a civil rights complaint with the Office of Personnel Management by mail at:

Office of Personnel Management
Healthcare and Insurance
Federal Employee Insurance Operations
Attention: Assistant Director, FEIO
1900 E Street NW, Suite 3400-S
Washington, DC 20415-3610

For further information about how to file a civil rights complaint, go to www.fepblue.org/en/rights-and-responsibilities/, or call the customer service phone number on the back of your member ID card. For TTY, dial 711.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. 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 take notes, ask questions and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medications or give your doctor and pharmacist a list of all the medications and dosages that you take, including non-prescription (over-the-counter) medications 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 medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Do not assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

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

For more information on patient safety, please visit:

- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. 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 healthcare providers and improve the quality of care you receive.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- 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 healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not 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, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

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. When such an event occurs, neither you nor your FEHB Plan will incur costs to correct the medical error.

You will not be billed for inpatient services when care is related to treatment of specific hospital-acquired conditions if you use Preferred or Member hospitals. This policy helps to protect you from having to pay for the cost of treating these conditions, and it encourages hospitals to improve the quality of care they provide.

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. 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, give you other plans' brochures 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.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for updates and questions about your benefit coverage.

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

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include 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 Plus One or Self and Family 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 are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee’s FEHB enrollment.

Contact your carrier to add a family member when there is already family Coverage.

Contact your employing or retirement office if you are changing from Self to Self Plus One or Self and Family or to add a family member if you currently have a Self Only plan.

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, you or they cannot be enrolled in or covered as a family member by another enrollee in 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 below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: 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
Coverage: 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
Coverage: 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
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

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

- **Children's Equity Act**

OPM implements 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 or children.

If this law applies to you, you must enroll in 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 lowest-cost nationwide Plan option as determined by OPM.

- 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 lowest-cost nationwide plan option as determined by OPM.

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 does not 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 does not 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 processed according to the 2023 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2022 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 family members 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 assistance with enrolling in a conversion policy (non-FEHB individual policy). FEP helps members with Temporary Continuation of Coverage (TCC) and with finding replacement coverage.

- **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 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. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

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

  If you leave Federal service or Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for TCC. 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, or if you are a covered 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 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 coverage.

  We also want to inform you that the Patient Protection and ACA did not eliminate TCC or change the TCC rules.

- **Finding replacement coverage**

  If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please refer to the next Section of this brochure. We will help you find replacement coverage inside or outside the Marketplace. For assistance, please contact your Local Plan at the phone 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 ACA's Health Insurance Marketplace. These rules are established by the Federal Government agencies that have responsibility for implementing the ACA and by the Marketplace.

- **Health Insurance Marketplace**

  If you would like to purchase health insurance through the ACA'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 healthcare 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.

OPM requires that FEHB plans be accredited to validate that Plan operations and/or care management meet nationally recognized standards. The local Plans and vendors that support the Blue Cross and Blue Shield Service Benefit Plan hold accreditation from National Committee for Quality Assurance (NCQA) and/or URAC. To learn more about this Plan's accreditations, please visit the following websites:

- National Committee for Quality Assurance (www.ncqa.org);
- URAC (www.URAC.org).

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 healthcare 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 Preferred 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. 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 20 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 phone 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 healthcare facilities, physicians, and other healthcare 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 156-157). 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 20 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.
- **Pilot Programs.** We may implement pilot programs in one or more Local Plan areas and overseas to test the feasibility and examine the impact of various initiatives. The pilot programs do not affect all Plan areas. Information on specific pilots is not published in this brochure; it is communicated to members and network providers in accordance with our agreement with OPM. Certain pilot programs may incorporate benefits that are different from those described in this brochure. For example, certain pilot programs may revise the Plan Allowance for Non-participating providers described in Section 10 of this brochure.

Your rights and responsibilities

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/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence
- Profit status
- Care management, including case management and disease management programs
- How we determine if procedures are experimental or investigational

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, at www.fepblue.org/en/rights-and-responsibilities.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.fepblue.org/en/terms-and-privacy/notice-of-privacy-practices/ to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

If you want more information about us, call or write to us. Our phone 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 2023

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.

Changes to our Standard Option only

- Preferred insulins are now covered with a $35 copayment for up to a 30-day supply or a $65 copayment for a 31 to 90-day supply, when dispensed by a Preferred retail pharmacy. Previously, you paid 20% of the Plan allowance for each purchase of up to a 90-day supply. (See page 112.)

Changes to our Basic Option only

- Your cost-share for outpatient surgical and treatment services performed and billed by a facility is now a $150 copayment per day per facility. Previously, you paid a $100 copayment per day per facility for these services. (See page 81.)
- Your cost-share for laboratory tests (such as blood tests and urinalysis), pathology services, and EKGs is now a 15% coinsurance. Previously, you paid nothing for these services. (See page 40 and 85.)
- Your copayment for an inpatient admission is now a $250 per day copayment for up to $1,500 per admission for unlimited days. Previously, you paid a $175 copayment per admission up to $875 for unlimited days. (See pages 47, 76, 79, 87 and 100.)
- We now cover 12 acupuncture visits per calendar year. Previously, we covered 10 acupuncture visits per calendar year. (See page 60.)
- Your copayment for outpatient observation services performed and billed by a hospital or freestanding ambulatory facility is now a $250 per day copayment up to $1,500. Previously, you paid a $175 per day copayment up to $875. (See page 82.)
- Your cost-share for outpatient diagnostic testing and treatment services performed and billed by a facility is now a $200 copayment per day per facility. Previously, you paid a $150 copayment per day per facility for these services. (See page 83.)
- Your cost-share for 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 is now a $250 per day per facility copayment. Previously, your copayment for these services was $175. (See pages 95 and 96.)
- Your copayment for Tier 1 (generic drugs) without Medicare Part B primary, is now $15 for each purchase of up to a 30-day supply ($40 for a 31 to 90-day supply). Previously, your copayment was $10 for each purchase of up to a 30-day supply ($30 for a 31 to 90-day supply). (See page 114.)
- Your copayment for Tier 2 (preferred brand-name drugs) without Medicare Part B primary, is now $60 for each purchase of up to a 30-day supply ($180 for a 31 to 90-day supply). Previously, your copayment was $55 for each purchase of up to a 30-day supply ($165 for a 31 to 90-day supply). (See page 114.)
- You are now responsible for up to a $90 minimum copayment for Tier 3 (non-preferred brand-name) drugs for up to a 30-day supply ($250 minimum for a 31 to 90-day supply) without Medicare Part B primary. Previously, you were responsible for a $75 minimum for up to a 30-day supply ($210 minimum for a 31 to 90-day supply). (See page 114.)

Changes to both our Standard and Basic Options

- We now cover preventive low-dose CT screenings for lung cancer for members aged 50 to 80. Previously, preventive benefits did not start until age 55.
- We now require prior approval for certain high-cost drugs obtained outside of a pharmacy setting. Previously, prior approval was not required. (See page 22.)
- We now require prior approval for proton beam therapy. Previously, prior approval was not required. (See page 22.)
- We now require prior approval for stereotactic radiosurgery and stereotactic body radiation therapy. Previously, prior approval was not required. (See page 22.)

- We now cover one year of sperm and egg storage for those individuals facing iatrogenic infertility. Previously, there was no benefit for this service. (See pages 22, 50 and 154.)
- We now cover computed tomography (CT) colonography under the adult preventive benefit for colorectal cancer tests. Previously, this was not covered under the preventive benefit. (See page 42.)
- We will make changes as soon as possible and provide you with preventive benefits for the USPSTF A and B, ACIP, HRSA, and Bright Futures recommendations as they occur throughout the year. Previously, these updates were made annually. (See pages 43 and 45.)
- We now provide 8 visits per calendar year to treat depression associated with pregnancy with no member cost-share when a Preferred provider is used. Previously, we provided coverage for only 4 visits per calendar year. (See page 47.)
- We now provide individuals who are pregnant with a free blood pressure monitor when ordered through our vendor. (See page 48.)
- We now cover medical foods for the treatment of inborn errors of amino acid metabolism regardless of age. Previously, we limited this to individuals under the age of 22. (See page 109.)
- We now provide benefits for medically necessary bariatric surgery beginning at the age of 16. Previously, this benefit was limited to individuals aged 18 and older. (See page 64.)
- We no longer limit the number of non-full sibling donor screening tests for transplants. Previously, we limited non-full sibling donor test screenings to three. (See page 75.)
- We now cover the generic naloxone nasal spray with zero cost-share for the first purchase of up to a 90-day supply per calendar year. Previously, we covered the Narcan nasal spray under this benefit. (See page 113.)
- We now provide coverage for weight loss medications to treat obesity when obtained through one of our pharmacy drug programs. Previously, these drugs were not covered for the treatment of obesity.
- We now cover over-the-counter (OTC) condoms for all members with zero member cost-share when you have a prescription from your physician and they are purchased in a Preferred retail pharmacy. Previously, benefits were available only for female condoms. (See page 110.)

Section 3. How You Get Care

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 20 for the exceptions to this requirement. Refer to page 13 for more information about Preferred providers.

Under both Standard and Basic Option, you can also get care for the treatment of minor acute conditions (see page 155 for definition), dermatology care (see page 39), counseling for behavioral health and substance use disorder (see page 99), and nutritional counseling (see pages 42 and 46), using teleconsultation services delivered via phone by calling 855-636-1579, TTY: 711, or via secure online video/messaging at www.fepblue.org/telehealth.

The term "primary care provider" includes family practitioners, general practitioners, medical internists, pediatricians, obstetricians/gynecologists, and physician assistants. Physician assistants working for a specialist may also be considered specialists.

Balance Billing Protection

FEHB Carriers must have clauses in their in-network (participating) provider agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or in some cases for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

- **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. Covered professional providers within the United States, Puerto Rico, and the U.S. Virgin Islands are healthcare 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 healthcare services in the normal course of business. Covered services must be provided in the state in which the provider is licensed or certified. **If the state has no applicable licensing or certification requirement, the provider must meet the requirements of the Local Plan.** 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.

This plan recognizes that transgender, non-binary, and other gender diverse members require healthcare delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

If you have questions about covered providers, would like the names of PPO (Preferred) providers, or need a Care Coordinator for complex conditions, please contact the Local Plan where services will be performed.

- **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-Preferred (Member/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 surgicenter, 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 use disorder. Accredited healthcare 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 use disorder 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 87-88 and 100-101. If you have questions about treatment at an RTC, please contact us at the customer service phone number listed on the back of your ID card.

Blue Distinction® Specialty Care

Blue Distinction Specialty Care, our centers of excellence program, focuses on effective treatment for specialty procedures, such as: Bariatric Surgery, Cardiac Care, Knee and Hip Replacement, Spine Surgery, Transplants, Cancer Care, Cellular Immunotherapy (CAR-T), Gene Therapy, Maternity Care, and Substance Use Treatment and Recovery. Using national evaluation criteria developed with input from medical experts, the Blue Distinction Centers offer comprehensive care delivered by multidisciplinary teams with subspecialty training and distinguished clinical expertise. Providers demonstrate quality care, treatment expertise and better overall patient results.

We cover specialty care at designated Blue Distinction Centers at Preferred benefit levels. See pages 86-87 for information regarding enhanced inpatient and outpatient benefits for bariatric, spine, knee and hip surgeries performed at a Blue Distinction Center. We also provide enhanced benefits for covered transplant services performed at the Blue Distinction Centers for Transplant designated centers as described on page 76.

For listings of Blue Distinction Centers, visit https://www.bcbs.com/blue-distinction-center/facility; access our National Doctor & Hospital Finder via www.fepblue.org/provider/; or call us at the customer service phone number listed on the back of your ID card.

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 phone 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 70).

Skilled Nursing Facility (SNF)

A SNF is a freestanding institution or a distinct part of a hospital which customarily bills insurance as a skilled nursing facility and meets the following criteria:

- Is Medicare-certified as a skilled nursing facility;
- Is licensed in accordance with state or local law or is approved by the state or local licensing agency as meeting the licensing standards (where state or local law provides for the licensing of such facilities);
- Has a transfer agreement in effect with one or more Preferred hospitals; and
- Is primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care; or rehabilitation services for the rehabilitation of injured, disabled or sick persons.

To be covered, skilled nursing facility care cannot be maintenance or custodial care. The term skilled nursing facility does not include any institution that is primarily for the care and treatment of mental diseases.

Note: Additional criteria apply when Medicare Part A is not the primary payor (see page 88).

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.

Exceptions:

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, neonatologists, 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 pregnant 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 phone number listed in your local phone directory. If you already have your new Service Benefit Plan ID card, call us at the phone 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 may require precertification and prior approval. If you do not obtain precertification, there may be a reduction or denial of benefits. Be sure to read all of the precertification and prior approval information below and on pages 22-26. Our FEP medical policies may be found by visiting www.fepblue.org/policies.

- **Inpatient hospital admission, inpatient residential treatment center admission, or skilled nursing facility admission**

Precertification is the process by which – prior to your inpatient 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, inpatient residential treatment center, or skilled nursing facility whether or not they have contacted us and provided all necessary information. You may contact us at the phone number on the back of your ID card to ask if we have received the request for precertification. You are also responsible for enrolling in case management and working with your case manager if your care involves residential treatment or a skilled nursing facility. For information about precertification of an emergency inpatient hospital admission, please see page 26.

Warning: We will reduce our benefits for the inpatient hospital stay by $500, even if you have obtained prior approval for the service or procedure being performed during the stay, 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: If precertification was not obtained prior to admission, inpatient benefits (such as room and board) are not available for inpatient care at a residential treatment center, or, when Medicare Part A is not the primary payor, at a skilled nursing facility. 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; with the exception of admissions for gender affirming surgery and admissions to residential treatment centers, and skilled nursing facilities.
- You have another group health insurance policy that is the primary payor for the hospital stay; with the exception of admissions for gender affirming surgery. (See page 76 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)
- Medicare Part A is the primary payor for the hospital or skilled nursing facility stay; with the exception of admissions for gender affirming surgery. (See page 76 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 64-65 in order for benefits to be provided for the admission and surgical procedure.

- **Other services**

You must obtain prior approval for these services under both Standard and Basic Option in all outpatient and inpatient settings unless otherwise noted. Precertification is also required if the service or procedure requires an inpatient hospital admission. Contact us using the customer service phone 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:

- **Gene therapy and cellular immunotherapy, for example, CAR-T and T-Cell receptor therapy**
- **High-cost drugs –** We require prior approval for certain high-cost drugs obtained outside of a pharmacy setting. Contact the customer service number on the back of your ID card or visit us at www.fepblue.org/highcostdrugs for a list of these drugs.
- **Air Ambulance Transport (non-emergent)** – Air ambulance transport related to immediate care of a medical emergency or accidental injury does not require prior approval; see Section 5 (c), page 92, for more information.
- **Outpatient facility-based sleep studies** – Prior approval is required for sleep studies performed in a provider's office, sleep center, clinic, any type of outpatient center, or any location other than your home.
- **Applied behavior analysis (ABA)** – Prior approval is required for ABA and all related services, including assessments, evaluations, and treatments.
- **Gender affirming surgery –** Prior to surgical treatment of gender dysphoria, your provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and your provider later modifies the plan.
- **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.
  Note: You must receive genetic counseling and evaluation services before preventive BRCA testing is performed. See page 44.
- **Surgical services** – The surgical services on the following list require prior approval for care performed by Preferred, Participating/Member, and Non-participating/Non-member professional and facility providers:
  - 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 page 64-65.
  - Surgical correction of congenital anomalies (see definition on page 152);
  - Surgery needed to correct accidental injuries (see definition on page 152) to jaws, cheeks, lips, tongue, roof and floor of mouth except when care is provided within 72 hours of the accidental injury
- **Intensity-modulated radiation therapy (IMRT)** – Prior approval is required for all 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.
- **Proton beam therapy, stereotactic radiosurgery, and stereotactic body radiation therapy**
- **Sperm/egg storage** – Prior approval is required for the storage of sperm and eggs for individuals facing iatrogenic infertility.
- **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 page 69 for the list of covered organ/tissue transplants. **Prior approval is required** for both the procedure and the facility. Contact us at the customer service phone 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 pages 70-71 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. Contact your local Plan for Medicare's approved transplant programs.

  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 phone number listed on the back of your ID card.

  The blood or marrow stem cell transplants listed on pages 71-73 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 74** must be performed at a FACT-accredited facility. See page 19 for more information about these types of facilities.

  Not every transplant program 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 phone number listed 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 73-74 for the list of conditions covered **only** in clinical trials. Contact us at the customer service phone 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.

  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 Blue Distinction Center for Transplants to treat your condition. If your physician has recommended you receive a transplant or that you participate in a transplant clinical trial, we encourage you to contact the Case Management Department at your Local Plan.

  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 73) where the procedure is to be performed.
- **Transplant travel –** 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 companions. If the transplant recipient is age 21 or younger, we pay up to $10,000 for eligible travel costs for the member and companions. Reimbursement is subject to IRS regulations.

- **Prescription drugs and supplies – Certain prescription drugs and supplies require prior approval.** Contact CVS Caremark, our Pharmacy Program administrator, at 800-624-5060, TTY: 711, 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 pages 106-107 for more information 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 for a drug requiring prior approval 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 unable to be filled and a letter will be mailed to you explaining the prior approval procedures.

  Note: The Specialty Drug Pharmacy Program will not fill your prescription for a drug requiring prior approval 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 unable to be filled and a letter will be mailed to you explaining the prior approval procedures.
- **Medical foods covered under the pharmacy benefit require prior approval.** See Section 5 (f), page 109, for more information.

- **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 phone 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 70-74) – 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 phone 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 87-88 and 100-101 for additional information.

Note: If we approve the request for prior approval or precertification, you will be provided with a notice that identifies the approved services and the authorization period. You must contact us with a request for a new approval five (5) business days prior to a change to the approved original request, and for requests for an extension beyond the approved authorization period in the notice you received. We will advise you of the information needed to review the request for change and/or extension.

- **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 27.) If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not 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 phone number listed on the back of your Service Benefit Plan ID card. You may also call OPM's FEHB 1 at 202-606-0727 between 8 a.m. and 5 p. m. Eastern Time (excluding holidays) 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 phone 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, 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 phone 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 phone 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* below.

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, your physician or the hospital must contact us for precertification of additional days. Further, if your newborn stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your newborn.

Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **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, 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 152 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 verbal or written requests for appeals and the exchange of information by phone, 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-share/Cost-sharing

Cost-share or 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 $150 (see page 81). 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 83).

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 prior 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. See Section 5(i) for information about the deductible and overseas benefits.

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 or not 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 phone 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 the 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 the bill.

  Remember, under Basic Option, you must use Preferred providers in order to receive benefits. See page 20 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 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 the bill.

  Under Basic Option, there are no benefits for care performed by Participating providers; you pay all charges. See page 20 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 phone 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 156-158). 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 the 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 20 for the exceptions to this requirement.

The following examples 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 39; see page 81 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
Physician's charge: $250
Our allowance: We set it at: 100
We pay: 85% of our allowance: 85
You owe: Coinsurance: 15% of our allowance: 15
You owe: Copayment: Not applicable
+Difference up to charge?: No: 0
TOTAL YOU PAY: $15

Participating Physician Standard Option
Physician's charge: $250
Our allowance: We set it at: 100
We pay: 65% of our allowance: 65
You owe: Coinsurance: 35% of our allowance: 35
You owe: Copayment: Not applicable
+Difference up to charge?: No: 0
TOTAL YOU PAY: $35

Non-participating Physician Standard Option
Physician's charge: $250
Our allowance: We set it at: 100
We pay: 65% of our allowance: 65
You owe: Coinsurance: 35% of our allowance: 35
You owe: Copayment: Not applicable
+Difference up to charge?: Yes: 150
TOTAL YOU PAY: $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.

You should also see section *Important Notice About Surprise Billing – Know Your Rights* on page 32 that describes your protections against surprise billing under the No Surprises Act.

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
Facility's charge: $5,000
Our allowance: We set it at: 2,900
We pay: 85% of our allowance: 2,465
You owe: Coinsurance: 15% of our allowance: 435
You owe: Copayment: Not applicable
+Difference up to charge?: No: 0
TOTAL YOU PAY: $435

Member Ambulatory Surgical Facility Standard Option
Facility's charge: $5,000
Our allowance: We set it at: 2,900
We pay: 65% of our allowance: 1,885
You owe: Coinsurance: 35% of our allowance: 1,015
You owe: Copayment: Not applicable
+Difference up to charge?: No: 0
TOTAL YOU PAY: $1,015

Non-member Ambulatory Surgical Facility* Standard Option
Facility's charge: $5,000
Our allowance: We set it at: 2,500
We pay: 65% of our allowance: 1,625
You owe: Coinsurance: 35% of our allowance: 875
You owe: Copayment: Not applicable
+Difference up to charge?: Yes: 2,500
TOTAL YOU PAY: $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 Surprise Billing — Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" under certain circumstances. A surprise bill is an unexpected bill you receive from a Non-participating healthcare provider, facility, or air ambulance service for healthcare. Surprise bills can happen when you receive emergency care – when you have little or no say in the facility or provider from whom you receive care. They can also happen when you received non-emergency services at participating facilities, but you receive some care from Non-participating providers.

Balance billing happens when you receive a bill from the non-participating provider, facility, or air ambulance service for the difference between the Non-participating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from unexpected bills.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.fepblue.org/NSA or contact the customer service phone number on the back of your ID card.

Your costs for other care

Overseas care. Services provided outside the United States, Puerto Rico, and the U.S. Virgin Islands are considered overseas care. **Under Standard and Basic Options**, we pay overseas claims at Preferred benefit levels. Therefore, the Basic Option requirement to use Preferred providers in order to receive benefits does not apply. See Section 5(i) for specific 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 20 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 healthcare 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 $6,000 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 $12,000 for Preferred provider services. Only eligible expenses for Preferred provider services, and the cost-shares associated with care from Non-participating providers under the NSA (see page 32), 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 $8,000 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 $16,000 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 $6,500 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 $13,000 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 29-30;
- 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 facility;
- 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 20 for the exceptions to the requirement to use Preferred providers.

If your provider's prescription allows for generic substitution and you select a brand-name drug, your expenses for the difference in cost-share do not count toward your catastrophic protection out-of-pocket maximum (see page 103 for additional information).

Carryover

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 above) from that point until the effective date of your new plan.

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

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 prior 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.

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.

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 contract holder.

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.

The Federal Flexible Spending Account Program – FSAFEDS

Healthcare FSA (HCFSA) – Reimburses you for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, 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).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 5. Benefits

See page 15 for how our benefits changed this year. Pages 163-166 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.

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Section 5. Standard and Basic Option Overview

The benefit package for Standard and Basic Options are described in Section 5, which is divided into subsections 5(a) through 5(i). Make sure that you review the benefits that are available under the option in which you are enrolled.

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 phone number on the back of your Service Benefit Plan ID card or on our website at www.fepblue.org. Each option offers unique features. Members do not need to have referrals to see specialists.

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 Retail Pharmacy Program, a Mail Service Prescription Drug Program, and a 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). 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 Retail Pharmacy Program and a 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 Healthcare 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 Get Care*, for information on covered professional providers and other healthcare 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 healthcare 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 or facility bills for the service.
- The services listed in this Section are for the charges billed by a physician or other healthcare 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.
- You should be aware that some Non-preferred (non-PPO) professional providers may provide services in Preferred (PPO) facilities.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 114 for information about Tier 4 and Tier 5 specialty drug fills from Preferred providers and Preferred pharmacies. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731. Basic Option members must use Preferred providers and Preferred pharmacies (see page 104).
- We waive the cost-share for the first 2 visits for telehealth per calendar year. This applies to a combined total for treatment of minor acute conditions, dermatology care, and mental health and substance use disorder conditions. (See pages 39 and 99.)
- **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, neonatologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You may be responsible for any difference between our payment and the billed amount. See page 32, NSA, for information on when you are not responsible for this difference.
- **Under Basic Option,**
  - There is **no calendar year deductible**.
  - **You must use Preferred providers in order to receive benefits. See below and page 20 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, neonatologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You may be responsible for any difference between our payment and the billed amount. See page 32, NSA, for information on when you are not responsible for this difference.

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 healthcare professionals: • Consultations • Genetic counseling • 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) • Phone consultations and online medical evaluation and management services (telemedicine) Note: Please refer to pages 40-42 for our coverage of laboratory, X-ray, and other diagnostic tests billed for by a healthcare professional, and to page 83 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 healthcare 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 healthcare 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 152 for more information about “agents.”) Participating/Non-participating: You pay all charges
Telehealth professional services for: • Minor acute conditions (see page 155 for definition) • Dermatology care (see page 159 for definition) Note: Refer to Section 5(h), *Wellness and Other Special Features*, for information on telehealth services and how to access a provider. Note: Benefits are combined with telehealth services listed in Section 5(e), see page 99. Note: Copayments are waived for members with Medicare Part B primary.	Preferred Telehealth Provider: Nothing (no deductible) for the first 2 visits per calendar year for any covered telehealth service $10 copayment per visit (no deductible) after the 2nd visit Participating/Non-participating: You pay all charges	Preferred Telehealth Provider: Nothing for the first 2 visits per calendar year for any covered telehealth service $15 copayment per visit after the 2nd visit 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	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

Benefit Description	You Pay	
Diagnostic and Treatment Services (cont.)	**Standard Option**	**Basic Option**
• 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
Not covered: • *Routine services except for those Preventive care services described on pages 42-46* • *Costs associated with enabling or maintaining providers' telehealth (telemedicine) technologies, non-interactive telecommunication such as email communications, or asynchronous store-and-forward telehealth 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	**Standard Option**	**Basic Option**
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	Preferred: 15% of the Plan allowance Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 152 for more information about "agents.")

Lab, X-ray and Other Diagnostic Tests - continued on next page

Benefit Description	You Pay	
Lab, X-ray and Other Diagnostic Tests (cont.)	**Standard Option**	**Basic Option**
	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.	Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount, in addition to the Preferred coinsurance listed on the previous page.
Diagnostic tests including but not limited to: • Cardiovascular monitoring • EEGs • Home-based/unattended sleep studies • 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 152 for more information about “agents.”) Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by 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 • Nuclear medicine • Facility-based sleep studies (prior approval required) • 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.	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 152 for more information about “agents.”) Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount in addition to the Preferred copayment listed above.

Lab, X-ray and Other Diagnostic Tests - continued on next page

Benefit Description	You Pay	
Lab, X-ray and Other Diagnostic Tests (cont.)	**Standard Option**	**Basic Option**
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 page 44). Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.	See previous page	See previous page
Preventive Care, Adult	**Standard Option**	**Basic Option**
Benefits are provided for preventive care services for adults age 22 and over. Covered services include: • Counseling on prevention and reducing health risks • Nutritional counseling Note: When nutritional counseling is via the contracted telehealth provider network, we provide benefits as shown here for Preferred providers. Refer to Section 5(h), *Wellness and Other Special Features*, for information on how to access a telehealth provider. • Visits/exams for preventive care Note: See the definition of Preventive Care, Adult, on page 158 for included health screening services. Preventive care benefits for each of the services listed below are limited to one per calendar year. • 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. See Section 5(h) for complete information. • Basic or comprehensive metabolic panel test • CBC • Cervical cancer screening tests - Human papillomavirus (HPV) tests of cervix - Pap tests of the cervix • Colorectal cancer tests, including: - Colonoscopy, with or without biopsy (see page 63 for our payment levels for diagnostic colonoscopies) - CT colonography - DNA analysis of stool samples - Double contrast barium enema - Fecal occult blood test - Sigmoidoscopy	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. 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.	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 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

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
• Fasting lipoprotein profile (total cholesterol, LDL, HDL, and/or triglycerides) • General health panel • Prostate cancer test – Prostate Specific Antigen (PSA) • Screening for chlamydial infection • Screening for diabetes mellitus • Screening for gonorrhea infection • Screening for human immunodeficiency virus (HIV) • Screening mammograms, including mammography using digital technology • Ultrasound for abdominal aortic aneurysm for adults, ages 65 to 75, limited to one screening per lifetime • Urinalysis The following preventive services are covered at the time intervals recommended at each of the links below. • Immunizations such as COVID-19, Pneumococcal, influenza, shingles, tetanus/DTaP and human papillomavirus (HPV). For a complete list of immunizations, go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules. 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. • USPSTF A and B recommended screenings such as cancer, osteoporosis, depression, and high blood pressure. For a complete list of covered A and B recommendation screenings and age and frequency limitations, go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org. • Well woman care such as gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of Well Women preventive care services, go to the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/. • To build your personalized list of preventive services go to https://health.gov/myhealthfinder.	Continued from previous page: Note: Many Preferred retail pharmacies participate in our vaccine network. See page 111 for our coverage of these vaccines when provided by pharmacies in the vaccine network.	Continued from previous page: 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: Many Preferred retail pharmacies participate in our vaccine network. See page 111 for our coverage of these vaccines when provided by pharmacies in the vaccine network.

Preventive Care, Adult - continued on next page

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
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. If you receive both preventive and diagnostic services from your Provider on the same day, you are responsible for paying your cost-share for the diagnostic services. Note: See page 112 for our payment levels for medications to promote better health as recommended under the Affordable Care Act. Note: See page 113 for our payment levels for certain bowel preparation medications, and antiretroviral medications for the prevention of HIV. Note: Unless otherwise noted, the benefits listed above and on pages 42-43 do not apply to children up to age 22. (See benefits under *Preventive Care, Child*, this Section.)	See previous page	See previous page
Hereditary Breast and Ovarian Cancer Screening Benefits are available for screening members, age 18 and over (including children ages 18 – 21) limited to one of each type of test per lifetime, 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 and additional BRCA coverage or call the phone number on the back of your ID card for additional policy information. Note: See page 63 for the benefits available for the surgical removal of breast, ovaries, or prostate when screening reveals a BRCA mutation; preventive care benefits are not available.	See page 42	See page 42

Preventive Care, Adult - continued on next page

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance and deductible.	See page 42	See page 42
Not covered: • *Genetic testing related to family history of cancer or other disease, except as described on page 44* *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* • *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* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure. Medical benefits may be available for these services.* • *Phone consultations and online medical evaluation and management services (telemedicine) for preventive services, except as noted on page 42 for nutritional counseling.*	*All charges*	*All charges*
Preventive Care, Child	**Standard Option**	**Basic Option**
Benefits are provided for preventive care services for children up to age 22. This includes: • Well-child visits, examinations, and other preventive services described in the Bright Future Guidelines as provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Future Guidelines, go to https://brightfutures.aap.org. • Immunizations such as DTaP, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations, go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html. Note: U.S. FDA licensure may restrict the use of the immunizations and vaccines listed above to specific age ranges, frequencies, and/or other patient-specific indications, including gender. • To build your personalized list of preventive services, go to https://health.gov/myhealthfinder.	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 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.

Preventive Care, Child - continued on next page

Benefit Description	You Pay	
Preventive Care, Child (cont.)	**Standard Option**	**Basic Option**
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 • Cervical cancer screening tests - Pap tests of the cervix - Human papillomavirus (HPV) tests of the cervix Note: See page 44 for covered BRCA testing. • Screening for human immunodeficiency virus (HIV) infection • Screening for syphilis infection • Screening for latent tuberculosis infection for children ages 18 through 21 • Nutritional counseling 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. Note: When nutritional counseling is via the contracted telehealth provider network, we provide benefits as shown here for Preferred providers. Refer to Section 5(h), *Wellness and Other Special Features*, for information on how to access a telehealth provider. Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: See page 112 for our payment levels for medications to promote better health as recommended under the Affordable Care Act.	Continued from previous page: 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.	Continued from previous page: 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.
Not covered: • *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* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel* • *Immunizations, boosters, and medications for travel or work-related exposure. Medical benefits may be available for these services.*	*All charges*	*All charges*

Preventive Care, Child - continued on next page

Benefit Description	You Pay	
Preventive Care, Child (cont.)	**Standard Option**	**Basic Option**
• *Phone consultations and online medical evaluation and management services (telemedicine) for preventive services, except as noted above for nutritional counseling.*	*All charges*	*All charges*
Maternity Care	**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 or during a covered observation stay • Breastfeeding education and individual coaching on breastfeeding by healthcare providers such as physicians, physician assistants, midwives, nurse practitioners/clinical specialists, and lactation consultants Note: See page 48 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 8 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 42 for our coverage of nutritional counseling. Note: Benefits for home nursing visits (skilled) related to covered maternity care are subject to the visit limitations described on page 59. Note: Maternity care benefits are not provided for prescription drugs required during pregnancy, except as recommended under the Affordable Care Act. See page 112 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 phone 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 $250 per admission. For outpatient facility services related to maternity, see the notes on pages 82-85. Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by 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

Benefit Description	You Pay	
Maternity Care (cont.)	**Standard Option**	**Basic Option**
Note: Here are some things to keep in mind: • You do not need to precertify your delivery; see page 26 for other circumstances, such as extended stays for you or your newborn. • You may remain in the hospital up to 48 hours after a vaginal 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 when performed during the covered portion of the mother's maternity stay and billed by the facility. We cover other care of a newborn who requires professional services or non-routine treatment, only if we cover the newborn under a Self Plus One or Self and Family enrollment. Surgical benefits apply to circumcision when billed by a professional provider for a male newborn. • Hospital services are listed in Section 5(c) and Surgical benefits are in Section 5(b). Note: See page 156 for our payment for inpatient stays resulting from an emergency delivery at a hospital or other facility not contracted with your Local Plan. Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in their own right. Regular medical or surgical benefits apply rather than maternity benefits. See page 63 for our payment levels for circumcision.	See previous page	See previous page
• Breast pump, limited to one per calendar year for members who are pregnant and/or nursing • Blood pressure monitor, limited to one every two years Note: Benefits for the breast pump, milk storage bags, and blood pressure monitors are only available when you order them through our fulfillment vendor by visiting www.fepblue.org/maternity or calling 1-800-411-2583. Milk storage bags will be included with your breast pump.	Nothing (no deductible)	Nothing
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* • *Doula, birth companion, and similar supporter* • *Breast pumps and milk storage bags except as stated on the previous page*	*All charges*	*All charges*

Maternity Care - continued on next page

Benefit Description	You Pay	
Maternity Care (cont.)	**Standard Option**	**Basic Option**
• *Breastfeeding supplies other than those contained in the breast pump kit described on the previous page including clothing (e.g., nursing bras), baby bottles, or items for personal comfort or convenience (e.g., nursing pads)* • *Tocolytic therapy and related services except as described on page 47* • *Maternity care for members not enrolled in the Service Benefit Plan*	*All charges*	*All charges*
Family Planning	**Standard Option**	**Basic Option**
A range of voluntary family planning services for women, limited to: • Contraceptive counseling • Diaphragms and contraceptive rings • Injectable contraceptives • Intrauterine devices (IUDs) • Implantable contraceptives • Tubal ligation or tubal occlusion/tubal blocking procedures only Family planning services for men, limited to: • Vasectomy Note: We also provide benefits for professional services associated with tubal ligation/occlusion/blocking procedures, vasectomy, 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
• 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 110 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*

Benefit Description	You Pay	
Reproductive Services	**Standard Option**	**Basic Option**
Diagnosis and treatment of infertility including covered: • Diagnostic and treatment services • Laboratory tests • Diagnostic tests • Surgical procedures • Prescription drugs Note: We cover one year of sperm and egg storage for individuals facing iatrogenic infertility, once per lifetime. We provide the benefits seen here when billed by a facility. See page 22 for prior approval requirements. See Section 10 for our definition of iatrogenic infertility. Note: See Section 5(a) for covered labs, diagnostic tests, and X-rays. Note: See Section 5(b) for covered surgical services. Note: See Section 5(f) for covered prescription drugs. Note: See below for a list of services not covered as treatments for infertility or as alternatives to conventional conception.	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 healthcare professional: $30 copayment per visit Preferred specialist: $40 copayment per visit Note: You pay 30% of the Plan allowance for sperm and egg storage, agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 152 for more information about “agents.”) Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.
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) and 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 except as described above* • *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*

Benefit Description	You Pay	
Allergy Care	**Standard Option**	**Basic Option**
• Allergy testing • Allergy treatment • Sublingual allergy desensitization drugs as licensed by the U.S. FDA 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 healthcare 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 152 for more information about “agents.”) Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by 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 healthcare 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 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*

Benefit Description	You Pay	
Treatment Therapies	**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 21-24). Note: **You must get prior approval for certain radiation therapy treatments.** Please refer to page 22 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 59. • Outpatient cardiac rehabilitation • Pulmonary rehabilitation therapy • Applied behavior analysis (ABA) for the treatment of an autism spectrum disorder (see prior approval requirements on page 22) Note: See Section 5(c) for our payment levels for treatment therapies billed for by the outpatient department of a hospital. Note: See page 60 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 healthcare 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 152 for more information about “agents.”) Participating/Non-participating: You pay all charges
• Auto-immune infusion medications: Remicade, Renflexis and Inflectra Note: See above for your costs for intravenous (IV)/ infusion therapy - Home IV or infusion therapy.	Preferred: 10% 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 billed amount	Preferred: 15% of the Plan allowance Participating/Non-participating: You pay all charges

Treatment Therapies - continued on next page

Benefit Description	You Pay	
Treatment Therapies (cont.)	**Standard Option**	**Basic Option**
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 21-24). • 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.) • Applied behavior analysis (ABA) for the treatment of an autism spectrum disorder (see prior approval requirements on page 22)	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 Rehabilitation Therapy	**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 healthcare 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.	Preferred primary care provider or other healthcare 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 152 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.

Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Rehabilitation Therapy - continued on next page

Benefit Description	You Pay	
Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Rehabilitation Therapy (cont.)	**Standard Option**	**Basic Option**
	Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown on page 53, according to the contracting status of the facility.	
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* • *Equine therapy and hippotherapy (exercise on horseback)* • *Massage therapy*	*All charges*	*All charges*
Hearing Services (Testing, Treatment, and Supplies)	**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 57.	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 healthcare 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 152 for more information about “agents.”) Participating/Non-participating: You pay all charges
Not covered: • *Routine hearing tests (except as indicated on page 45)* • *Hearing aids (except as described on page 57)*	*All charges*	*All charges*
Vision Services (Testing, Treatment, and Supplies)	**Standard Option**	**Basic Option**
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;	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies)	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges

Vision Services (Testing, Treatment, and Supplies) - continued on next page

Benefit Description	You Pay	
Vision Services (Testing, Treatment, and Supplies) (cont.)	**Standard Option**	**Basic Option**
• For the nonsurgical treatment for amblyopia and strabismus, for children from birth through age 21 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 and on page 54.	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
• Eye examinations related to a specific medical condition • Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 21 Note: See above and on page 54 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 40-42 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 above.	Preferred primary care provider or other healthcare 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 healthcare 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 152 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 above and on page 54* • *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 above*	*All charges*	*All charges*

Benefit Description	You Pay	
Foot Care	**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 healthcare 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 healthcare 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 152 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	**Standard Option**	**Basic Option**
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 limited to treatment of erectile dysfunction or as part of an approved plan for gender affirming surgery • Surgical implants 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

Benefit Description	You Pay	
Orthopedic and Prosthetic Devices (cont.)	**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 5 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, 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* • *Over the counter hearing aids, enhancement devices, accessories or supplies (including remote controls and warranty packages)*	*All charges*	*All charges*
Durable Medical Equipment (DME)	**Standard Option**	**Basic Option**
Durable medical equipment (DME) is equipment and supplies that are: 1. Prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Medically necessary; 3. Primarily and customarily used only for a medical purpose; 4. Generally useful only to a person with an illness or injury; 5. Designed for prolonged use; and 6. Used to 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	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.

Durable Medical Equipment (DME) - continued on next page

Benefit Description	You Pay	
Durable Medical Equipment (DME) (cont.)	**Standard Option**	**Basic Option**
• 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
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 48* • *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 above)* • *Equipment for cosmetic purposes* • *Topical Hyperbaric Oxygen Therapy (THBO)* • *Charges associated with separate or extended warranties*	*All charges*	*All charges*
Medical Supplies	**Standard Option**	**Basic Option**
• Medical foods and nutritional supplements when administered by catheter or nasogastric tubes Note: See Section 10, *Definitions*, for more information about medical foods. • Ostomy and catheter supplies	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

Medical Supplies - continued on next page

Benefit Description	You Pay	
Medical Supplies (cont.)	**Standard Option**	**Basic Option**
• 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* • *Medical foods administered orally, except as described in Section 5(f)*	*All charges*	*All charges*
Home Health Services	**Standard Option**	**Basic Option**
Home nursing care (skilled) 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 152 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*	*All charges*	*All charges*

Home Health Services - continued on next page

Benefit Description	You Pay	
Home Health Services (cont.)	**Standard Option**	**Basic Option**
• *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 pages 88-89.* • *Private duty nursing*	*All charges*	*All charges*
Manipulative Treatment	**Standard Option**	**Basic Option**
Manipulative treatment performed by a professional provider, 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. 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: $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	**Standard Option**	**Basic Option**
Acupuncture Note: Acupuncture must be performed and billed by a healthcare 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 17 for more information. Note: When billed by a facility such as the outpatient department of a hospital, you are limited to the number of visits per calendar year listed on this page. See Section 5(c) for your cost-share. Note: See page 77 for our coverage of acupuncture when provided as anesthesia for covered surgery. Note: See page 47 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 healthcare professional: $30 copayment per visit Preferred specialist: $40 copayment per visit Note: Benefits for acupuncture are limited to 12 visits per calendar year. Note: You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges

Alternative Treatments - continued on next page

Benefit Description	You Pay	
Alternative Treatments (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Biofeedback* • *Self-care or self-help training*	*All charges*	*All charges*
Educational Classes and Programs	**Standard Option**	**Basic Option**
• Smoking and tobacco cessation treatment - Counseling for smoking and tobacco cessation - 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 40, 42 and 46 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 healthcare 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, or applied behavior analysis (ABA), when performed as part of an educational class or program* • *Premenstrual syndrome (PMS), lactation (except as described on page 47), headache, eating disorder (except as described on pages 40 and 42), 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*	*All charges*	*All charges*

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare 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 healthcare 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 healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e., hospital, surgical center, etc.).
- **YOU MUST GET PRIOR APPROVAL for the following surgical services: surgery for morbid obesity; surgical correction of congenital anomalies; and surgery needed to correct accidental injuries (see *Definitions*, page 152) to jaws, cheeks, lips, tongue, roof and floor of mouth, except when care is provided within 72 hours of the accidental injury. Please refer to page 22 for more information.**
- **YOU MUST GET PRIOR APPROVAL for all organ transplant surgical procedures (except corneal 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.**
- **YOU MUST GET PRIOR APPROVAL for gender affirming surgery. Prior to any gender affirming surgery, your provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and your provider later modifies the plan (including changes to the procedures to be performed or the anticipated dates for the procedures). See page 22 and page 66 for additional information. If your surgical procedure requires an inpatient admission, YOU MUST ALSO GET PRECERTIFICATION of the inpatient care.**
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 114 for information about Tier 4 and Tier 5 specialty drug fills from Preferred providers and Preferred pharmacies. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731. Basic Option members must use Preferred providers and Preferred pharmacies (see page 104).
- **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, neonatologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You may be responsible for any difference between our payment and the billed amount. See page 32, NSA, for information on when you are not responsible for this difference.
  - 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 20 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, neonatologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You may be responsible for any difference between our payment and the billed amount. See page 32, NSA, for information on when you are not responsible for this difference.

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 • Assistant surgeons/surgical assistance if required because of the complexity of the surgical 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 42). 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 66) • 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.	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 152 for more information about "agents.") Participating/Non-participating: You pay all charges

Surgical Procedures - continued on next page

Benefit Description	You Pay	
Surgical Procedures (cont.)	**Standard Option**	**Basic Option**
• **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 16 or over. Benefits are available only for the following procedures: - Roux-en-Y gastric bypass - Laparoscopic adjustable gastric banding - Sleeve gastrectomy - Biliopancreatic bypass with duodenal switch **Note: Benefits for the surgical treatment of morbid obesity are subject to the requirements listed on pages 64-65.** 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 86-87 for information. Note: **Prior approval is required for 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 above) for a period of 1 year 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 pages 42 and 46 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 use disorder for 1 year prior to surgery and there is no evidence of substance use disorder during the 1-year period prior to surgery	See page 63	See page 63

Surgical Procedures - continued on next page

Benefit Description	You Pay	
Surgical Procedures (cont.)	**Standard Option**	**Basic Option**
• 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, except when the subsequent surgery is necessary to treat a complication from the prior morbid obesity surgery. - 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 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.	See page 63	See page 63
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 sexual inadequacy (except surgical placement of penile prostheses to treat erectile dysfunction and gender affirming surgeries specifically listed as covered)* • *Reversal of gender affirming surgery*	*All charges*	*All charges*

Benefit Description	You Pay	
Reconstructive Surgery	**Standard Option**	**Basic Option**
• Surgery to correct a functional defect • Surgery to correct a congenital anomaly (See Section 10, page 152, for definition.) • 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 152 for more information about "agents.") Participating/Non-participating: You pay all charges
• **Gender affirming surgical benefits** are limited to the following: - For female to male surgery: mastectomy (including nipple reconstruction), hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty, electrolysis (hair removal at the covered operative site), and placement of testicular and erectile prosthesis - For male to female surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, labiaplasty, and electrolysis (hair removal at the covered operative site) **Note: Prior approval is required for gender affirming surgery.** For more information about prior approval, please refer to page 22.	See above	See above

Reconstructive Surgery - continued on next page

Benefit Description	You Pay	
Reconstructive Surgery (cont.)	**Standard Option**	**Basic Option**
Note: Benefits for gender affirming surgery are limited to once per covered procedure, per lifetime. Benefits are not available for repeat or revision procedures when benefits were provided for the initial procedure. Benefits are not available for gender affirming surgery for any condition other than gender dysphoria. • Gender affirming surgery on an inpatient or outpatient basis is subject to the pre-surgical requirements listed below. **The member must meet all requirements**. - **Prior approval is obtained** - **Member must be at least 18 years of age at the time prior approval is requested and the treatment plan is submitted** - Diagnosis of gender dysphoria by a qualified healthcare professional • New gender identity has been present for at least 24 continuous months • Member has a strong desire to be rid of primary and/or secondary sex characteristics because of a marked incongruence with the member's identified gender • Member's gender dysphoria is not a symptom of another mental disorder or chromosomal abnormality • Gender dysphoria causes clinical distress or impairment in social, occupational, or other important areas of functioning - Member must meet the following criteria: • Living 12 months of continuous, full-time, real-life experience in the desired gender (including place of employment, family, social and community activities) • 12 months of continuous hormone therapy appropriate to the member's gender identity (not required for mastectomy) • Two referral letters from qualified mental health professionals – one must be from a psychotherapist who has treated the member for a minimum of 12 months. Letters must document: diagnosis of persistent and chronic gender dysphoria; any existing co-morbid conditions are stable; member is prepared to undergo surgery and understands all practical aspects of the planned surgery (one referral letter required for mastectomy) • If medical or mental health concerns are present, they are being optimally managed and are reasonably well-controlled	See page 66	See page 66

Reconstructive Surgery - continued on next page

Benefit Description	You Pay	
Reconstructive Surgery (cont.)	**Standard Option**	**Basic Option**
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 sexual dysfunction or sexual inadequacy (except surgical placement of penile prostheses to treat erectile dysfunction)* • *Reversal of gender affirming surgery*	*All charges*	*All charges*
Oral and Maxillofacial Surgery	**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: **Prior approval is required for oral/maxillofacial surgery needed to correct accidental injuries as described above, except when care is provided within 72 hours of the accidental injury.** 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 phone 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 152 for more information about "agents.") Participating/Non-participating: You pay all charges

Oral and Maxillofacial Surgery - continued on next page

Benefit Description	You Pay	
Oral and Maxillofacial Surgery (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Oral implants and transplants except for those required to treat accidental injuries as specifically described on page 68 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 on page 68 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 on page 68 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 on page 68 and in Section 5(g)*	*All charges*	*All charges*

Organ/Tissue Transplants

Prior approval requirements:

You must obtain prior approval (see page 23) from the Local Plan, for both the procedure and the facility, for the transplant procedures listed below. Prior approval is not required for transplants of corneal tissue.

- Blood or marrow stem cell transplant procedures (Note: Pages 73-74 have **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)
- Kidney
- Liver transplant
- Lung (single, double, or lobar) transplant
- Pancreas transplant

Note: Refer to pages 21-22 for information about precertification of inpatient care.

Covered organ/tissue transplants are listed on pages 70-71. 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. Contact your local Plan for Medicare's approved transplant programs.

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 phone number on the back of your ID card.

Blood or marrow stem cell transplants are covered as shown on pages 71-75. 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 71-75, the medical necessity limitation is considered satisfied if the patient meets the staging description.

The blood or marrow stem cell transplants listed on pages 71-73 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 74** must be performed at a FACT-accredited facility. See page 19 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 phone number listed 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 71-72 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 73-74 for information about **blood or marrow stem cell transplants covered only in clinical trials** and the **additional requirements** that apply.

Note: See page 145 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 76 for more information).

Benefit Description	You Pay	
Organ/Tissue Transplants	**Standard Option**	**Basic Option**
• Transplants of corneal tissue • Heart transplant • Heart-lung transplant • Kidney transplant • Liver transplant • Pancreas transplant • Combination liver-kidney transplant • Combination pancreas-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	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 corneal 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.

Organ/Tissue Transplants - continued on next page

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
• 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 pages 69-70 for the prior approval and facility requirements that apply to **organ/tissue transplants**.	See previous page	Continued from previous page: 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 for the diagnoses as indicated below: • 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, Hurler's syndrome and Maroteaux-Lamy syndrome variants) • 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)	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

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
• Primary immunodeficiencies (e.g., severe combined immunodeficiency, Wiskott-Aldrich syndrome, hemophagocytic lymphohistiocytosis, X-linked lymphoproliferative syndrome, Kostmann's syndrome, leukocyte adhesion deficiencies) Note: See pages 69-70 for the prior approval and facility requirements that apply to **blood or marrow stem cell transplants**. Note: Refer to pages 73-75 for information about **blood or marrow stem cell transplants covered only in clinical trials**.	See previous page	See previous page
Autologous blood or marrow stem cell transplants for the diagnoses as indicated below: • 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) • Scleroderma Note: See pages 69-70 for the prior approval and facility requirements that apply to **blood or marrow stem cell transplants.** Note: Refer to pages 73-75 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

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
Blood or marrow stem cell transplants for the diagnoses as indicated below, **only** when performed as part of a clinical trial that meets the facility criteria described on page 69 and the **requirements** listed on page 74: • Allogeneic blood or marrow stem cell transplants for: - Breast cancer - Colon cancer - Epidermolysis bullosa - Glial tumors (e.g., anaplastic astrocytoma, choroid plexus tumors, ependymoma, glioblastoma multiforme) - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Retinoblastoma - Rhabdomyosarcoma - Sarcoma - Wilm's tumor • Autologous blood or marrow stem cell transplants for: - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - 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 74 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

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
Blood or marrow stem cell transplants for the diagnoses as indicated below, **only** when performed at a FACT-accredited facility (see page 19) as part of a **clinical trial** that meets the **requirements** listed below: • Allogeneic blood or marrow stem cell transplants for: - Autoimmune disease (limited to: multiple sclerosis, scleroderma, systemic lupus erythematosus and chronic inflammatory demyelinating polyneuropathy) • Autologous blood or marrow stem cell transplants for: - Autoimmune disease (limited to: multiple sclerosis, systemic lupus erythematosus and 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 phone 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 73, 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.	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

Benefit Description	You Pay	
Organ/Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
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 145 for our coverage of other costs associated with clinical trials.	See previous page	See previous page
Related transplant services: • Extraction or reinfusion of blood or marrow stem cells as part of a covered allogeneic or autologous 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 71-74 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 71-74 • Covered medical and hospital expenses of the donor, when we cover the recipient • Covered services or supplies provided to the recipient • Donor screening tests for 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 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 $250 per day copayment ($1,500 maximum) under Basic Option, for the transplant period. See page 159 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 phone 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)
- Kidney (adult and pediatric)
- Liver (adult and pediatric liver alone; adult only for combination liver-kidney)
- Single or double lung (adult only)
- Blood or marrow stem cell transplants (adult and pediatric) listed on pages 71-74
- Related transplant services listed on page 75

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 companions. If the transplant recipient is age 21 or younger, we pay up to $10,000 for eligible travel costs for the member and companions. Reimbursement is subject to IRS regulations.

Note: You must obtain prior approval for travel benefits (see page 23).

Note: Benefits for cornea, intestinal, pancreas, pediatric lung, and heart-lung transplants are not available through Blue Distinction Centers for Transplants. See pages 70-71 for benefit information for these transplants.

Note: See Section 5(c) for our benefits for facility care.

Note: See pages 70-76 for requirements related to blood or marrow stem cell transplant coverage.

Benefit Description	You Pay	
Organ/Tissue Transplants	**Standard Option**	**Basic Option**
Not covered: • *Any transplant not listed as covered and transplants for any diagnosis not listed as covered* • *Donor screening tests and donor search expenses, including associated travel expenses, except as defined on page 75* • *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 pages 70-71* • *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*

Benefit Description	You Pay	
Anesthesia	**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: Anesthesia acupuncture services do not accumulate toward the member's annual maximum. 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
Not covered: • *Anesthesia related to noncovered surgeries or procedures*	*All charges*	*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 AND SKILLED NURSING FACILITY 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 82. See page 155 for more information about these types of services.
- **YOU MUST GET PRIOR APPROVAL for the following services: facility-based sleep studies; surgery for morbid obesity; surgical correction of congenital anomalies; and surgery needed to correct accidental injuries (see *Definitions*, page 152) to jaws, cheeks, lips, tongue, roof and floor of mouth, except when care is provided within 72 hours of the accidental injury. Please refer to page 22 for more information.**
- **YOU MUST GET PRIOR APPROVAL for gender affirming surgery. See page 22 for prior approval and pages 66-67 for the surgical benefit.**
- You should be aware that some Non-preferred (non-PPO) professional providers may provide services in Preferred (PPO) facilities.
- We base payment on whether a facility or a healthcare 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 or facility bills for the service.
- 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.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage. See page 114 for information about Tier 4 and Tier 5 specialty drug fills from Preferred providers and Preferred pharmacies. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731. Basic Option members must use Preferred providers and Preferred pharmacies (see page 104).
- **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 20 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 pages 155-157 for more information. See pages 87-88 and 100-101 for inpatient residential treatment center. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • 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	Preferred facilities: $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 facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: $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 $350 per admission copayment for unlimited days and we then provide benefits at 100% of the Plan allowance.	Preferred facilities: $250 per day copayment up to $1,500 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 $250 per admission. Member/Non-member facilities: You pay all charges

Inpatient Hospital - continued on next page

Benefit Description	You Pay	
Inpatient Hospital (cont.)	**Standard Option**	**Basic Option**
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 82. See page 155 for more information about these types of services. Note: Here are some things to keep in mind: • You do not need to precertify your delivery; see page 26 for other circumstances, such as extended stays for you or your newborn. • 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 page 26 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 47-48 for other covered maternity services. Note: See page 59 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 pages 86-87 for information.	See previous page	See previous page
Not covered: • *Admission to noncovered facilities, such as nursing homes, extended care facilities, schools, or residential treatment centers (except as described on pages 87-88 and 100-101)* • *Personal comfort items, such as guest meals and beds, phone, television, beauty and barber services* • *Private duty nursing* • *Facility room and board expenses when, in our judgment, an 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*	*All charges*	*All charges*

Inpatient Hospital - continued on next page

Benefit Description	You Pay	
Inpatient Hospital (cont.)	**Standard Option**	**Basic Option**
• *Care that is 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.* - *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 an inpatient 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 18-19).*	*All charges*	*All charges*
Outpatient Hospital or Ambulatory Surgical Center	**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 • Acupuncture • 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 42). 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	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 facilities: $150 copayment per day per facility (except as noted below) Note: You may be responsible for paying a $200 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 152 for more information about "agents.") Member/Non-member facilities: You pay all charges

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**Standard Option**	**Basic Option**
• 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 Notes: • See pages 95-97 for our payment levels for care related to a medical emergency or accidental injury. • See page 49 for our coverage of family planning services. • For our coverage of hospital-based clinic visits, please refer to the professional benefits described on pages 39-40 and page 55 for vision services. • 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 86-87 for information. • 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 47-49 for other included maternity services. • See page 85 for outpatient drugs, medical devices, and durable medical equipment billed for by a facility. • 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.	See previous page	See previous page
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.	Preferred facilities: $350 copayment for the duration of services (no deductible) Member facilities: $450 copayment for the duration of services, plus 35% of the Plan allowance (no deductible)	Preferred facilities: $250 per day copayment up to $1,500 Member/Non-member facilities: You pay all charges

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**Standard Option**	**Basic Option**
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.	Continued from previous page: Non-member facilities: $450 copayment for the duration of services, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	See previous page
Outpatient **diagnostic testing and treatment services** performed and billed by a facility, limited to: • Angiographies • Bone density tests • CT scans/MRIs/PET scans • Nuclear medicine • Facility-based sleep studies (prior approval is required) • 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.	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 facilities: $200 copayment per day per facility Member facilities: $200 copayment per day per facility Non-member facilities: $200 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 152 for more information about “agents.”)
Outpatient **diagnostic testing services** performed and billed by a facility, such as: • Cardiovascular monitoring • EEGs • Home-based/unattended sleep studies • 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 facilities: $40 copayment per day per facility Member facilities: $40 copayment per day per facility Non-member facilities: $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 152 for more information about “agents.”)

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**Standard Option**	**Basic Option**
Outpatient **treatment and therapy services** performed and billed by a facility, limited to: • Cognitive rehabilitation therapy • Physical, occupational, and speech therapy - Standard Option benefits are limited to a combined total of 75 visits per person per calendar year - Basic Option benefits are limited to a combined total of 50 visits per person per calendar year • Manipulative treatment services - Standard Option benefits are limited to a combined total of 12 visits per person per calendar year - Basic Option benefits are limited to a combined total of 20 visits per person per calendar year	Preferred facilities: $25 copayment per day per facility (no deductible) 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 facilities: $30 copayment per day per facility Member/Non-member facilities: You pay all charges Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 152 for more information about “agents.”)
Outpatient **treatment services** performed and billed by a facility, limited to: • Cardiac rehabilitation • Pulmonary rehabilitation • Applied behavior analysis (ABA) for an autism spectrum disorder (see prior approval requirements on page 22)	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 facilities: $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 152 for more information about “agents.”) Member/Non-member facilities: You pay all charges

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**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 facilities: 15% of the Plan allowance Member facilities: 15% of the Plan allowance Non-member facilities: 15% of the Plan allowance plus 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 152 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 42-45 • Cancer screenings listed on pages 42-43 and ultrasound screening for abdominal aortic aneurysm Note: See page 44 for our coverage requirements for preventive BRCA testing. Note: See pages 45-46 for our payment levels for covered preventive care services for children billed for by facilities and performed on an outpatient basis.	See page 42 for our payment levels for covered preventive care services for adults	Preferred facilities: Nothing Member/Non-member facilities: 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 • Surgical implants 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 facilities: 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 81-84 for specific coverage information. Member/Non-member facilities: You pay all charges

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**Standard Option**	**Basic Option**
Note: Certain self-injectable drugs are covered only when dispensed by a pharmacy under the pharmacy benefit. These drugs will be covered once per lifetime per therapeutic category of drugs when dispensed by a non-pharmacy-benefit provider. This benefit limitation does not apply if you have primary Medicare Part B coverage.	See previous page	See previous page
Blue Distinction® Specialty Care	**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 Knee and Hip Replacement, Blue Distinction Center for Spine Surgery, or Blue Distinction Center for Comprehensive Bariatric Surgery. • Bariatric surgeries covered are: - Roux-en-Y gastric bypass - Laparoscopic adjustable gastric banding - Sleeve gastrectomy - Biliopancreatic bypass with duodenal switch • 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 phone 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 78-80 for regular inpatient hospital benefits and pages 81-85 for outpatient facility benefit levels. Note: See pages 18-19 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

Blue Distinction® Specialty Care - continued on next page

Benefit Description	You Pay	
Blue Distinction® Specialty Care (cont.)	**Standard Option**	**Basic Option**
Outpatient facility services related to specific covered bariatric surgical procedures, when the surgery is performed at a designated Blue Distinction Center for Bariatric Surgery. Outpatient facility services related to specific covered hip and knee replacement or revision surgeries and certain spine surgery procedures, when performed at a designated Blue Distinction Center for hip/knee/spine surgery. Note: You must meet the pre-surgical requirements listed on pages 64-65 for bariatric surgeries. Note: 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 phone 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 benefits do not apply to other types of outpatient surgical services, even when performed at a Blue Distinction Center. See pages 81-82 for the benefits we provide. Note: See pages 18-19 for more information about Blue Distinction Centers.	Blue Distinction Center: $100 per day per facility (no deductible)	Blue Distinction Center: $25 per day per facility
Residential Treatment Center	**Standard Option**	**Basic Option**
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 use disorder: • 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.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: 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 facilities: $250 per day copayment up to $1,500 per admission for unlimited days Member/Non-member facilities: You pay all charges

Residential Treatment Center - continued on next page

Benefit Description	You Pay	
Residential Treatment Center (cont.)	**Standard Option**	**Basic Option**
Note: Benefits are not available for noncovered services, including: respite care; outdoor residential programs; services provided outside of the provider's scope of licensure; recreational therapy; educational therapy; educational classes; biofeedback; Outward Bound programs; equine/hippotherapy provided during the approved stay; personal comfort items, such as guest meals and beds, phone, 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. Note: For outpatient residential treatment center services, see page 101.	See previous page	See previous page
Extended Care Benefits/Skilled Nursing Care Facility Benefits	**Standard Option**	**Basic Option**
When Medicare Part A is not your primary payor: For members who do not have Medicare Part A, we cover skilled nursing facility (SNF) inpatient care for a maximum of 30 days annually, when the member can be expected to benefit from short-term SNF services with a goal of returning home. The following criteria must also be met: • Member is enrolled in case management prior to admission to the SNF (signed consent required), and actively participates in case management both prior to and during admission to the SNF. • Precertification is obtained prior to admission (including overseas care). • We approve the preliminary treatment plan prior to admission (plan must include proposed therapies and document the need for inpatient care). • Member participates in all treatment and care planning activities, including discharge planning/transition to home. Benefits are not available for inpatient SNF care solely for management of tube feedings, for home level dialysis treatment, as an interim transition to long-term care placement, or for any other noncovered services. Note: No inpatient benefits (such as room and board) will be provided if precertification is not obtained prior to admission (see page 21). Members are responsible for enrolling in case management (see page 21).	Preferred facilities: $175 (no deductible) per admission Member facilities: $275 plus 35% of the Plan allowance (no deductible) per admission Non-member facilities: $275 plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment, per admission	All charges

Extended Care Benefits/Skilled Nursing Care Facility Benefits - continued on next page

Benefit Description	You Pay	
Extended Care Benefits/Skilled Nursing Care Facility Benefits (cont.)	**Standard Option**	**Basic Option**
When Medicare Part A is your primary payor: When Medicare Part A is the primary payor (meaning it pays first) and has made a 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. Note: See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c03.pdf for complete Medicare benefit period definition. 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 84 for benefits provided for outpatient physical, occupational, speech, and cognitive rehabilitation therapy, and manipulative treatment services when billed by a skilled nursing facility. See Section 5(f) for benefits for prescription drugs. ***Note: If Medicare Part A is your primary payor, we will only provide benefits if Medicare provided benefits for the admission.***	Preferred facilities: Nothing (no deductible) Member facilities: Nothing (no deductible) Non-member facilities: Nothing (no deductible) Note: You pay all charges not paid by Medicare after the 30th day.	All charges
Not covered: *Phone, television, personal comfort items, such as guest meals and beds, beauty and barber services, recreational outings/trips, stretcher or wheelchair transportation, non-emergent 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, custodial or long term-care (see* Definitions*), and domiciliary care provided because care in the home is not available or is unsuitable*	*All charges*	*All charges*
Hospice Care	**Standard Option**	**Basic Option**
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 pages 90-92.	See pages 90-92.

Hospice Care - continued on next page

Benefit Description	You Pay	
Hospice Care (cont.)	**Standard Option**	**Basic Option**
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 **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 page 22 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 on this page and on pages 91-92. **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.**	Nothing (no deductible)	Nothing
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: • Advanced care planning (see Section 10, page 152) • Dietary counseling • Durable medical equipment rental • Medical social services • Medical supplies • Nursing care	See next page	See next page

Hospice Care - continued on next page

Benefit Description	You Pay	
Hospice Care (cont.)	**Standard Option**	**Basic Option**
• Oxygen therapy • Periodic physician visits • Physical therapy, occupational therapy, and speech therapy related to the terminal medical condition • Prescription drugs and medications • Services of home health aides (certified or licensed, if the state requires it, and provided by the home hospice agency)	See below	See below
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. An episode of care is one home hospice treatment plan per calendar year. See page 90 for prior approval requirements.	Preferred facilities: Nothing (no deductible) Member/Non-member facilities: $450 copayment per episode (no deductible)	Preferred facilities: Nothing Member/Non-member facilities: You pay all charges
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. The member must be enrolled in a home hospice program in order to receive benefits for subsequent continuous home hospice care, and the services must be provided by the home hospice program in which the member is enrolled.	Preferred facilities: Nothing (no deductible) Member facilities: $450 per episode copayment (no deductible) Non-member facilities: $450 per episode copayment, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred facilities: Nothing Member/Non-member facilities: 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 30 consecutive days in a facility licensed as an inpatient hospice facility. 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 facilities: Nothing (no deductible) Member facilities: $450 per admission copayment, plus 35% of the Plan allowance (no deductible) Non-member facilities: $450 per admission copayment, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred facilities: Nothing Member/Non-member facilities: You pay all charges

Hospice Care - continued on next page

Benefit Description	You Pay	
Hospice Care (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Advanced care planning, except when provided as part of a covered hospice care treatment plan (see page 90)* • *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	**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. Note: Prior approval is required for all non-emergent air ambulance transport.	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 the Overseas Assistance Center (provided by GMMI) by calling 804-673-1678. See page 130 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 $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*	*All charges*	*All charges*

Ambulance - continued on next page

Benefit Description	You Pay	
Ambulance (cont.)	**Standard Option**	**Basic Option**
• *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 Non-preferred (non-PPO) professional providers may provide services in Preferred (PPO) facilities.
- 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. For more information, see page 32, NSA.
- 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 member, the health of the member and their 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, 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: Nothing (no deductible)	Preferred: Nothing Participating: Nothing Non-participating: Nothing
• **Professional provider services** in the providers office, including, 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)	Regular benefit levels apply to covered services provided in this setting. See Sections 5(a) and 5(b).
• 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: Nothing (no deductible)	Preferred emergency room: $250 copayment per day per facility Member emergency room: $250 copayment per day per facility Non-member emergency room: $250 copayment per day per facility Note: If you are admitted directly to the hospital from the emergency room, you do not have to pay the $250 emergency room copayment. However, the $250 per day copayment for Preferred inpatient care still applies.
• Urgent care centers, licensed as and permitted to provide emergency services and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider Note: The urgent care center must be licensed as and permitted to provide emergency services in order to receive protections under the NSA. See page 32 for more information.	Preferred urgent care center: Nothing (no deductible) Participating urgent care center: Nothing (no deductible) Non-participating urgent care center: Nothing (no deductible)	Preferred urgent care center: $35 copayment per visit Participating/Non-participating urgent care center: $35 copayment per visit
• Urgent care centers, not licensed as or permitted to provide emergency services and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider	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

Benefit Description	You Pay	
Accidental Injury (cont.)	**Standard Option**	**Basic Option**
Note: If you are treated by a non-PPO professional provider in a PPO facility, you will only be responsible for your cost-share and will not owe any difference between our allowance and the billed amount. (See page 32.) 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 on page 95 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	**Standard Option**	**Basic Option**
• **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)	Preferred: Nothing Participating: Nothing Non-participating: Nothing
• 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).	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)	Preferred emergency room: $250 copayment per day per facility Member emergency room: $250 copayment per day per facility Non-member emergency room: $250 copayment per day per facility Note: If you are admitted directly to the hospital from the emergency room, you do not have to pay the $250 emergency room copayment. However, the $250 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

Benefit Description	You Pay	
Medical Emergency (cont.)	**Standard Option**	**Basic Option**
• Urgent care centers, licensed as and permitted to provide emergency services and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider Note: The urgent care center must be licensed as and permitted to provide emergency services in order to receive protections under the NSA. See page 32 for more information. Note: Benefits for crutches, splints, braces, etc. when billed by a provider other than the urgent care center are stated in Section 5(a), pages 57-58.	Preferred urgent care center: $30 copayment per visit (no deductible) Participating urgent care center: $30 copayment per visit (no deductible) Non-participating urgent care center: $30 copayment per visit (no deductible)	Preferred urgent care center: $35 copayment per visit Participating/Non-participating urgent care center: $35 copayment per visit
• Urgent care centers, not licensed as or permitted to provide emergency services and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider Note: Benefits for crutches, splints, braces, etc. when billed by a provider other than the urgent care center are stated in Section 5(a), pages 57-58.	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
Not covered: Emergency room professional charges for shift differentials	*All charges*	*All charges*
Ambulance	**Standard Option**	**Basic Option**
See pages 92-93 for complete ambulance benefit and coverage information.	See pages 92-93	See pages 92-93

Section 5(e). Mental Health and Substance Use Disorder 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 an acute 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 page 128. Contact us at the phone number listed on the back of your Service Benefit Plan ID card if you have any questions or would like to discuss your healthcare 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.
- Every year, we conduct an analysis of the financial requirements and treatment limitations which apply to this Plan's mental health and substance use disorder benefits in compliance with the federal Mental Health Parity and Addiction Equity Act (the Act), and the Act's implementing regulations. Based on the results of this analysis, we may suggest changes to program benefits to OPM. More information on the Act is available on the following Federal Government websites:
  https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html
  https://www.dol.gov/ebsa/
  www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL OR RESIDENTIAL TREATMENT CENTER STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY**. 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 use disorder 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 20 for the exceptions to this requirement.**
  - There is **no calendar year deductible.**
- You should be aware that some Non-preferred (non-PPO) professional providers may provide services in Preferred (PPO) facilities.

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 use disorder 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 use disorder practitioners when acting within the scope of their license • Individual psychotherapy • Group psychotherapy • Pharmacologic (medication) management • Psychological testing • Office visits • Clinic visits • Home visits • Phone consultations and online medical evaluation and management services (telemedicine) 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 use disorder phone number on the back of your ID card. Note: See pages 61 and 117 for our coverage of smoking and tobacco cessation treatment. Note: See page 47 for our coverage of mental health visits to treat postpartum depression and depression during pregnancy. Note: We cover outpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers at the levels shown here.	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
Telehealth professional services for: • Behavioral health counseling • Substance use disorder counseling Note: Refer to Section 5(h), *Wellness and Other Special Features*, for information on telehealth services and how to access our telehealth provider network. Note: Benefits are combined with telehealth services listed in Section 5(a), page 39. Note: Copayments are waived for members with Medicare Part B primary.	Preferred Telehealth provider: Nothing (no deductible) for the first 2 visits per calendar year for any covered telehealth service $10 copayment per visit (no deductible) after the 2nd visit Participating/Non-participating: You pay all charges	Preferred Telehealth provider: Nothing for the first 2 visits per calendar year for any covered telehealth service $15 copayment per visit after the 2nd visit Participating/Non-participating: You pay all charges

Professional Services - continued on next page

Benefit Description	You Pay	
Professional Services (cont.)	**Standard Option**	**Basic Option**
• 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	**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 use disorder includes room and board and ancillary charges for confinements in a hospital/treatment facility for rehabilitative treatment of alcoholism or substance use disorder. Note: You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: 35% of the Plan allowance for unlimited days (no deductible), and any remaining balance after our payment	Preferred facilities: $250 per day copayment up to $1,500 per admission for unlimited days Member/Non-member facilities: You pay all charges
Residential Treatment Center	**Standard Option**	**Basic Option**
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.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible)	Preferred facilities: $250 per day copayment up to $1,500 per admission for unlimited days Member/Non-member facilities: You pay all charges

Residential Treatment Center - continued on next page

Benefit Description	You Pay	
Residential Treatment Center (cont.)	**Standard Option**	**Basic Option**
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 use disorder: • 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 licensed as a skilled nursing facility, group home, halfway house, or similar type facility. Note: Benefits are not available for noncovered services, including: respite care; outdoor residential programs; services provided outside of the provider's scope of practice; recreational therapy; educational therapy; educational classes; biofeedback; Outward Bound programs; hippotherapy/equine therapy provided during the approved stay; personal comfort items, such as guest meals and beds, phone, television, beauty and barber services; custodial or long-term care (see *Definitions*, page 153); and domiciliary care provided because care in the home is not available or is unsuitable. Note: For outpatient residential treatment center services, see the next Section.	Non-member facilities: 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.	See previous page
Outpatient Hospital or Other Covered Facility	**Standard Option**	**Basic Option**
Outpatient services provided and billed by a covered facility Note: We cover outpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers at the levels shown here. • 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 Hospital or Other Covered Facility - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Other Covered Facility (cont.)	**Standard Option**	**Basic Option**
Outpatient services provided and billed by a covered facility • Diagnostic tests • Psychological testing Note: A residential treatment center is a covered facility for outpatient care (see Section 10, Definitions, for more information). We cover inpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers, other than room and board and inpatient physician care, at the levels shown here.	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)	**Standard Option**	**Basic Option**
• *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* • *Inpatient services performed or billed by residential treatment centers, except as described on pages 87-88 and 100-101* • *Services performed or billed by schools, halfway houses, group homes or members of their staffs* *Note: We cover professional services as described on pages 99-100 when they are provided and billed by a covered professional provider acting within the scope of their 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.)* • *Hippotherapy/equine therapy (exercise on horseback)* • *Light boxes* • *Custodial or long-term care (see* Definitions*)* • *Costs associated with enabling or maintaining providers' telehealth (telemedicine) technologies, non-interactive telecommunication such as email communications, or asynchronous store-and-forward telehealth services*	*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 108.
- If there is no generic drug available, you must pay the brand-name cost-sharing amount when you receive a brand-name drug.
- If there is a generic substitution available and you or your provider requests a brand-name drug, you will be responsible for the applicable tier cost-share plus the difference in the cost of the brand-name and generic drug. If the provider's prescription is for the brand-name drug and indicates "dispense as written," you are responsible only for the applicable tier cost-share.
- 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.
- Benefits for certain self-injectable (self-administered) drugs are provided only when they are dispensed by a pharmacy under the pharmacy benefit. See pages 114-115 for Tier 4 and Tier 5 specialty drug fills from a Preferred pharmacy.
- Benefits for certain auto-immune infusion medications (limited to Remicade, Renflexis and Inflectra) are covered only when they are obtained by a non-pharmacy provider, such as a physician or facility (hospital or ambulatory surgical center). See *Drugs From Other Sources* in this section, pages 119-120, for more 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.
- Medication prices vary among different retail pharmacies, the Mail Service Prescription Drug Program, and the Specialty Drug Pharmacy Program. **Review purchasing options for your prescriptions to get the best price.** A drug cost tool is available at www.fepblue.org or call:
  - **Retail Pharmacy Program: 800-624-5060, TTY: 711**
  - **Mail Service Prescription Drug Program: 800-262-7890, TTY: 711**
  - **Specialty Drug Pharmacy Program: 888-346-3731, TTY: 711**
- **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 pages 106-107 for more information about the PSQM program and to Section 3 for more information about prior approval. Our prior approval process may include step therapy, which requires you to use a generic and/or preferred medication(s) before a non-preferred medication is covered.
- 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 or biosimilar becomes available or if new safety concerns arise. If your drug is moved to a higher tier, your cost-share will increase. See pages 114-116 for the amounts members pay for Preferred retail, mail service, and specialty drug purchases. If your drug is moved to noncovered, you pay the full cost of the medication. Tier reassignments during the year are not considered benefit changes.
- A pharmacy restriction may be applied for clinically inappropriate use of prescription drugs and supplies.
- The Standard Option and Basic Option formularies both contain a comprehensive list of drugs under all therapeutic categories with two exceptions: some drugs, nutritional supplements and supplies are not covered (see pages 118-119); we may also exclude certain U.S. FDA-approved drugs when multiple generic equivalents/alternative medications are available. See pages 104 and 105 for details.

- **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.
  - There is no calendar year deductible for 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 retail pharmacies or the Specialty Drug Pharmacy Program in order to receive benefits.** Our specialty drug pharmacy is a Preferred pharmacy.
  - The Mail Service Prescription Drug Program is available only to members with primary Medicare Part B coverage.
  - There is **no calendar year deductible.**
  - We use a managed formulary for certain drug classes.

We will send each new enrollee a Plan identification card, which covers pharmacy and medical benefits. 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 pre-addressed reply envelope.

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

- **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/certified provider with prescriptive authority prescribing within their scope of practice 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 159 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 159 for the definition of “specialty drugs.”

Under Standard Option and Basic Option

Note: The Mail Service Prescription Drug Program will not fill your prescription for a drug requiring prior approval 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 unable to be filled and a letter will be mailed to you explaining the prior approval procedures.

Note: The Specialty Drug Pharmacy Program will not fill your prescription for a drug requiring prior approval 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 unable to be filled and a letter will be mailed to you explaining the prior approval procedures.

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 pages 115-116.

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 pages 114-115 for information about your cost-share for specialty drugs purchased at a Preferred retail pharmacy that are affected by these restrictions.

- **What is covered.**

  Under Basic Option, we use a managed formulary for certain drug classes. 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.

  Under Standard Option and Basic Option

  Note: Both formularies include lists of preferred drugs that are safe, effective and appropriate for our members, and are available at lower costs than non-preferred drugs. If your physician prescribed a more expensive non-preferred drug for you, we may ask that he or she prescribe a preferred drug instead; we encourage you to do the same. If you purchase a drug that is not on our preferred drug list, your cost will be higher. Your cooperation with our cost-savings efforts helps keep your premium affordable.

  Note: Some drugs, nutritional supplements, and supplies are not covered (see pages 118-119); we may also exclude certain U.S. FDA-approved drugs when multiple generic equivalents/alternative medications are available. If you purchase a drug, nutritional supplement, or supply that is not covered, you will be responsible for the full cost of the item.

  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. Changes to the preferred drug list are not considered benefit changes.

  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. 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 call 800-624-5060, TTY: 711, for assistance. Changes to the formulary are not considered benefit changes. 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 U.S. FDA-approved generic equivalent, unless you or your physician specifically requests a brand-name drug and indicates "dispense as written." Keep in mind that **Basic Option members must use Preferred providers in order to receive benefits.** See Section 10, *Definitions*, page 154, 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. 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 unless otherwise noted. 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.

  Under Standard Option and Basic Option

  Benefits for Tier 4 and Tier 5 specialty drugs purchased at a 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. 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 of the specialty drug. See page 116 for more information.

  Note: Certain drugs such as narcotics may have additional limits or requirements as established by the U.S. FDA or by national scientific or medical practice guidelines (such as Centers for Disease Control and Prevention, American Medical Association, etc.) 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 22, 30, and 90-day supplies of those medications. **In most cases, refills cannot be obtained until 75% of the prescription has been used. Controlled substances cannot be refilled until 80% of the prescription has been used.** Controlled substances are medications that can cause physical and mental dependence, and have restrictions on how they can be filled and refilled. They are regulated and classified by the DEA (Drug Enforcement Administration) based on how likely they are to cause dependence. 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.

  Note: Benefits for certain self-injectable (self-administered) drugs are provided only when they are dispensed by a pharmacy under the pharmacy benefit. Medical benefits will be provided for a once-per-lifetime dose per therapeutic category of drugs dispensed by your provider or any non-pharmacy-benefit provider. This benefit limitation does not apply if you have primary Medicare Part B coverage. See pages 114-115 for Tier 4 and Tier 5 specialty drug fills from a Preferred pharmacy.

  Note: Benefits for certain auto-immune infusion medications (Remicade, Renflexis and Inflectra) are provided only when obtained by a non-pharmacy provider, such as a physician or facility (hospital or ambulatory surgical center). See *Drugs From Other Sources* in this Section, page 120, for more information.

- **Important contact information**

  Retail Pharmacy Program: 800-624-5060, TTY: 711;
  Mail Service Prescription Drug Program: 800-262-7890, TTY: 711;
  Specialty Drug Pharmacy Program: 888-346-3731, TTY: 711; or www.fepblue.org.

Patient Safety and Quality Monitoring (PSQM)

We have a special program to promote patient safety and monitor healthcare 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 on page 107, 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 U.S. FDA-approved recommendations, national scientific and generally accepted standards of medical practice guidelines (such as Centers for Disease Control and Prevention, American Medical Association, etc.), 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 800-624-5060, TTY: 711.

Prior Approval

As part of our Patient Safety and Quality Monitoring (PSQM) program (see page 106), **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 generally accepted standards of medical, dental, or psychiatric practice in the United States. Our prior approval process may include step therapy, which requires you to use a generic and/or preferred medication(s) before a non-preferred medication is covered. **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 800-624-5060, TTY: 711. You can also obtain the list and forms 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.

Note: It is your responsibility to know the prior approval authorization expiration date for your medication. We encourage you to work with your physician to obtain prior approval renewal in advance of the expiration date.

Standard Option Generic Incentive Program

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

- If you switch from one generic drug to another, you will be responsible for your copayment.

Note: The list of eligible generic drug replacements may change and is not considered a benefit change. For the most up-to-date information, please visit www.fepblue.org/en/benefit-plans/coverage/pharmacy/generic-incentive-program or call:

Retail Pharmacy Program: 800-624-5060, TTY: 711
Mail Service Prescription Drug Program: 800-262-7890, TTY: 711
Specialty Drug Pharmacy Program: 888-346-3731, TTY: 711

Benefits 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	**Standard Option**	**Basic Option**
Asthma Medications **Preferred Retail Pharmacies:** Note: See page 24 for information about drugs and supplies that require prior approval.	Tier 1 (generic drug): $5 copayment (no deductible) Tier 2 (preferred brand-name drug): 20% of the Plan allowance (no deductible)	Tier 1 (generic drug): $5 copayment for each purchase of up to a 90-day supply Tier 2 (preferred brand-name drug): $35 copayment for each purchase of up to a 30-day supply ($105 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment Tier 2 (preferred brand-name drug): $30 copayment for each purchase of up to a 30-day supply ($90 copayment for a 31 to 90-day supply)
Mail Service Prescription Drug Program: 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 107. Note: See pages 114-116 for Tier 3, 4 and 5 prescription drug benefits.	Tier 1 (generic drug): $5 copayment (no deductible) Tier 2 (preferred brand-name drug): $65 copayment (no deductible)	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment Tier 2 (preferred brand-name drug): $75 copayment
Anti-hypertensive Medications **Preferred Retail Pharmacies:** Note: See page 24 for information about drugs and supplies that require prior approval.	Tier 1 (generic drug): $3 copayment (no deductible)	Tier 1 (generic drug): $5 copayment for each purchase of up to a 90-day supply
Mail Service Prescription Drug Program: 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 107. Note: See pages 114-116 for Tier 2, 3, 4, and 5 prescription drug benefits.	Tier 1 (generic drug): $3 copayment (no deductible)	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**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 pages 112-113 for our coverage of medications to promote better health as recommended under the Affordable Care Act. • Medical foods, as defined by the U.S. Food and Drug Administration, that are consumed or administered enterally and are intended for the specific dietary management of a disease or condition for which there are distinctive nutritional requirements. The Plan covers medical food formulas and enteral nutrition products that are ordered by a healthcare provider, and are medically necessary to prevent clinical deterioration in members at nutritional risk. (See Coverage below) - Must meet the definition of medical food (see definition on page 155) - Must be receiving active, regular, and ongoing medical supervision and must be unable to manage the condition by modification of diet alone Coverage is provided as follows: - Inborn errors of amino acid metabolism - Food allergy with atopic dermatitis, gastrointestinal symptoms, IgE mediation, malabsorption disorder, seizure disorder, failure to thrive, or prematurity, when administered orally and is the sole source (100%) of nutrition. This once per lifetime benefit is limited to one year following the date of the initial prescription or physician order for the medical food (e.g., Neocate, in a formula form or powders mixed to become formulas) - Medical foods and nutritional supplements when administered by catheter or nasogastric tubes Note: A prescription and prior approval are required for medical foods provided under the pharmacy benefit. Renewals of the prior authorization are required every benefit year for inborn errors of metabolism and tube feeding. Note: See Section 5(a), page 58, for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube under the medical benefit.	See page 108 and pages 110-116	See page 108 and pages 110-116

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
• Insulin, diabetic test strips, lancets, and tubeless insulin delivery systems Note: See page 58 for our coverage of insulin pumps with tubes. • Needles and disposable syringes for the administration of covered medications • Clotting factors and anti-inhibitor complexes for the treatment of hemophilia	See page 108 and pages 110-116	See page 108 and pages 110-116
• 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 117. Note: You may be eligible to receive smoking and tobacco cessation medications at no charge. See page 117 for more information. • Drugs for the diagnosis and treatment of infertility, except as described on pages 118-119 • Drugs to treat gender dysphoria (gonadotropin-releasing hormone (GnRH) antagonists and testosterones) • 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 115 and 116 for details.	See below and pages 111-117	See below and pages 111-117
• Over-the-counter (OTC) contraceptive drugs and devices, limited to: - Emergency contraceptive pills - Condoms - Spermicides - Sponges	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

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Note: We provide benefits in full for OTC contraceptive drugs and devices when the contraceptives meet U.S. FDA standards for OTC products. To receive benefits, you must use a retail pharmacy and present the pharmacist with a written prescription from your physician.	See previous page	See previous page
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. See pages 43 and 45 for specific coverage. Note: Our vaccine network is a network of Preferred retail pharmacies that have agreements with us to administer one or more routine immunizations. Check with your pharmacy or call our Retail Pharmacy Program at 800-624-5060, TTY: 711, to find out 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 every 365 days at no cost through our Diabetic Meter Program. To use this program, you must call the phone 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 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. See page 112 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
Metformin and metformin extended release (excluding osmotic and modified release generic drugs) **Preferred Retail Pharmacies:** **Mail Service Prescription Drug Program:**	Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply (no deductible) Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply (no deductible)	Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Other Preferred Diabetic Medications, Test Strips, and Supplies **Preferred Retail Pharmacies:** **Mail Service Prescription Drug Program:** **Note: See pages 115-116 for Tier 2, 3, 4, and 5 prescription drug benefits.** Benefits will be provided for syringes, pens and pen needles and test strips at Tier 2 (diabetic medications and supplies) for Standard Option members, and Basic Option members with primary Medicare Part B, through the Mail Service Prescription Drug Program. See pages 115-116 for more information.	Tier 2 (preferred diabetic medications and supplies): 20% of the Plan allowance for each purchase of up to a 90-day supply (no deductible) Tier 2 (preferred insulins): $35 copayment for each purchase of up to a 30-day supply ($65 copayment for a 31 to 90-day supply) (no deductible) Non-preferred retail pharmacies: You pay all charges Tier 2 (preferred brand-name drug): $40 copayment for each purchase of up to a 90-day supply (no deductible)	Tier 2 (preferred diabetic medications and supplies): $35 copayment for each purchase of up to a 30-day supply ($65 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 2 (preferred brand-name drugs): $30 copayment for each purchase of up to a 30-day supply ($60 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 2 (preferred brand-name drugs) $50 copayment for each purchase of up to a 90-day supply
Medications 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 individuals capable of pregnancy • Low-dose aspirin (81 mg per day) for pregnant members at risk for preeclampsia • Aspirin for men age 45 through 79 and women age 50 through 79 • Generic cholesterol-lowering statin drugs Note: Benefits are not available for acetaminophen, ibuprofen, naproxen, etc.	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

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Note: Benefits for the medications listed on the previous page are subject to the dispensing limitations described on page 106 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/preventive-care-benefits. See pages 42-46 in Section 5(a) for information about other covered preventive care services. Note: See page 117 for our coverage of smoking and tobacco cessation medications.	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 medications 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 800-624-5060, TTY: 711, to request this form. You can also obtain the Coverage Request Form through our website at www.fepblue.org.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges Mail Service Prescription Drug Program: Nothing (no deductible)	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
We cover the first prescription filled for certain **bowel preparation** medications for colorectal cancer screenings with no member cost-share. We also cover certain **antiretroviral therapy** medications for HIV for those at risk but who do not have HIV. You can view the list of covered medications on our website at www.fepblue.org or call 800-624-5060, TTY: 711, for assistance.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges Mail Service Prescription Drug Program: Nothing (no deductible)	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
Opioid Reversal Agents: Tier 1 medications limited to generic naloxone nasal spray and injectable		
Preferred Retail Pharmacies	Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year (no deductible) Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost-share.	Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost-share.
Non-preferred Retail Pharmacies	You pay all charges	You pay all charges

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Opioid Reversal Agents (cont.) **Mail Service Prescription Drug Program**	Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year (no deductible) Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost-share.	**When Medicare Part B is primary, you pay the following:** Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost-share.
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 retail pharmacy to request your prescriptions online and delivery, if available. • For a listing of Preferred retail pharmacies, call the Retail Pharmacy Program at 800-624-5060, TTY: 711, 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 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 116 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 Preferred 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 115.**	Tier 1 (generic drug): $7.50 copayment for each purchase of up to a 30-day supply ($22.50 copayment for a 31 to 90-day supply) (no deductible) Note: You pay a $5 copayment for each purchase of up to a 30-day supply ($15 copayment for a 31 to 90-day supply) 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 107 for information. Tier 2 (preferred brand-name drug): 30% of the Plan allowance for each purchase of up to a 90-day supply (no deductible) Tier 3 (non-preferred brand-name drug): 50% of the Plan allowance for each purchase of up to a 90-day supply (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): $15 copayment for each purchase of up to a 30-day supply ($40 copayment for a 31 to 90-day supply) Tier 2 (preferred brand-name drug): $60 copayment for each purchase of up to a 30-day supply ($180 copayment for a 31 to 90-day supply) Tier 3 (non-preferred brand-name drug): 60% of the Plan allowance ($90 minimum) for each purchase of up to a 30-day supply ($250 minimum for a 31 to 90-day supply) Tier 4 (preferred specialty drug): $85 copayment limited to one purchase of up to a 30-day supply Tier 5 (non-preferred specialty drug): $110 copayment limited to one purchase of up to a 30-day supply **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $10 copayment for each purchase of up to a 30-day supply ($30 copayment for a 31 to 90-day supply) Tier 2 (preferred brand-name drug): $50 copayment for each purchase of up to a 30-day supply ($150 copayment for a 31 to 90-day supply)

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Note: For a list of the Preferred Network Long-Term Care pharmacies, call 800-624-5060, TTY: 711. 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 800-624-5060, TTY: 711, 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.	See previous page	Continued from previous page: Tier 3 (non-preferred brand-name drug): 50% of the Plan allowance ($60 minimum) for each purchase of up to a 30-day supply ($175 minimum for a 31 to 90-day supply) Tier 4 (preferred specialty drug): $80 copayment limited to one purchase of up to a 30-day supply Tier 5 (non-preferred specialty drug): $100 copayment limited to one purchase of up to a 30-day supply
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 For Standard Option and Basic Option members when Medicare Part B is Primary, 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: 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 107. 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 116 for information about the Specialty Drug Pharmacy Program.	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 107 for information. Tier 2 (preferred brand-name drug): $90 copayment (no deductible) Tier 3 (non-preferred brand-name drug): $125 copayment (no deductible)	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $20 copayment Tier 2 (preferred brand-name drug): $100 copayment Tier 3 (non-preferred brand-name drug): $125 copayment **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 108 of this Section for our payment levels for drugs obtained through Preferred retail pharmacies.

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
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 800-262-7890, TTY: 711. 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.	See previous page	See previous page
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 phone number below or visit our website, www.fepblue.org. (See page 159 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 are most convenient for you, as well as ask you about any side effects you may be experiencing. See page 138 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 31 to 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 888-346-3731, TTY: 711.	Tier 4 (preferred specialty drug): $65 copayment for each purchase of up to a 30-day supply ($185 copayment for a 31 to 90-day supply) (no deductible) Tier 5 (non-preferred specialty drug): $85 copayment for each purchase of up to a 30-day supply ($240 copayment for a 31 to 90-day supply) (no deductible)	Tier 4 (preferred specialty drug): $85 copayment for each purchase of up to a 30-day supply ($235 copayment for a 31 to 90-day supply) Tier 5 (non-preferred specialty drug): $110 copayment for each purchase of up to a 30-day supply ($300 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 4 (preferred specialty drug): $80 copayment for each purchase of up to a 30-day supply ($210 copayment for a 31 to 90-day supply) Tier 5 (non-preferred specialty drug): $100 copayment for each purchase of up to a 30-day supply ($255 copayment for a 31 to 90-day supply)

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Smoking and Tobacco Cessation Medications If you are a covered member, 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, create a Tobacco Cessation Quit Plan using our Online Health Coach. For more information, see page 125. Note: There may be age restrictions based on U.S. FDA guidelines for these medications. The following medications are covered through this program: • Generic medications available by prescription: - Bupropion ER 150 mg tablet - Bupropion SR 150 mg tablet - Varenicline 0.5 mg tablets - Varenicline 1 mg tablets - Varenicline starting pack • Brand-name medications available by prescription: - 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 61 for our coverage of smoking and tobacco cessation treatment, counseling, and classes.	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

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Remicade, Renflexis, and Inflectra are not covered for prescriptions obtained from a retail pharmacy, Mail Service Prescription or through the Specialty Drug Program* • *Medical supplies such as dressings and antiseptics* • *Drugs and supplies for cosmetic purposes* • *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 58 and 110)* • *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 112 for our coverage of medications recommended under the Affordable Care Act and page 117 for smoking and tobacco cessation medications.* • *Medical foods administered orally are not covered if not obtained at a retail pharmacy or through the Mail Service Prescription Drug Program* *Note: See Section 5(a), page 58, for our coverage of medical foods when administered by catheter or nasogastric tube.* • *Products and foods other than liquid formulas or powders mixed to become formulas; foods and formulas readily available in a retail environment and marketed for persons without medical conditions; low-protein modified foods (e.g., pastas, breads, rice, sauces and baking mixes); nutritional supplements, energy products; and similar items* *Note: See Section 5(a), page 58 for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube.* • *Infant formula other than described on pages 58 and 109*	*All charges*	*All charges*

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
• *Drugs for which prior approval has been denied or not obtained* • *Drugs and supplies related to sexual dysfunction or sexual inadequacy* • *Drugs and covered-drug-related supplies for the treatment of 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 110* • *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 110* • *Drugs used to terminate pregnancy* • *Sublingual allergy desensitization drugs, except as described on page 51*	*All charges*	*All charges*
Drugs From Other Sources	**Standard Option**	**Basic Option**
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. This includes drugs and supplies covered only under the medical benefit. Note: Prior approval is required for certain high-cost drugs obtained outside one of our pharmacy programs. Contact the customer service number on the back of your ID card or visit us at www.fepblue.org/highcostdrugs for a list of these drugs. See page 22 for more information on prior approval. 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 page 131 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.	Preferred: 15% of the Plan allowance (deductible applies) Participating professional provider: 35% of the Plan allowance (deductible applies) Non-participating professional provider: 35% of the Plan allowance (deductible applies) plus any difference between our allowance and the billed amount Member facilities: 35% of the Plan allowance (deductible applies) Non-member facilities: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating professional provider: You pay all charges Non-participating professional provider: You pay all charges Member/Non-member facilities: You pay all charges

Drugs From Other Sources - continued on next page

Benefits Description	You Pay	
Drugs From Other Sources (cont.)	**Standard Option**	**Basic Option**
• Please refer to the Sections indicated for additional benefit information related to drugs obtained from other sources: - Physician's office – Section 5(a) - Facility (inpatient or outpatient) – Section 5(c) - Hospice agency – Section 5(c) • Please refer to page 114 for prescription drugs obtained from a Preferred retail pharmacy, that are billed for by a skilled nursing facility, nursing home, or extended care facility.	See previous page	See previous page
• Auto-immune infusion medications: Remicade, Renflexis and Inflectra Note: Benefits for certain auto-immune infusion medications (limited to Remicade, Renflexis and Inflectra) are covered only when they are obtained by a non-pharmacy provider, such as a physician or facility (hospital or ambulatory surgical center).	Preferred: 10% of the Plan allowance (deductible applies) Participating professional provider: 15% of the Plan allowance (deductible applies) Non-participating professional provider: 15% of the Plan allowance (deductible applies) plus any difference between our allowance and the billed amount Member facilities: 15% of the Plan allowance (deductible applies) Non-member facilities: 15% of the Plan allowance (deductible applies), plus any difference between our allowance and billed amount.	Preferred: 15% of the Plan allowance Participating professional provider: You pay all charges Non-participating professional provider: You pay all charges Member/Non-member facilities: You pay 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.**

Benefit Description	You Pay	
Accidental Injury Benefit	**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.	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 for associated oral evaluations 30% of the Plan allowance for all other care 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 cost-share amounts 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.

Accidental Injury Benefit - continued on next page

Benefit Description	You Pay	
Accidental Injury Benefit (cont.)	**Standard Option**	**Basic Option**
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.	See previous page	See previous page

Dental Benefits

What is Covered

Standard Option dental benefits are presented in the chart on the following page.

Basic Option dental benefits appear on page 124.

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 phone 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 phone 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 page. 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 page 122).

Standard Option Dental Benefits	Standard Option Only		
Covered Service	**We Pay to Age 13**	**We Pay Age 13 and Over**	**You Pay**
Clinical oral evaluations			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).
Periodic oral evaluation *(up to 2 per person per calendar year)*	$12	$8	
Limited oral evaluation	$14	$9	
Comprehensive oral evaluation	$14	$9	
Detailed and extensive oral evaluation	$14	$9	
Diagnostic imaging			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	
Palliative treatment			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).
Palliative treatment of dental pain – minor procedure	$24	$15	
Protective restoration	$24	$15	
Preventive			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).
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 (*up to 2 per person per calendar year*)	$13	$8	
Not covered: Any service not specifically listed above	*Nothing*	*Nothing*	*All charges*

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; see page 122). 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 phone 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*)	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
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)*	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
Not covered: Any service not specifically listed above	*Nothing*	*All charges*

Section 5(h). Wellness and Other 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 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 phone, secure email, or live chat. Ask questions and get medical advice. Please keep in mind that benefits for any healthcare 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 healthcare expenses. See below and page 126 for more information. • **Online Health Coach (OHC)** – Manage your health proactively by setting and managing health goals, create a plan of care, track your progress, and pursue healthy activities. The OHC offers members a combination of guidance, support, and resources. • **Tobacco Cessation Incentive Program** – If you would like to quit smoking, you can participate in this program and receive tobacco cessation products at no charge. 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 page 117 for more information. Note: There may be age restrictions based on U.S. FDA guidelines for these medications. • **Health Topics and WebMD Videos** offer an extensive variety of educational tools using videos, recorded messages, and colorful online materials that provide up-to-date information about a wide range of health-related topics.
Services for the Deaf and Hearing Impaired	All Blue Cross and Blue Shield Plans provide TTY 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 well-being. For more information, go to www.fepblue.org.
Diabetes Management Program	The Diabetes Management Program is a program to help members with diabetes manage their condition. All members with type 1 and type 2 diabetes, including those for whom Medicare is primary, are eligible for this program. You will receive a free glucose meter and have unlimited test strips and lancets shipped directly to you. Automated reordering is based on your usage. Personalized coaching and support are also provided. The program offers live interventions triggered by acute alerts based on your glucose meter test results. Member support is offered 24/7/365. For more information go to www.fepblue.org/diabetes.
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, both the contract holder and spouse are eligible for the $50 health account. We will send each eligible member a debit card to access their 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, hypertension, 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, 2023**. 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 888-258-3432 toll-free.
Diabetes Management Incentive Program	The **Diabetes Management Incentive Program** is designed to encourage members to achieve and maintain control of their blood sugar and help manage or slow the progression of complications related to diabetes. Through this program you can earn a maximum of $100 toward a health account to be used for most qualified medical expenses. This incentive is in addition to other incentives described in this brochure and is available to all covered adult members, age 18 and over. To qualify for the Diabetes Management Incentive Program, each eligible member must have at least one medical claim that has been processed during the past 12 months with a reported diagnosis of diabetes and complete the following steps: • Provide us with lab test results for an HbA1c performed in the first 6 months of the calendar year (January 1 to June 30) to receive a $25 incentive reward. • Provide us with lab test results for an HbA1c performed in the last 6 months of the calendar year (July 1 to December 31) to receive a $75 incentive reward; the test results must show: - Your HbA1c result is less than 8 percent; or - If your HbA1c is greater than or equal to 8 percent, you will receive the incentive if we provided benefits for three nutritional counseling visits performed during the calendar year. Note: See pages 43 and 46 for information on nutritional counseling. Information on how to submit your HbA1c lab results can be found on our website, www.fepblue.org/diabetes. See page 111 for information about the Diabetic Meter Program.
Hypertension Management Program	The **Hypertension Management Program** gives members age 18 and older with hypertension (otherwise known as high blood pressure) 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 the contract holder and spouse who meet the following criteria. 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, you will be sent a letter advising you of your eligibility for the free BPM. You are eligible to receive a free BPM every two calendar years. You must follow the directions in the letter, which include taking the letter to your healthcare 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 criteria or for those who obtain a BPM outside of this program. For more information, call us at the phone number on the back of your ID card. See page 108 for information on preferred generic anti-hypertensive medications.
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. 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. All covered adult members, age 18 and over may be eligible for this incentive. To qualify for the Pregnancy Care Box, you must be pregnant. Information on the program is available on our website, www.fepblue.org. To qualify for the $75 incentive, you must meet the criteria above for the Pregnancy Care Box and send us a copy of your healthcare provider's medical record that confirms you had a prenatal care visit during the first trimester of your pregnancy. Information that must be included when submitting your medical record can be found on our website, www.fepblue.org/maternity. To receive 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 are limited to two pregnancies per calendar year.
Annual Incentive Limitation	Financial incentives earned through participation in the Blue Health Assessment, personalized goals through the Online Health Coach, the Diabetes Management Incentive Program, and the Pregnancy Care Incentive Program are limited to a total of $420 per person per calendar year for the contract holder and spouse.
Reimbursement Account for Basic Option Members Enrolled in Medicare Part A and Part B	Basic Option members enrolled in Medicare Part A and Part B are eligible to be reimbursed up to $800 per calendar year for their Medicare Part B premium payments. The account is used to reimburse member-paid Medicare Part B premiums. For more information on how to obtain reimbursement, please visit www.fepblue.org/mra or call 888-706-2583.
MyBlue® Customer eService	Visit **MyBlue Customer eService** at www.fepblue.org/myblue or use the fepblue mobile app 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 "View My Claims"; from there you can search claims and select the "EOB" link next to each claim to access your EOB. You can also access EOBs via the fepblue mobile app. Simply link to MyBlue, and click on Claims.

	• **Opt In or Out of Mailed Paper EOBs** – The Service Benefit Plan offers an environmentally friendly way of accessing your EOBs via www.fepblue.org/myblue. You can opt in or out of receiving mailed paper EOBs by following 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. • **Financial Dashboard** – Log in to MyBlue to access important information in real time, including deductibles, out-of-pocket costs, remaining covered provider visits, medical claims, and pharmacy claims. You also can review your year-to-date summary of completed claims, MyBlue Wellness Card balance, and pharmacy spending throughout the year.
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 healthcare needs, the Service Benefit Plan offers two types of Care Management Programs that provide assistance with the coordination of your care, provide member education and clinical support. • **Case Management** provides members who have acute or chronic complex healthcare needs with the services and assistance of a licensed healthcare professional with a nationally recognized case management certification. Case managers may be a registered nurse, licensed social worker, or other licensed healthcare professional practicing within the scope of their license, who may work with you and your providers to assess your healthcare needs, coordinate needed care and available resources, evaluate the outcomes of your care, and support and monitor the progress of the member's treatment plan and healthcare needs. Some members may receive guidance and clinical support for an acute healthcare need while others may benefit from a short-term case management enrollment. Enrollment in case management requires your consent. Members in case management are asked to provide verbal consent prior to enrollment in case management and must provide written consent for case management. Note: Benefits for care provided by residential treatment centers and for inpatient care provided by skilled nursing facilities for members enrolled in Standard Option who do not have Medicare Part A require written consent and participation in Case Management prior to admission; please see pages 87-88, 100 and 130 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, including if you are eligible for enrollment and assistance with enrollment, please contact us at the customer service phone 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 will review the member's healthcare needs and may at our sole discretion, identify a less costly alternative treatment plan for the member. The member (or their healthcare proxy) and provider (s) must cooperate in the process. Case Management Program enrollment is required for eligibility. Prior to the starting date of the alternative treatment plan, members who are eligible to receive services through the flexible benefits option are required to sign and return a written consent for case management and 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. **We must receive the consent for case management and the alternative benefits agreement signed by the member/ healthcare proxy before you receive any services included in the alternative benefits agreement.**

	• Alternative benefits will be made available for a limited period of time and are subject to our ongoing review. You must cooperate with and participate in the review process. Your provider(s) must submit the information necessary for our reviews. You and/or your healthcare proxy must participate in care conferences and caregiver training as requested by your provider(s) or by us. • We may revoke the alternative benefits agreement immediately at any time, if we discover we were misled by the information given to us by you, your provider, or anyone else involved in your care, or that you are not meeting the terms of the agreement. • If we approve alternative benefits, we do not guarantee that they will be extended beyond the limited time period and/or scope of the alternative benefits agreement 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 at our sole discretion, 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 alternative benefits for the stated time period, unless we are misled by the information given to us or circumstances change. Benefits as stated in this brochure will apply to all services and dates of care not included in the alternative benefits agreement. You or your provider may request an extension of the time period initially approved for alternative benefits, no later than five business days prior to the end of the alternative benefits agreement. We will review the request, including the services proposed as an alternative and the cost of those services, but benefits as stated in this brochure will apply if we do not approve your request. Note: If we deny a request for precertification or prior approval of regular contract benefits, as stated in this brochure, 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).
Telehealth Services	Go to www.fepblue.org/telehealth or call 855-636-1579, TTY: 711, toll free to access on-demand, affordable, high-quality care for adults and children experiencing non-emergency medical issues, including treatment of minor acute conditions (see page 155 for definition), dermatology care, counseling for behavioral health and substance use disorder, and nutritional counseling. Note: This benefit is available only through the contracted telehealth provider network.
The fepblue Mobile Application	Blue Cross and Blue Shield's fepblue mobile application is available for download for both iOS and Android mobile phones. The application provides members with 24/7 access to helpful features, tools and information related to Blue Cross and Blue Shield Service Benefit Plan benefits. Members can log in with their MyBlue® username and password to access personal healthcare information such as benefits, out-of-pocket costs, deductibles (if applicable) and physician visit limits. They can also view claims and approval status, view/share Explanations of Benefits (EOBs), view/share member ID cards, locate in-network providers, and connect with our telehealth services.

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 131-132 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 healthcare 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 overseas, with the exception of admissions for gender affirming surgery (see pages 22 and 66-67 for information) and admissions to residential treatment centers and skilled nursing facilities. Prior approval is required for all non-emergent air ambulance transport services for overseas members (refer to page 92 for more information). Protections offered under the NSA (see page 32) do not apply to overseas claims.

Overseas 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 Overseas 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 Overseas 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 Overseas Assistance Center (provided by GMMI), by calling 804-673-1678. Members in the United States, Puerto Rico, or the U.S. Virgin Islands should call 800-699-4337 or email the Overseas Assistance Center at fepoverseas@gmmi.com. GMMI 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.

Hospital and professional provider benefits

For **professional care** you receive overseas, we provide benefits at Preferred benefit levels using either our Overseas Fee Schedule, a customary percentage of the billed charge, or a provider-negotiated discount as our Plan allowance. **The Basic Option requirement to use Preferred providers in order to receive benefits does not apply when you receive overseas care. Standard Option members have no deductible for overseas services.**

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. When the Plan allowance is a provider-negotiated discount, you are only responsible for your coinsurance and/or copayment amounts. You must also pay any charges for noncovered services.

For **inpatient facility care** you receive overseas, we provide benefits at the Preferred level **under both Standard and Basic Options. For Basic Option, there is no member cost-share** for admissions to a DoD facility, or when the Overseas Assistance Center (provided by GMMI) has arranged direct billing or acceptance of a guarantee of benefits with the facility. For all other inpatient facility care, Basic Option members are responsible for the per admission copayment. Standard Option members have no cost-share for inpatient facility care.

For **outpatient 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 have no deductible for overseas services.

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.

Pharmacy benefits

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 119 in Section 5(f) for more information.

Overseas claims payment

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.

Filing overseas claims

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 260070, Pembroke Pines, FL 33026.
2. Fax: 001-954-308-3957. 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 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@gmmi.com, or from your Local Plan.

Filing a claim for 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. Timely filing for overseas pharmacy claims is limited to one year from the prescription fill date. 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 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

These benefits are not part of the FEHB contract or premium, and you cannot file an FEHB dispute regarding these benefits. Fees paid 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® – The Blue Cross and Blue Shield Service Benefit Plan presents Blue365, a program that offers exclusive health and wellness deals that will assist in your efforts to be healthy and happy, every day of the year. Blue365 delivers top discounts from national and local retailers such as hearing aids through TruHearing, healthy food delivery via Sun Basket, wearable devices from Fitbit, and genetic composition testing by Molecular Fitness, just to name a few. Each week, Blue365 members receive great health and wellness deals via email. With Blue365, there is no paperwork to fill out. Just 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 – Fitness Your Way by Tivity Health can help you meet your health and fitness goals, on your budget, and on your own time. Fitness Your Way by Tivity Health offers access to more than 10,000 different fitness locations for a discounted monthly rate. You'll have access to well-being support, health articles, and online health coaching, as well as exercise tracking and nutrition goals, social networking, rewards, and the Daily Challenge 24 hours a day, 7 days a week. For more information or to enroll, visit www.fepblue.org/healthclub or call customer service at 888-242-2060, Monday through Friday, 8 a.m. – 8 p.m., in all U.S. time zones.

Discount Drug Program – The Discount Drug Program is available to members 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 24%. The program permits you to obtain discounts on several drugs related to dental care, weight loss, hair removal and hair growth, and other miscellaneous health conditions. Please refer to www.fepblue.org/ddp for a full list of discounted drugs, including those that may be added to this list as they are approved by the U.S. Food and Drug Administration (U.S. FDA). To use the program, simply present a valid prescription and your Service Benefit Plan ID card at a Preferred 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 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 888-897-9350 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.

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 155).
- Experimental or investigational procedures, treatments, drugs, or devices (see Section 5(b) 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 and gender affirming surgeries specifically listed as covered).
- Travel expenses except as specifically provided for covered transplants performed in a Blue Distinction Center for Transplant (see page 76).
- 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 149), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge, see page 150), or state premium taxes however applied.
- Prescriptions, 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 provided 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 or supplies for the treatment of obesity, weight reduction, or dietary control, except for office visits, diagnostic tests, prior approved weight loss drugs covered under the pharmacy program, and procedures and services for the treatment of morbid obesity listed on page 65.
- 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 phone.
- 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 *Preventive Care, Child* in Sections 5(a) and 5(c), the preventive screenings specifically listed on pages 42-46 and page 85; and certain routine services associated with covered clinical trials (see page 145).
- Recreational or educational therapy, and any related diagnostic testing, except as provided by a hospital during a covered inpatient stay.
- Applied behavior analysis (ABA) and related services for any condition other than an autism spectrum disorder.
- Applied behavior analysis (ABA) services and related services performed as part of an educational program; or provided in or by a school/educational setting; or provided as a replacement for services that are the responsibility of the educational system.
- 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 118), meditation techniques, relaxation techniques, movement therapies, and energy therapies.
- Services, drugs, or supplies related to medical marijuana.
- Advanced care planning, except when provided as part of a covered hospice care treatment plan (see page 90).
- Membership or concierge service fees charged by a healthcare provider.
- Fees associated with copies, forwarding or mailing of records except as specifically described in Section 8.
- Services not specifically listed as covered.
- Services or supplies we are prohibited from covering under the Federal Law.

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 phone 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 provider 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, speech, or cognitive rehabilitation therapy, you must provide a written statement from the provider 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 provider's name, date, and charge. (See pages 137-138 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 (e.g., medical records) 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 retail 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 retail 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 paragraphs 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 800-624-5060 to request a retail prescription drug claim form to claim benefits. Hearing-impaired members with TTY equipment may call 711. 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 800-262-7890, TTY: 711. 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 phone 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 116 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 888-346-3731, TTY: 711, or you may send your prescription to: BCBS FEP Specialty Drug Pharmacy Program, CVS Specialty, 9310 Southpark Center Loop, Orlando, FL 32819. 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 are most convenient for you. To order refills, call the same phone 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 888-346-3731, TTY: 711, 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 following year after 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 (e.g., diagnosis codes, dates of service, etc.), you must resubmit it within 90 days, or before the timely filing period expires, whichever is later.

Note: Timely filing for overseas pharmacy claims is limited to one year from the prescription fill date.

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

Overseas claims

Please refer to the claims filing information on pages 131-132 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 healthcare 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% 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 phone 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 healthcare 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 or to make an inquiry 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 call your Plan's customer service representative at the phone number found on your enrollment card, our brochure, or our website (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 phone 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 healthcare 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 their 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.

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, FEHB 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;
- Your daytime phone number and the best time to call; and
- 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 healthcare 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 phone 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 FEHB 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 family member 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 healthcare 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 healthcare 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 on NAIC rules regarding the coordinating of benefits, visit our website at www.fepblue.org/coordinationofbenefits.

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 processes the benefit, 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 150). 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 healthcare 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 or employing 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**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

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 or employing 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 healthcare 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, 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 covered 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 69-76. **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 phone 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 (U.S. FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I enroll in Medicare?" please contact Medicare at 1-800-Medicare 800-633-4227, TTY: 711, or at www.medicare.gov.

- **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 21 for exceptions).

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 phone 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 healthcare 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 (skilled) 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**

If you are enrolled in Medicare Part B, 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 healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227), TTY: 711, 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 20 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 or employing 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		✓*
9) Are a Federal employee receiving 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 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: Participates with Medicare or accepts Medicare assignment for the claim and is in our Preferred network
Then you are responsible for:

Standard Option - your deductibles, coinsurance, and copayments.
Basic Option - your copayments and coinsurance.

If your physician: Participates with Medicare or accepts Medicare assignment and is not in our Preferred network
Then you are responsible for:

Standard Option - your deductibles, coinsurance, and copayments, and any balance up to the Medicare-approved amount.
Basic Option - all charges.

If your physician: Does not participate with Medicare and is in our Preferred network
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.
Then you are responsible for:

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.

If your physician: Does not participate with Medicare and is not in our Preferred network
Then you are responsible for:

Standard Option - your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare-approved amount.
Basic Option - all charges.

If your physician: Opts-out of Medicare via private contract
Then you are responsible for:

Standard Option - your deductibles, coinsurance, copayments, and any balance your physician charges.
Basic Option - your deductibles, coinsurance, copayments, and any balance your physician 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.

Physicians Who Opt-Out of Medicare

A physician may have opted-out of Medicare and may or may not ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. This is different than a Non-participating doctor, and we recommend you ask your physician if they have opted-out of Medicare. Should you visit an opt-out physician, the physician will not be limited to 115% of the Medicare-approved amount. You may be responsible for paying the difference between the billed amount and our regular in-network/out-of-network benefits.

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, you pay nothing for covered charges (see note below for Basic Option).
- If your physician **does not accept** Medicare assignment, 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 20 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.

Please review the following examples illustrating your cost-share liabilities when Medicare is your primary payor **and** your provider is in our network and participates with Medicare compared to what you pay without Medicare. Please do not rely on this chart alone but read all information in this section of the brochure. You can find more information about how our Plan coordinates with Medicare in our *Medicare and You Guide for Federal Employees* available online at www.fepblue.org.

Benefit Description: Deductible
Standard Option You Pay **Without** Medicare: $350-Self, $700-Family
Standard Option You Pay **With** Medicare Parts A & B: $0.00
Basic Option You Pay **Without** Medicare: N/A
Basic Option **With** Medicare Parts A & B: $0.00

Benefit Description: Catastrophic Protection Out-of-Pocket Maximum
Standard Option You Pay **Without** Medicare: $8,000-Self, $16,000-Family
Standard Option You Pay **With** Medicare Parts A & B: $8,000-Self, $16,000-Family
Basic Option You Pay **Without** Medicare: $6,500-Self, $13,000-Family
Basic Option **With** Medicare Parts A & B: $6,500-Self, $13,000-Family

Benefit Description: Part B Premium Reimbursement
Standard Option You Pay **Without** Medicare: N/A
Standard Option You Pay **With** Medicare Parts A & B: N/A
Basic Option You Pay **Without** Medicare: N/A
Basic Option **With** Medicare Parts A & B: $800

Benefit Description: Primary Care Physician
Standard Option You Pay **Without** Medicare: $25
Standard Option You Pay **With** Medicare Parts A & B: $0.00
Basic Option You Pay **Without** Medicare: $30
Basic Option **With** Medicare Parts A & B: $0.00

Benefit Description: Specialist
Standard Option You Pay **Without** Medicare: $35
Standard Option You Pay **With** Medicare Parts A & B: $0.00
Basic Option You Pay **Without** Medicare: $40
Basic Option **With** Medicare Parts A & B: $0.00

Benefit Description: Inpatient Hospital
Standard Option You Pay **Without** Medicare: $450
Standard Option You Pay **With** Medicare Parts A & B: $0.00
Basic Option You Pay **Without** Medicare: $250/day up to $1,500
Basic Option **With** Medicare Parts A & B: $0.00

Benefit Description: Outpatient Hospital
Standard Option You Pay **Without** Medicare: 15% or $25 copayment
Standard Option You Pay **With** Medicare Parts A & B: $0.00
Basic Option You Pay **Without** Medicare: 30% or $30-$500 copayment
Basic Option **With** Medicare Parts A & B: $0.00

Benefit Description: Incentives Offered
Standard Option You Pay **Without** Medicare: N/A
Standard Option You Pay **With** Medicare Parts A & B: N/A
Basic Option You Pay **Without** Medicare: N/A
Basic Option **With** Medicare Parts A & B: N/A

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.
Advanced care planning	Receiving information on the types of life-sustaining treatments that are available, completing advance directives and other standard forms, and/or if you are diagnosed with a terminal illness and making decisions about the care you would want to receive if you become unable to speak for yourself.
Agents	Medications 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 medications 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. Benefits provided under the contract are not assignable by the member to any person without express written approval of the Carrier, and in the absence of such approval, any such assignment shall be void. Please visit www.fepblue.org to obtain a valid authorization form.
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 an ovulating individual, combine them with sperm in the laboratory, and then implant the embryos or donate them to an individual capable of pregnancy.
Biologic drug	A complex drug or product that is manufactured in a living organism, or its components, that is used as a diagnostic, preventive or therapeutic agent.
Biosimilar drug	A U.S. FDA-approved biologic drug, which is considered highly similar to an original brand-name biologic drug, with no clinically meaningful differences from the original biologic drug in terms of safety, purity and potency.
Biosimilar, interchangeable drug	A U.S. FDA-approved biosimilar drug that may be automatically substituted for the original brand-name biologic drug.
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.
Clinical trials	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 U.S. Food and Drug Administration (U.S. FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.
Coinsurance	See Section 4 page 29.
Concurrent care claims	A claim for continuing care or an ongoing course of treatment that is subject to prior approval. See page 26 in Section 3.
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; ambiguous genitalia; and webbed fingers and toes. Note: Congenital anomalies do not include conditions related to the teeth or intra-oral structures supporting the teeth.

Copayment See Section 4 page 28.

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 See Section 4 page 28.

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 healthcare 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.

Durable medical equipment Equipment and supplies that are:

1. Prescribed by your physician (i.e., the physician who is treating your illness or injury);
2. Medically necessary;
3. Primarily and customarily used only for a medical purpose;
4. Generally useful only to a person with an illness or injury;
5. Designed for prolonged use; and
6. Used to serve a specific therapeutic purpose in the treatment of an illness or injury.

Experimental or investigational services Experimental or investigational shall mean:

1. A drug, device, or biological product that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (U.S. FDA); and approval for marketing has not been given at the time it is furnished; or
2. Reliable evidence shows that the healthcare 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
3. Reliable evidence shows that the consensus of opinion among experts regarding the healthcare 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

4. Reliable evidence shows that the healthcare 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:

1. Published reports and articles in the authoritative medical and scientific literature;
2. 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
3. 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 a U.S. 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 U.S. FDA as interchangeable with your brand-name drug.

Group health coverage Healthcare 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).

Healthcare professional A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law. See page 17 for information about how we determine which healthcare 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 healthcare provider. For more information, visit our website, www.fepblue.org.

Iatrogenic infertility Infertility caused by a medically necessary medical or surgical intervention used to treat a condition or disease.

Inpatient You are an inpatient when you are formally admitted to a hospital with a doctor's order.

Note: Inpatient care requires precertification. For some services and procedures prior approval must also be obtained. See pages 21-26.

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 use disorders. 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 healthcare 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:

1. In accordance with generally accepted standards of medical practice in the United States; and
2. 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
3. Not primarily for the convenience of the patient, physician, or other healthcare 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
4. Not part of or associated with scholastic education or vocational training of the patient; and
5. In the case of inpatient care, able to be provided safely only in the inpatient 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.

Minor acute conditions

Under the telehealth benefit you have on-demand access to care for common, non-emergent conditions. Examples of common conditions include sinus problems, rashes, allergies, cold and flu symptoms, etc.

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. For more information, see pages 7-8.

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.

Outpatient

You are an outpatient if you are getting emergency department services, observation services, outpatient surgery, lab tests, X-rays, or any other hospital services, and the doctor has not written an order to admit you to a hospital as an inpatient. In these cases, you are an outpatient even if you are admitted to a room in the hospital for observation and spend the night at the hospital.

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 healthcare 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 123 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 healthcare 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 Local Plan Allowance. The Local Plan Allowance varies by region and is determined by each Plan. If you would like additional information, or to obtain the current allowed amount, please call the customer service phone number on the back of your ID card. For inpatient stays resulting from medical emergencies or accidental injuries, or for emergency deliveries, our allowance is the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations;
  - For outpatient, non-emergency 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 Local Plan Allowance. This allowance applies to all of the covered services billed by the hospital. If you plan on using a Non-member hospital, or other Non-member facility, for your outpatient procedure, please call us before you receive services at the customer service phone 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 to use our National Doctor and Hospital Finder, or call us at the customer service phone number on the back of your ID card;

- For outpatient services resulting from a medical emergency or accidental injury that are billed by Non-member facilities, our allowance is the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations (minus any amount for noncovered services);
- For non-emergency medical services performed in Preferred hospitals provided by physicians and other covered healthcare professionals identified under the NSA (see page 32) that do not contract with your local Blue Cross and Blue Shield Plan and cannot balance bill you under this regulation, our allowance is equal to the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations;
- For physicians and other covered healthcare 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 Local Plan Allowance. In the absence of a Medicare participating fee schedule amount or ASP for any service, drug, or supply, our allowance is the Local Plan Allowance. 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 healthcare professionals, and air ambulance providers that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations;
- 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 the Overseas Assistance Center (provided by GMMI), 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, D.C., area, or a customary percent of billed charge, whichever is higher.

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 phone 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. See page 32.

For more information, see *Differences between our allowance and the bill* in Section 4. For more information about how we pay providers overseas, see pages 32 and 130.

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, healthcare institutions, and other covered healthcare 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 healthcare 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)); general health panel; basic or comprehensive metabolic panel; fasting lipoprotein profile; urinalysis; CBC; screening for diabetes mellitus, hepatitis B and hepatitis C, and latent tuberculosis; screening for alcohol/substance use disorders; counseling on reducing health risks; screening for depression; screening for chlamydia, syphilis, gonorrhea, HPV, and HIV; screening for intimate partner violence for women of reproductive age; administration and interpretation of a Health Risk Assessment questionnaire; cancer screenings including low-dose CT screening for lung cancer; screening for abdominal aortic aneurysms; osteoporosis screening, as specifically stated in this brochure; and immunizations as licensed by the U.S. Food and Drug Administration (U.S. FDA).

Note: Anesthesia services and pathology services associated with preventive colorectal surgical screenings are also paid as preventive care.

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 21-24.

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 page 144).

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.

Telehealth dermatology

Under the telehealth benefit, dermatologic conditions seen and treated include but are not limited to acne, dermatitis, eczema, psoriasis, rosacea, seborrheic keratosis, fungal infections, scabies, suspicious moles, and warts. Members capture important digital images, combine those with the comprehensive questionnaire responses, and send those to the dermatology network without requiring a phone or video interaction.

Telehealth services

Non-emergency services provided by phone or secure online video/messaging for minor acute conditions (see page 155 for definition), dermatology care, behavioral health and substance use disorder counseling, and nutritional counseling. Go to www.fepblue.org/telehealth or call 855-636-1579, TTY: 711, toll free to access this benefit. After your telehealth visit, please follow up with your primary care provider.

Telemedicine services

Services provided by phone or secure online video/messaging for evaluation and management services. This does not include the use of fax machine or email; costs associated with enabling or maintaining providers' telehealth (telemedicine) technologies; or fees for asynchronous services—medical information stored and forwarded to be reviewed at a later time by a physician or healthcare practitioner at a distant site without the patient being present. Providers must perform covered services acting within the scope of their license or certification under applicable state law. Please note, your healthcare provider must know when and where they can treat you. You, in turn, are responsible for accurately identifying to your provider where you are physically located for the service you received through telehealth (telemedicine) technologies. You and your physician must be in the same U.S. State, Territory, or foreign country as required by applicable legislation.

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 phone 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.

Index

Do not rely only 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.

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Summary of Benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2023

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a decision, please read this FEHB brochure.

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 healthcare professional, you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown below.

You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.fepblue.org/brochure.

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 healthcare professionals $35 per office visit for specialists Non-PPO: 35%* of our allowance	39-46
Medical services provided by physicians: Telehealth services	PPO: Nothing for the first 2 visits per calendar year; after the 2nd visit: $10 copayment per visit Non-PPO: You pay all charges	39, 99
Services provided by a hospital: Inpatient	PPO: $350 per admission Non-PPO: $450 per admission, plus 35% of our allowance	79-81
Services provided by a hospital: Outpatient	PPO: 15%* of our allowance Non-PPO: 35%* of our allowance	81-85
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	95-96
Emergency benefits: 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)	96-97

Standard Option Benefits	You pay	Page
Mental health and substance use disorder 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	98-102
Prescription drugs	**Retail Pharmacy Program:** • PPO: $7.50 for each purchase of up to a 30-day supply generic ($5.00 for a 30-day supply if you have Medicare Part B primary)/30% of our allowance Preferred brand-name/50% 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 Part B primary)/$90 Preferred brand-name/$125 non-preferred brand-name per prescription; up to a 90-day supply **Specialty Drug Pharmacy Program:** • $65 preferred specialty drug for a purchase of up to a 30-day supply; $85 non-preferred specialty drug for a purchase of up to a 30-day supply	108-120
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	123
Wellness and other special features: Health Tools; Blue Health Assessment; MyBlue® Customer eService; Diabetes Management Incentive Program; National Doctor and Hospital Finder; Healthy Families; travel benefit/services overseas; Care Management Programs; and Flexible benefits option	See Section 5(h).	125-129
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	• Self Only: Nothing after $6,000 (PPO) or $8,000 (PPO/Non-PPO) per contract per year • Self Plus One: Nothing after $12,000 (PPO) or $16,000 (PPO/Non-PPO) per contract per year • Self and Family: Nothing after $12,000 (PPO) or $16,000 (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 – 2023

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a decision, please read this FEHB brochure.

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 20. There is no deductible for Basic Option.

You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.fepblue.org/brochure.

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 healthcare professionals; $40 per office visit for specialists Non-PPO: You pay all charges	39-46
Medical services provided by physicians: Telehealth services	PPO: Nothing for the first 2 visits per calendar year after the 2nd visit: $15 copayment per visit Non-PPO: You pay all charges	39, 99
Services provided by a hospital: Inpatient	PPO: $250 per day up to $1,500 per admission Non-PPO: You pay all charges	79-81
Services provided by a hospital: Outpatient	PPO: $150 per day per facility Non-PPO: You pay all charges	81-85
Emergency benefits: Accidental injury	PPO: $35 copayment for urgent care; $250 copayment for emergency room care Non-PPO: $250 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	95-96
Emergency benefits: Medical emergency	Same as for accidental injury	96-97
Mental health and substance use disorder treatment	PPO: Regular cost-sharing, such as $30 office visit copayment; $250 per day up to $1,500 per inpatient admission Non-PPO: You pay all charges	98-102

Basic Option Benefits	You pay	Page
Prescription drugs	**Retail Pharmacy Program:** • PPO: $15 generic/($10 if you have primary Medicare Part B)/$60 Preferred brand-name per prescription ($50 if you have primary Medicare Part B)/60% coinsurance ($90 minimum) for non-preferred brand-name drugs (50% ($60 minimum) if you have primary Medicare Part B) • Non-PPO: You pay all charges **Specialty Drug Pharmacy Program:** • $85 preferred specialty drug for a purchase of up to a 30-day supply; $110 non-preferred specialty drug for a purchase of up to a 30-day supply **Mail Service Prescription Drug Program** (for primary Medicare Part B members only): • $20 generic/$100 Preferred brand-name/$125 non-preferred brand-name per prescription; up to a 90-day supply	108-120
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 associated oral evaluations required due to accidental injury; regular benefits for covered oral and maxillofacial surgery Non-PPO: You pay all charges	124
Wellness and other special features: Health Tools; Blue Health Assessment; MyBlue® Customer eService; Diabetes Management Incentive Program; National Doctor and Hospital Finder; Healthy Families; travel benefit/services overseas; Care Management Programs; and Flexible benefits option	See Section 5(h).	125-129
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	• Self Only: Nothing after $6,500 (PPO) per contract per year • Self Plus One: Nothing after $13,000 (PPO) per contract per year • Self and Family: Nothing after $13,000 (PPO) per contract per year; nothing after $6,500 (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

2023 Rate Information for the Blue Cross and Blue Shield Service Benefit Plan

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

Premiums for Tribal employees are shown under the Monthly Premium Rate 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	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Nationwide					
Standard Option Self Only	104	$259.72	$142.40	$562.73	$308.53
Standard Option Self Plus One	106	$560.52	$318.85	$1,214.46	$690.84
Standard Option Self and Family	105	$611.42	$347.89	$1,324.74	$753.77
Nationwide					
Basic Option Self Only	111	$259.72	$86.67	$562.73	$187.78
Basic Option Self Plus One	113	$560.52	$217.90	$1,214.46	$472.12
Basic Option Self and Family	112	$611.42	$237.91	$1,324.74	$515.48

EXHIBIT O

Blue Cross® and Blue Shield® Service Benefit Plan

www.fepblue.org

2024

A Fee-For-Service Plan (FEP Blue Standard and FEP Blue Basic Options) with a Preferred Provider Organization

This Plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See our FEHB Facts for details. This Plan is accredited. See Section 1.

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

IMPORTANT

- Rates: Back Cover
- Changes for 2024: Page 14
- Summary of Benefits: Page 163

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:
United States Office of Personnel Management
Healthcare and Insurance
http://www.opm.gov/insure

Blue Cross® and Blue Shield® Service Benefit Plan

www.fepblue.org

2024

A Fee-For-Service Plan (FEP Blue Standard and FEP Blue Basic Options) with a Preferred Provider Organization

Corrections to 2024 brochure

Please note the following correction to the brochure:

- Page 130: NSA information is identified as being in Section 3. It is actually in Section 4.
- Page 165, Mental health and substance use disorder treatment – The Basic Option office visit copayment is $35, not $30.

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

The Office of Personnel Management (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 is 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% 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 800-772-1213, TTY: 711.

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 800-MEDICARE 800-633-4227, TTY 711.

Potential Additional Premium for Medicare's High Income Members

Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return.** You do not make any IRMAA payment to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website to see if you would be subject to this additional premium.

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Introduction

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Standard and FEP Blue Basic Options** under contract (CS 1039) between the Blue Cross and Blue Shield Association and 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 phone number appearing on the back of your ID card.

The address for the Blue Cross and Blue Shield Service Benefit Plan administrative office is:

Blue Cross and Blue Shield Service Benefit Plan
750 9th Street NW
Washington, DC 20001-4524

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 healthcare benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2024, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2024, and changes are summarized in Section 2. Rates are shown on the back cover of this brochure.

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 and each covered 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 Healthcare Fraud!

Fraud increases the cost of healthcare 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 phone or to people you do not know, except for your healthcare provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare 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 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 800-FEP-8440 (800-337-8440) and explain the situation.
  - If we do not resolve the issue:

CALL THE HEALTHCARE FRAUD HOTLINE
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)
  - Your child age 26 or over (unless they were disabled and incapable of self-support prior to age 26)
- A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- 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 (TCC).
- 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.

Discrimination is Against the Law

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination.

We:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator of your Local Plan by contacting your Local Plan at the phone number appearing on the back of your ID card.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator of your Local Plan. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, your Local Plan's Civil Rights Coordinator is available to help you.

Members may file a complaint with the HHS Office for Civil Rights, OPM, or FEHB Program Carriers.

For further information about how to file a civil rights complaint, go to www.fepblue.org/en/rights-and-responsibilities/, or call the customer service phone number on the back of your member ID card. For TTY, dial 711.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. 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 take notes, ask questions, and understand answers.
2. **Keep and bring a list of all the medications you take.**
   - Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosages that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
   - Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as 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 medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
   - Read the label and patient package insert when you get your medication, including all warnings and instructions.
   - Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
   - Contact your doctor or pharmacist if you have any questions.
   - Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.
3. **Get the results of any test or procedure.**
   - Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
   - Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
   - Ask what the results mean for your care.
4. **Talk to your doctor about which hospital or clinic is best for your health needs.**
   - Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
   - Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

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

For more information on patient safety, please visit:

- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. 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 healthcare providers and improve the quality of care you receive.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- 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 healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions (“Never Events”)

When you enter the hospital for treatment of one medical problem, you do not 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, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called “Never Events” or “Serious Reportable Events.”

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. When such an event occurs, neither you nor your FEHB Plan will incur costs to correct the medical error.

You will not be billed for inpatient services when care is related to treatment of specific hospital-acquired conditions if you use Preferred or Member hospitals. This policy helps to protect you from having to pay for the cost of treating these conditions, and it encourages hospitals to improve the quality of care they provide.

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. 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, give you other plans' brochures 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.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include 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 Plus One or Self and Family 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 are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee’s FEHB enrollment.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday, unless your child is eligible for continued coverage because they are incapable of support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in 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 below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: 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
Coverage: 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
Coverage: 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
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

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

- **Children's Equity Act**

OPM implements 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 or children.

If this law applies to you, you must enroll in 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 lowest-cost nationwide Plan option as determined by OPM.
- 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 lowest-cost nationwide plan option as determined by OPM.

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 does not 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 does not 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 processed according to the 2024 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2023 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 family members 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 assistance with enrolling in a conversion policy (non-FEHB individual policy). FEP helps members with Temporary Continuation of Coverage (TCC) and with finding replacement coverage.

- **Upon divorce**

If you are an enrollee, and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You must contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member 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 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. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

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

If you leave Federal service or Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for TCC. 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, or if you are a covered 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 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 coverage.

We also want to inform you that the Patient Protection and ACA did not eliminate TCC or change the TCC rules.

- **Finding replacement coverage**

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please refer to the next Section of this brochure. We will help you find replacement coverage inside or outside the Marketplace. For assistance, please contact your Local Plan at the phone 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 ACA's Health Insurance Marketplace. These rules are established by the Federal Government agencies that have responsibility for implementing the ACA and by the Marketplace.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA'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 healthcare 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.

OPM requires that FEHB plans be accredited to validate that Plan operations and/or care management meet nationally recognized standards. The local Plans and vendors that support the Blue Cross and Blue Shield Service Benefit Plan hold accreditation from National Committee for Quality Assurance (NCQA) and/or URAC. To learn more about this Plan's accreditations, please visit the following websites:

- National Committee for Quality Assurance (www.ncqa.org);
- URAC (www.URAC.org).

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 healthcare 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 Preferred 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. 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 Section 3 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 phone 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 healthcare facilities, physicians, and other healthcare 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 NSA in Section 4). 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 Section 3 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.
- **Pilot Programs.** We may implement pilot programs in one or more Local Plan areas and overseas to test the feasibility and examine the impact of various initiatives. The pilot programs do not affect all Plan areas. Information on specific pilots is not published in this brochure; it is communicated to members and network providers in accordance with our agreement with OPM. Certain pilot programs may incorporate benefits that are different from those described in this brochure. For example, certain pilot programs may revise the Plan Allowance for Non-participating providers described in Section 10 of this brochure.

Your rights and responsibilities

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/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence
- Profit status
- Care management, including case management and disease management programs
- How we determine if procedures are experimental or investigational

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, at www.fepblue.org/en/rights-and-responsibilities.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.fepblue.org/en/terms-and-privacy/notice-of-privacy-practices/ to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

If you want more information about us, call or write to us. Our phone 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 2024

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.

Changes to our Standard Option only

- We no longer require a signed consent form agreeing to enrollment into and active participation in case management during a skilled nursing facility (SNF) stay prior to admission for members who do not have primary Medicare Part A. Previously, this was required prior to admission into a SNF.
- We now provide coverage for assisted reproductive technology (ART) procedures and services, limited to $25,000 annually for members who meet our definition of infertility and obtain prior approval. Previously, we did not provide coverage for these services. (See page 49.)
- Your copayment for office visits, physical therapy, occupational therapy, speech therapy, cognitive rehabilitation therapy, vision services, foot care services, and manipulative treatments when performed by Preferred primary care providers or other healthcare professionals, and when applicable Preferred facilities, is now $30 per visit. Previously, your copayment for these services was $25 per visit. (See pages 28, 37, 39, 52, 54, 58, 79, 94, 151, 163 and 164.)
- Your copayment for office visits, physical therapy, occupational therapy, speech therapy, cognitive rehabilitation therapy, vision services, and foot care services when performed by a Preferred specialist is now $40 per visit. Previously, your copayment for these services was $35 per visit. (See pages 37, 39, 52, 54, 151, and 163.)
- For eligible members, prescription drug benefits will now be provided under a new FEP Medicare Prescription Drug Program. Previously, we did not offer a separate prescription drug program. (See page 108.)
- Members enrolled under the FEP Medicare Prescription Drug Program will have a separate pharmacy drug out-of-pocket catastrophic maximum of $2,000. Previously, there was no separate catastrophic maximum. (See page 111.)
- For members enrolled in the FEP Medicare Prescription Drug Program, your copayment for Tier 1 generic drugs purchased at a network pharmacy is $5 for each purchase of up to a 30-day supply and $15 for a 31 to 90-day supply, deductible does not apply. Tier 1 generic drugs purchased through the Mail Service Prescription Drug Program are subject to a $5 copayment. Previously, we did not provide this separate prescription drug program. (See pages 111-112.)
- For members enrolled in the FEP Medicare Prescription Drug Program, your coinsurance for Tier 2 preferred brand-name drugs purchased at a network pharmacy is 15% of the Plan allowance for each purchase of up to a 90-day supply, deductible does not apply. Tier 2 preferred brand-name drugs purchased through the Mail Service Prescription Drug Program are subject to an $85 copayment. Previously, we did not provide this separate prescription drug program. (See pages 111-112.)
- For members enrolled in the FEP Medicare Prescription Drug Program, your coinsurance for Tier 3 non-preferred brand-name drugs purchased at a network pharmacy is 50% of the Plan allowance for each purchase of up to a 90-day supply, deductible does not apply. Tier 3 non-preferred brand-name drugs purchased through the Mail Service Prescription Drug Program are subject to a $125 copayment. Previously, we did not provide this separate prescription drug program. (See pages 111-112.)
- For members enrolled in the FEP Medicare Prescription Drug Program, your copayment for Tier 4 specialty drugs purchased at a network pharmacy is $60 for each purchase of up to a 30-day supply; $170 for a 31 to 90-day supply, deductible does not apply. Tier 4 specialty drugs purchased through the Mail Service Prescription Drug Program are subject to a $150 copayment. Previously, we did not provide this separate prescription drug program. (See pages 111-112.)

Changes to our Basic Option only

- Your copayment for office visits, allergy care, treatment therapies and services, physical therapy, occupational therapy, speech therapy, cognitive rehabilitation therapy, hearing services, vision services, foot care services, skilled home nursing care, manipulative and alternative treatments, diabetic education, and dental services when performed by Preferred primary care providers or other healthcare professionals, and when applicable Preferred facilities is now $35 per visit. Previously, your copayment for these services was $30 per visit. (See pages 29, 32, 37, 39, 50, 51, 52, 53, 54, 58, 59, 60, 79, 80, 94, 96, 121, 124, 151, 165 and 166.)

- Your copayment for office visits, allergy care, treatment therapies and services, physical therapy, occupational therapy, speech therapy, cognitive rehabilitation therapy, hearing services, vision services, foot care services, alternative treatments, and diabetic education, when performed by Preferred specialists is now $45 per visit. Previously, your copayment for these services was $40 per visit. (See pages 37, 39, 50, 51, 52, 53, 54, 58, 59, 60, 151, and 165.)
- For eligible members, prescription drug benefits will now be provided under a new FEP Medicare Prescription Drug Program. Previously, we did not offer a separate prescription drug program. (See page 108.)
- Members enrolled in the FEP Medicare Prescription Drug Program will have a separate pharmacy drug out-of-pocket catastrophic maximum of $3,250. Previously, there was no separate catastrophic maximum. (See page 111.)
- For members enrolled in the FEP Medicare Prescription Drug Program, your copayment for Tier 1 generic drugs purchased at a network pharmacy is $10 for each purchase of up to a 30-day supply and $30 for a 31 to 90-day supply. Tier 1 generic drugs purchased through the Mail Service Prescription Drug Program are subject to a $15 copayment. Previously, we did not provide this separate prescription drug program. (See pages 111-112.)
- For members enrolled in the FEP Medicare Prescription Drug Program, your copayment for Tier 2 preferred brand-name drugs purchased at a network pharmacy is $45 for each purchase of up to a 30-day supply and $135 for a 31 to 90-day supply. Tier 2 preferred brand-name drugs purchased through the Mail Service Prescription Drug Program are subject to a $95 copayment. Previously, we did not provide this separate prescription drug program. (See pages 111-112.)
- For members enrolled in the FEP Medicare Prescription Drug Program, your coinsurance for Tier 3 non-preferred brand-name drugs purchased at a network pharmacy is 50% of the Plan allowance ($60 minimum) for each purchase of up to a 30-day supply, and 50% of the Plan allowance ($175 minimum) for a 31 to 90-day supply. Tier 3 non-preferred brand-name drugs purchased through the Mail Service Prescription Drug Program are subject to a $125 copayment. Previously, we did not provide this separate prescription drug program. (See pages 111-112.)
- For members enrolled in the FEP Medicare Prescription Drug Program, your copayment for Tier 4 specialty drugs purchased at a network pharmacy is $75 for each purchase of up to a 30-day supply and $195 for a 31 to 90-day supply. Tier 4 specialty drugs purchased through the Mail Service Prescription Drug Program are subject to a $150 copayment. Previously, we did not provide this separate prescription drug program. (See pages 111-112.)

Changes to both our Standard and Basic Options

- We no longer require written consent and participation in a case management program prior to admission for inpatient care provided by a residential treatment center (RTC). Previously, this was required prior to admission into an RTC.
- We now provide coverage for bariatric surgeries in accordance with our medical policy. Previously, the criteria was listed in the brochure. (See page 22.)
- We now provide benefits for medically necessary genetic testing for members requesting this service due to susceptibility or possible high-risk of disease once prior approval has been obtained. Previously, we did not provide benefits for these services. (See pages 22 and 41.)
- You now must obtain prior approval to receive benefit reimbursement for hearing aids. Previously, prior approval was not required for hearing aids. (See pages 22 and 55.)
- We no longer require prior approval for the surgical treatment of a congenital anomaly. Previously, prior approval was required.
- We no longer require prior approval for intensity-modulated radiation therapy (IMRT). Previously, IMRT required prior approval for the treatment of certain cancers.
- We no longer require prior approval for proton beam therapy for members aged 21 and younger, or when care is related to the treatment of neoplasms of the nervous system including the brain and spinal cord; malignant neoplasms of the thymus; and Hodgkin and non-Hodgkin lymphomas. Previously, prior approval was required regardless of the age of the patient, or the condition being treated. (See page 22.)
- We no longer require prior approval for stereotactic radiosurgery related to the treatment of malignant neoplasms of the brain and of the eye specific to the choroid and ciliary body; benign neoplasms of the cranial nerves, pituitary gland, aortic body, paraganglia; neoplasms of the craniopharyngeal duct and glomus jugular tumors; trigeminal neuralgias, temporal sclerosis, certain epilepsy conditions, or arteriovenous malformations. Previously, prior approval was required regardless of the condition being treated. (See page 22.)

- We now provide coverage for the following artificial insemination (AI) procedures once prior approval has been obtained: intracervical insemination (ICI), intrauterine insemination (IUI), and intravaginal insemination (IVI) for individuals meeting our definition of infertility. (See pages 22, 49, and 154.)
- We now provide coverage for breast augmentation for male to female gender affirming care. Previously, we did not list this as a covered service. (See page 64.)
- We now provide coverage for a mastectomy beginning at the age of 16 for female to male gender affirming care. Previously, we did not provide benefits until the age of 18. (See page 65.)
- We now require only 6 months of continuous hormone therapy appropriate to the member's gender identity, unless medically contraindicated. Previously, we required 12 months of continuous hormone therapy. (See page 65.)
- We have reduced the number of referral letters documenting the diagnosis of gender dysphoria and other criteria to one. Previously, we required two letters. (See page 65.)
- We now cover certain facial surgeries for gender affirming care and no longer limit covered medically necessary gender affirming surgical services to once per lifetime. Previously, we did not cover facial gender affirming surgery, and we limited covered procedures to once per lifetime. (See page 64.)
- We have added the following diagnoses and/or stages of diagnoses to the allogeneic blood or marrow stem cell transplants that do not require a clinical trial: Blastic plasmacytoid dendritic cell neoplasm; Adrenoleukodystrophy, Globoid cell leukodystrophy (Krabbe's leukodystrophy); IPEX (immune dysregulation, polyendocrinopathy, enteropathy, X-linked syndrome); Dyskeratosis congenita; Hypereosinophilic syndromes; plasma cell leukemia; severe congenital neutropenia, common variable immunodeficiency, chronic granulomatous disease/phagocytic cell disorders; and Systemic mastocytosis, aggressive. Previously, we did not cover these diagnoses. (See page 68.)
- We have added the following diagnoses and/or stages of diagnoses to the autologous blood or marrow stem cell transplants that do not require a clinical trial: autoimmune – limited to: idiopathic (juvenile) rheumatoid arthritis, multiple sclerosis (treatment-refractory relapsing with high risk of future disability) and scleroderma/systemic sclerosis); chronic lymphocytic leukemia (e.g., T cell prolymphocytic leukemia, B cell prolymphocytic leukemia, hairy cell leukemia); relapsed neuroblastoma; osteosarcoma; plasma cell leukemia; and Wilms Tumor. Previously, we did not cover these diagnoses, or we required they be done as part of a clinical trial. (See page 69.)
- We no longer require a clinical trial for allogeneic or autologous bone or marrow stem cell transplants with the following diagnoses: Multiple Sclerosis and Wilms Tumor.
- We no longer cover allogeneic bone or marrow stem cell transplants with the following diagnoses: colon cancer; epidermolysis bullosa; glial tumors (e.g., anaplastic astrocytoma, choroid plexus tumors, ependymoma, glioblastoma multiforme); ovarian cancer; prostate cancer; or autologous bone or marrow transplants for retinoblastoma.
- For allogeneic blood or marrow stem cell transplants, we now cover additional diagnoses only when performed as part of a clinical trial: autoimmune disease (limited to scleroderma/systemic sclerosis, systemic lupus erythematosus, Idiopathic (juvenile) rheumatoid arthritis, CIDP (chronic inflammatory demyelinating polyneuropathy); Germ Cell Tumors; high-risk or relapsed neuroblastoma; lysosomal metabolic diseases: e.g., Mucopolysaccharidosis type II (Hunter syndrome), Mucopolysaccharidosis type IV (Morquio syndrome), Mucopolysaccharidosis type VI (Maroteaux-Lamy syndrome), Fabry disease, Gaucher disease. (See page 69.)
- For autologous blood or marrow stem cell transplants, we now cover additional diagnoses only when performed as part of a clinical trial: autoimmune disease (e.g., systemic lupus erythematosus, Crohn's disease, Polymyositis-dermatomyositis, rheumatoid arthritis, CIDP (chronic inflammatory demyelinating polyneuropathy); and sarcoma (e.g., rhabdomyosarcoma, soft tissue sarcoma). Previously, we did not cover transplants for these diagnoses. (See page 70.)
- We now provide coverage for marital and family counseling and psychotherapy services. Previously, we excluded care for these services. (See page 94.)
- We now provide benefits for drugs associated with covered artificial insemination (AI) procedures. Previously, we did not cover these drugs when associated with AI procedures. (See pages 103 and 111.)
- We now cover invitro fertilization related drugs limited to three cycles annually once prior approval has been obtained for individuals that meet our definition of infertility. (See pages 103 and 111.)
- We no longer offer the Diabetes Management Incentive Program. Members who qualified for the program and completed the program in 2023 will still receive their earned rewards. For more information about the ending of this program, please visit us at www.fepblue.org.

Section 3. How You Get Care

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 read further in this section for exceptions to this requirement.

Under both Standard and Basic Option, you can also get care for the treatment of minor acute conditions, dermatology care, counseling for behavioral health and substance use disorder, and nutritional counseling, using teleconsultation services delivered via phone by calling 855-636-1579, TTY: 711, or via secure online video/messaging at www.fepblue.org/telehealth.

The term "primary care provider" includes family practitioners, general practitioners, medical internists, pediatricians, obstetricians/gynecologists, and physician assistants. Physician assistants working for a specialist may also be considered specialists.

Balance Billing Protection

FEHB Carriers must have clauses in their in-network (participating) provider agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or in some cases for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in-network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

- **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. Covered professional providers within the United States, Puerto Rico, and the U.S. Virgin Islands are healthcare 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 healthcare services in the normal course of business. Covered services must be provided in the state in which the provider is licensed or certified. **If the state has no applicable licensing or certification requirement, the provider must meet the requirements of the Local Plan.** 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.

This plan recognizes that transgender, non-binary, and other gender diverse members require healthcare delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

If you have questions about covered providers, would like the names of PPO (Preferred) providers, or need a Care Coordinator for complex conditions, please contact the Local Plan where services will be performed.

- **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-Preferred (Member/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 surgicenter, 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 licensed by the state, district, or territory and may be accredited, where required, by a nationally recognized organization to provide residential treatment for medical conditions, mental health conditions, and/or substance use disorder. Accredited healthcare 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 use disorder 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. If you have questions about treatment at an RTC or need assistance coordinating this care, please contact us at the customer service phone number listed on the back of your ID card.

Blue Distinction® Specialty Care

Blue Distinction Specialty Care, our centers of excellence program, focuses on effective treatment for specialty procedures, such as: Bariatric Surgery, Cardiac Care, Knee and Hip Replacement, Spine Surgery, Transplants, Cancer Care, Cellular Immunotherapy (CAR-T), Gene Therapy, Maternity Care, and Substance Use Treatment and Recovery. Using national evaluation criteria developed with input from medical experts, the Blue Distinction Centers offer comprehensive care delivered by multidisciplinary teams with subspecialty training and distinguished clinical expertise. Providers demonstrate quality care, treatment expertise and better overall patient results.

We cover specialty care at designated Blue Distinction Centers at Preferred benefit levels. See Section 5(c) for information regarding enhanced inpatient and outpatient benefits for bariatric, spine, knee and hip surgeries performed at a Blue Distinction Center. We also provide enhanced benefits for covered transplant services performed at the Blue Distinction Centers for Transplant designated centers as described in Section 5(b).

For listings of Blue Distinction Centers, visit https://www.bcbs.com/blue-distinction-center/facility; access our National Doctor & Hospital Finder via www.fepblue.org/provider/; or call us at the customer service phone number listed on the back of your ID card.

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 phone number listed on the back of your ID card or by visiting www.factglobal.org.

Skilled Nursing Facility (SNF)

A SNF is a freestanding institution or a distinct part of a hospital which customarily bills insurance as a skilled nursing facility and meets the following criteria:

- Is Medicare-certified as a skilled nursing facility;
- Is licensed in accordance with state or local law or is approved by the state or local licensing agency as meeting the licensing standards (where state or local law provides for the licensing of such facilities);
- Has a transfer agreement in effect with one or more Preferred hospitals; and
- Is primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care; or rehabilitation services for the rehabilitation of injured, disabled or sick persons.

To be covered, skilled nursing facility care cannot be maintenance or custodial care. The term skilled nursing facility does not include any institution that is primarily for the care and treatment of mental diseases. If you have questions about treatment at a SNF, or need assistance coordinating this care, please contact us at the customer service phone number listed on the back of your ID card.

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.

Exceptions:

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, neonatologists, 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 pregnant 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 phone number listed in your local phone directory. If you already have your new Service Benefit Plan ID card, call us at the phone 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 may require precertification and prior approval. If you do not obtain precertification, there may be a reduction or denial of benefits. Be sure to read all of the following precertification and prior approval information. Our FEP medical policies may be found by visiting www.fepblue.org/policies.

- **Inpatient hospital admission, inpatient residential treatment center admission, or skilled nursing facility admission**

Precertification is the process by which – prior to your inpatient 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, inpatient residential treatment center, or skilled nursing facility whether or not they have contacted us and provided all necessary information. You may contact us at the phone number on the back of your ID card to ask if we have received the request for precertification. Keep reading this section for information about precertification of an emergency inpatient admission.

- **Warning:**

We will reduce our benefits for the inpatient hospital stay by $500, even if you have obtained prior approval for the service or procedure being performed during the stay, 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.

- **Exceptions:**

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States; with the exception of admissions for gender affirming surgery and admissions to residential treatment centers, and skilled nursing facilities.
- You have another group health insurance policy that is the primary payor for the hospital stay; with the exception of admissions for gender affirming surgery.
- Medicare Part A is the primary payor for the hospital or skilled nursing facility stay; with the exception of admissions for gender affirming surgery.

  Note: Precertification for covered organ/tissue transplants performed at Blue Distinction Centers for Transplants is required even if you have another primary group health insurance policy or have primary Medicare Part A coverage.

  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: Severe obesity surgery performed during an inpatient stay (even when Medicare Part A is your primary payor) must meet the surgical requirements listed in our medical policy in order for benefits to be provided for the admission and surgical procedure.

- **Other services**

You must obtain prior approval for these services under both Standard and Basic Option in all outpatient and inpatient settings unless otherwise noted. Precertification is also required if the service or procedure requires an inpatient hospital admission. Contact us using the customer service phone 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:

- **Gene therapy and cellular immunotherapy, for example, CAR-T and T-Cell receptor therapy**
- **High-cost drugs –** We require prior approval for certain high-cost drugs obtained outside of a pharmacy setting. Contact the customer service number on the back of your ID card or visit us at www.fepblue.org/highcostdrugs for a list of these drugs.
- **Air Ambulance Transport (non-emergent)** – Air ambulance transport related to immediate care of a medical emergency or accidental injury does not require prior approval.
- **Outpatient facility-based sleep studies** – Prior approval is required for sleep studies performed in a provider's office, sleep center, clinic, any type of outpatient center, or any location other than your home.
- **Applied behavior analysis (ABA)** – Prior approval is required for ABA and all related services, including assessments, evaluations, and treatments.
- **Gender affirming surgery –** Prior to surgical treatment of gender dysphoria, your provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and your provider later modifies the plan.
- **Genetic testing**
- **Hearing aids - prior approval is required to receive coverage for hearing aids**
- **Surgical services** – The surgical services on the following list require prior approval for care performed by Preferred, Participating/Member, and Non-participating/Non-member professional and facility providers:
  - Surgery for severe obesity;
    Note: Benefits for the surgical treatment of severe obesity – performed on an inpatient or outpatient basis – are subject to the pre-surgical requirements listed in our medical policy at www.fepblue.org/legal/policies-guidelines.
  - Surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth except when care is provided within 72 hours of the accidental injury
- **Proton beam therapy** – Prior approval is required for all proton beam therapy services except for members aged 21 and younger, or when related to the treatment of neoplasms of the nervous system including the brain and spinal cord; malignant neoplasms of the thymus; Hodgkin and non-Hodgkin lymphomas.
- **Stereotactic radiosurgery** – Prior approval is required for all stereotactic radiosurgery except when related to the treatment of malignant neoplasms of the brain, and of the eye specific to the choroid and ciliary body; benign neoplasms of the cranial nerves, pituitary gland, aortic body, or paraganglia; neoplasms of the craniopharyngeal duct and glomus jugular tumors; trigeminal neuralgias, temporal sclerosis, certain epilepsy conditions, or arteriovenous malformations.
- **Stereotactic body radiation therapy**
- **Reproductive Services** – Prior approval is required for intracervical insemination (ICI), intrauterine insemination (IUI), intravaginal insemination (IVI), and assisted reproductive technologies (ART).
- **Sperm/egg storage** – Prior approval is required for the storage of sperm and eggs for individuals facing iatrogenic infertility.
- **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.

- **Organ/tissue transplants** – **Prior approval is required** for both the procedure and the facility. Contact us at the customer service phone 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.

  Some **organ transplant procedures** listed in Section 5(b) 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. Contact your local Plan for Medicare's approved transplant programs.

  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 phone number listed on the back of your ID card.

  Some blood or marrow stem cell transplants listed in Section 5(b) 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. Other **transplant procedures listed in Section 5(b)** must be performed at a FACT-accredited facility. We described these types of facilities earlier in this section.

  Not every transplant program 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 phone number listed 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** – In Section 5(b) we provide the list of conditions covered **only** in clinical trials. Contact us at the customer service phone 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.

  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 Blue Distinction Center for Transplants to treat your condition. If your physician has recommended you receive a transplant or that you participate in a transplant clinical trial, we encourage you to contact the Case Management Department at your Local Plan.

  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 where the procedure is to be performed.
- **Transplant travel –** 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 companions. If the transplant recipient is age 21 or younger, we pay up to $10,000 for eligible travel costs for the member and companions. Reimbursement is subject to IRS regulations.

- **Prescription drugs and supplies – Certain prescription drugs and supplies require prior approval.** Contact CVS Caremark, our Pharmacy Program administrator, at 800-624-5060, TTY: 711, 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 Section 5(f) for more information 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 Program – 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: Neither the Mail Service Prescription Drug Program, nor the Specialty Drug Pharmacy Program, will fill your prescription for a drug requiring prior approval 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 unable to be filled and a letter will be mailed to you explaining the prior approval procedures.
- **Medical foods covered under the pharmacy benefit require prior approval.** See Section 5(f) for more information.

- **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 phone 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 in this section as requiring approval – 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 phone 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; and
- Any other information we may request related to the services to be provided.

Note: If we approve the request for prior approval or precertification, you will be provided with a notice that identifies the approved services and the authorization period. You must contact us with a request for a new approval five (5) business days prior to a change to the approved original request, and for requests for an extension beyond the approved authorization period in the notice you received. We will advise you of the information needed to review the request for change and/or extension.

- **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* later in this section.) If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not 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 phone number listed on the back of your Service Benefit Plan ID card. You may also call OPM's FEHB 1 at 202-606-0727 between 8 a.m. and 5 p. m. Eastern Time (excluding holidays) 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 phone 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, 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 phone 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 phone 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* below.

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, your physician or the hospital must contact us for precertification of additional days. Further, if your newborn stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your newborn.

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

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

If your **hospital** stay – including for maternity and RTC 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 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, 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. (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 verbal or written requests for appeals and the exchange of information by phone, 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-share/Cost-sharing

Cost-share or 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 $30 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 typically $150. 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 typically applied to the ultrasound.

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 prior 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. See Section 5(i) for information about the deductible and overseas benefits.

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 or not 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 phone 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 the 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 $35 copayment. Even though our allowance may be $100, you still pay just the $35 copayment. Because of the agreement, your Preferred physician will not bill you for the $215 difference between your copayment and the bill.

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

- **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 phone 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 described in the *No Surprises Act*, later in this section). 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 the 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.**

- **Remember, under Basic Option you must use Preferred providers in order to receive benefits. There are no benefits for care performed by Participating and Non-participating providers. See Section 3 for exceptions under *What you must do to get covered care.***

The following examples 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 in Section 5(a) and outpatient hospital or ambulatory surgical facility care begins in Section 5(c).

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
Physician's charge: $250
Our allowance: We set it at: 100
We pay: 85% of our allowance: 85
You owe: Coinsurance: 15% of our allowance: 15
You owe: Copayment: Not applicable
+Difference up to charge?: No: 0
TOTAL YOU PAY: $15

Participating Physician Standard Option
Physician's charge: $250
Our allowance: We set it at: 100
We pay: 65% of our allowance: 65
You owe: Coinsurance: 35% of our allowance: 35
You owe: Copayment: Not applicable
+Difference up to charge?: No: 0
TOTAL YOU PAY: $35

Non-participating Physician Standard Option
Physician's charge: $250
Our allowance: We set it at: 100
We pay: 65% of our allowance: 65
You owe: Coinsurance: 35% of our allowance: 35
You owe: Copayment: Not applicable
+Difference up to charge?: Yes: 150
TOTAL YOU PAY: $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.

You should also see *Important Notice About Surprise Billing – Know Your Rights* in this section that describes your protections against surprise billing under the No Surprises Act.

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
Facility’s charge: $5,000
Our allowance: We set it at: 2,900
We pay: 85% of our allowance: 2,465
You owe: Coinsurance: 15% of our allowance: 435
You owe: Copayment: Not applicable
+Difference up to charge?: No: 0
TOTAL YOU PAY: $435

Member Ambulatory Surgical Facility Standard Option
Facility’s charge: $5,000
Our allowance: We set it at: 2,900
We pay: 65% of our allowance: 1,885
You owe: Coinsurance: 35% of our allowance: 1,015
You owe: Copayment: Not applicable
+Difference up to charge?: No: 0
TOTAL YOU PAY: $1,015

Non-member Ambulatory Surgical Facility* Standard Option
Facility's charge: $5,000
Our allowance: We set it at: 2,500
We pay: 65% of our allowance: 1,625
You owe: Coinsurance: 35% of our allowance: 875
You owe: Copayment: Not applicable
+Difference up to charge?: Yes: 2,500
TOTAL YOU PAY: $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 Surprise Billing — Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out of network air ambulance services.

A surprise bill is an unexpected bill you receive for:

- emergency care - when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating healthcare facilities, or for
- air ambulance services furnished by nonparticipating air ambulance providers

Balance billing happens when you receive a bill from the non-participating provider, facility, or air ambulance service for the difference between the Non-participating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from bills.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.fepblue.org/NSA or contact the customer service phone number on the back of your ID card.

Your costs for other care

Overseas care. Services provided outside the United States, Puerto Rico, and the U.S. Virgin Islands are considered overseas care. **Under Standard and Basic Options**, we pay overseas claims at Preferred benefit levels. Therefore, the Basic Option requirement to use Preferred providers in order to receive benefits does not apply. See Section 5(i) for specific 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 $35 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 Section 3 under *What you must do to get covered care.*

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 healthcare 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 $6,000 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 $12,000 for Preferred provider services. Only eligible expenses for Preferred provider services, and the cost-shares associated with care from Non-participating providers under the NSA, see information earlier in this section, 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 $8,000 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 $16,000 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 $6,500 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 $13,000 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 earlier information in this section;
- 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 facility;
- 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 Section 3, *What you must do to get covered care*, for the exceptions to the requirement to use Preferred providers.

If your provider's prescription allows for generic substitution and you select a brand-name drug, your expenses for the difference in cost-share do not count toward your catastrophic protection out-of-pocket maximum (see Section 5(f) for additional information).

Carryover

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 here and previously in this section 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 previously shown) from that point until the effective date of your new plan.

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

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 prior 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.

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.

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 contract holder.

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.

The Federal Flexible Spending Account Program – FSAFEDS

Healthcare FSA (HCFSA) – Reimburses you for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, 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).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 5. Benefits

See Section 2 for how our benefits changed this year and towards the end of the brochure for a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. Standard and Basic Option Overview

The benefit package for Standard and Basic Options are described in Section 5, which is divided into subsections 5(a) through 5(i). Make sure that you review the benefits that are available under the option in which you are enrolled.

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 phone number on the back of your Service Benefit Plan ID card or on our website at www.fepblue.org. Each option offers unique features. Members do not need to have referrals to see specialists.

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 $30 copayment for office visits to primary care providers ($40 for specialists). Standard Option also features a Retail Pharmacy Program, a Mail Service Prescription Drug Program, a Specialty Drug Pharmacy Program, and the FEP Medicare Prescription Drug Program.

Basic Option

Basic Option does not have a calendar year deductible. Most services are subject to copayments ($35 for primary care providers and $45 for 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 the FEP Medicare Prescription Drug Program, a Retail Pharmacy Program and a 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 Healthcare 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 Get Care*, for information on covered professional providers and other healthcare 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 healthcare 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 or facility bills for the service.
- The services listed in this Section are for the charges billed by a physician or other healthcare 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.
- You should be aware that some Non-preferred (non-PPO) professional providers may provide services in Preferred (PPO) facilities.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage or are enrolled in the FEP Medicare Prescription Drug Program. See Section 5(f) for information about Tier 4 and Tier 5 specialty drug fills from Preferred providers and Preferred pharmacies. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731.
- **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, neonatologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You may be responsible for any difference between our payment and the billed amount. See Section 4, NSA, for information on when you are not responsible for this difference.
- **Under Basic Option,**
  - There is **no calendar year deductible**.
  - **You must use Preferred providers in order to receive benefits. See below and Section 3 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, neonatologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You may be responsible for any difference between our payment and the billed amount. See Section 4, NSA, for information on when you are not responsible for this difference.

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 healthcare professionals: • Consultations • Genetic counseling • 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) • Phone consultations and online medical evaluation and management services (telemedicine) Note: Please refer Section 5(c) 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 healthcare professional: $30 copayment per visit (no deductible) Preferred specialist: $40 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 healthcare professional: $35 copayment per visit Preferred specialist: $45 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. Participating/Non-participating: You pay all charges
Telehealth professional services for: • Minor acute conditions • Dermatology care Note: Refer to Section 5(h), *Wellness and Other Special Features*, for information on telehealth services and how to access a provider. Note: Benefits are combined with telehealth services listed in Section 5(e). Note: Copayments are waived for members with Medicare Part B primary.	Preferred Telehealth Provider: Nothing (no deductible) for the first 2 visits per calendar year for any covered telehealth service $10 copayment per visit (no deductible) after the 2nd visit Participating/Non-participating: You pay all charges	Preferred Telehealth Provider: Nothing for the first 2 visits per calendar year for any covered telehealth service $15 copayment per visit after the 2nd visit 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	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

Benefit Description	You Pay	
Diagnostic and Treatment Services (cont.)	**Standard Option**	**Basic Option**
• 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
Not covered: • *Routine services except for those Preventive care services described later in this section* • *Costs associated with enabling or maintaining providers' telehealth (telemedicine) technologies, non-interactive telecommunication such as email communications, or asynchronous store-and-forward telehealth 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	**Standard Option**	**Basic Option**
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	Preferred: 15% of the Plan allowance Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care.

Lab, X-ray and Other Diagnostic Tests - continued on next page

Benefit Description	You Pay	
Lab, X-ray and Other Diagnostic Tests (cont.)	**Standard Option**	**Basic Option**
	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.	Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount, in addition to the Preferred coinsurance listed under this benefit.
Diagnostic tests including but not limited to: • Cardiovascular monitoring • EEGs • Home-based/unattended sleep studies • 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. Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by 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 • Nuclear medicine • Facility-based sleep studies (prior approval required) • Genetic testing (prior approval required) 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. Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount in addition to the Preferred copayment listed above.

Benefit Description	You Pay	
Preventive Care, Adult	**Standard Option**	**Basic Option**
Benefits are provided for preventive care services for adults age 22 and over. Covered services include: • Counseling on prevention and reducing health risks • Nutritional counseling Note: When nutritional counseling is via the contracted telehealth provider network, we provide benefits as shown here for Preferred providers. Refer to Section 5(h), *Wellness and Other Special Features*, for information on how to access a telehealth provider. • Visits/exams for preventive care Note: See the definition of Preventive Care, Adult, in Section 10 for included health screening services. Preventive care benefits for each of the services listed below are limited to one per calendar year. • 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. See Section 5(h) for complete information. • Basic or comprehensive metabolic panel test • CBC • Cervical cancer screening tests - Human papillomavirus (HPV) tests of cervix - Pap tests of the cervix • Colorectal cancer tests, including: - Colonoscopy, with or without biopsy (see Section 5(b) for our payment levels for diagnostic colonoscopies) - CT colonography - DNA analysis of stool samples - Double contrast barium enema - Fecal occult blood test - Sigmoidoscopy • Fasting lipoprotein profile (total cholesterol, LDL, HDL, and/or triglycerides) • General health panel • Prostate cancer tests - Prostate Specific Antigen (PSA) • Screening for chlamydial infection • Screening for diabetes mellitus • Screening for gonorrhea infection • Screening for human immunodeficiency virus (HIV) • Screening mammograms, including mammography using digital technology	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. 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.	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 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. 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.

Preventive Care, Adult - continued on next page

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
• Ultrasound for abdominal aortic aneurysm for adults, ages 65 to 75, limited to one screening per lifetime • Urinalysis The following preventive services are covered at the time intervals recommended at each of the links below. • Immunizations such as COVID-19, Pneumococcal, influenza, shingles, tetanus/Tdap and human papillomavirus (HPV). For a complete list of immunizations, go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules. 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. • USPSTF A and B recommended screenings such as cancer, osteoporosis, depression, and high blood pressure. For a complete list of covered A and B recommendation screenings and age and frequency limitations, go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations. • Well woman care such as gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of Well Women preventive care services, go to the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/. • To build your personalized list of preventive services go to https://health.gov/myhealthfinder. 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. If you receive both preventive and diagnostic services from your Provider on the same day, you are responsible for paying your cost-share for the diagnostic services. Note: Unless otherwise noted, the benefits discussed under *Preventive Care, Adult*, do not apply to individuals aged 21 and younger. (See benefits under *Preventive Care, Child*, this section.)	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. 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.	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 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. 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.

Preventive Care, Adult - continued on next page

Benefit Description	You Pay	
Preventive Care, Adult (cont.)	**Standard Option**	**Basic Option**
Note: See Section 5(b) for the benefits available for the surgical removal of breast, ovaries, or prostate when screening reveals a BRCA mutation; preventive care benefits are not available. Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance and deductible.	See previous page	See previous page
Not covered: • *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* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure. Medical benefits may be available for these services.* • *Phone consultations and online medical evaluation and management services (telemedicine) for preventive services, except as previously noted in this section for nutritional counseling.*	*All charges*	*All charges*
Preventive Care, Child	**Standard Option**	**Basic Option**
Benefits are provided for preventive care services for children up to age 22. This includes: • Well-child visits, examinations, and other preventive services described in the Bright Future Guidelines as provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Future Guidelines, go to https://brightfutures.aap.org. • Immunizations such as Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations, go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html. Note: U.S. FDA licensure may restrict the use of the immunizations and vaccines listed above to specific age ranges, frequencies, and/or other patient-specific indications, including gender.	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 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.

Preventive Care, Child - continued on next page

Benefit Description	You Pay	
Preventive Care, Child (cont.)	**Standard Option**	**Basic Option**
• You may also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • To build your personalized list of preventive services, go to https://health.gov/myhealthfinder. • Nutritional counseling 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 • Cervical cancer screening tests - Pap tests of the cervix - Human papillomavirus (HPV) tests of the cervix • Screening for human immunodeficiency virus (HIV) infection • Screening for syphilis infection • Screening for latent tuberculosis infection for children ages 18 through 21 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. Note: When nutritional counseling is via the contracted telehealth provider network, we provide benefits as shown here for Preferred providers. Refer to Section 5(h), *Wellness and Other Special Features*, for information on how to access a telehealth provider. Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	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. 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.	Preferred: Nothing Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by Non-participating laboratories or radiologists, 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.
Not covered: • *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* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel*	*All charges*	*All charges*

Preventive Care, Child - continued on next page

Benefit Description	You Pay	
Preventive Care, Child (cont.)	**Standard Option**	**Basic Option**
• *Immunizations, boosters, and medications for travel or work-related exposure. Medical benefits may be available for these services.* • *Phone consultations and online medical evaluation and management services (telemedicine) for preventive services, except as noted above for nutritional counseling.*	*All charges*	*All charges*
Maternity Care	**Standard Option**	**Basic Option**
Maternity (obstetrical) care including related conditions resulting in childbirth or miscarriage, such as: • Prenatal and postpartum care (including ultrasound, laboratory, and diagnostic tests) Note: See Section 5(h) for details about our Pregnancy Care Incentive Program. • Delivery • 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 or during a covered observation stay • Breastfeeding education and individual coaching on breastfeeding by healthcare providers such as physicians, physician assistants, midwives, nurse practitioners/clinical specialists, and lactation consultants • Mental health treatment for postpartum depression and depression during pregnancy Note: We provide benefits to cover up to 8 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 *Preventive Care, Adult*, earlier in this section for our coverage of nutritional counseling. Note: *Home Health Services* benefits for home nursing visits (skilled) related to covered maternity care are subject to the visit limitations described later in this section. Note: Maternity care benefits are not provided for prescription drugs required during pregnancy, except as recommended under the Affordable Care Act. See Section 5(f) for your 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 phone 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 $250 per admission. For outpatient facility services related to maternity, see the notes throughout Section 5(c). Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by 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

Benefit Description	You Pay	
Maternity Care (cont.)	**Standard Option**	**Basic Option**
Note: Here are some things to keep in mind: • You do not need to precertify your delivery; see Section 3 for other circumstances, such as *extended* stays for you or your newborn. • You may remain in the hospital up to 48 hours after a vaginal 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 when performed during the covered portion of the mother's maternity stay and billed by the facility. We cover other care of a newborn who requires professional services or non-routine treatment, only if we cover the newborn under a Self Plus One or Self and Family enrollment. Surgical benefits apply to circumcision when billed by a professional provider for a male newborn. • Hospital services are listed in Section 5(c) and Surgical benefits are in Section 5(b). Note: See Section 10 for our allowance for inpatient stays resulting from an emergency delivery at a hospital or other facility not contracted with your Local Plan. Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in their own right. Regular medical or surgical benefits apply rather than maternity benefits. See Section 5(b) for our payment levels for circumcision.	See previous page	See previous page
• Breast pump, limited to one per calendar year for members who are pregnant and/or nursing • Blood pressure monitor, limited to one every two years Note: Benefits for the breast pump, milk storage bags, and blood pressure monitors are only available when you order them through our fulfillment vendor by visiting www.fepblue.org/maternity or calling 1-800-411-2583. Milk storage bags will be included with your breast pump.	Nothing (no deductible)	Nothing
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* • *Childbirth preparation, Lamaze, and other birthing/ parenting classes* • *Doula, birth companion, and similar supporter* • *Breast pumps and milk storage bags except as previously noted* • *Breastfeeding supplies other than those contained in the breast pump kit previously described including clothing (e.g., nursing bras), baby bottles, or items for personal comfort or convenience (e.g., nursing pads)*	*All charges*	*All charges*

Maternity Care - continued on next page

Benefit Description	You Pay	
Maternity Care (cont.)	**Standard Option**	**Basic Option**
• *Tocolytic therapy and related services except as previously described* • *Maternity care for members not enrolled in the Service Benefit Plan*	*All charges*	*All charges*
Family Planning	**Standard Option**	**Basic Option**
A range of voluntary family planning services for women, limited to: • Contraceptive counseling • Diaphragms and contraceptive rings • Injectable contraceptives • Intrauterine devices (IUDs) • Implantable contraceptives • Tubal ligation or tubal occlusion/tubal blocking procedures only Family planning services for men, limited to: • Vasectomy Note: We also provide benefits for professional services associated with tubal ligation/occlusion/blocking procedures, vasectomy, 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
• 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 Section 5(f) 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*

Benefit Description	You Pay	
Reproductive Services	**Standard Option**	**Basic Option**
Members who meet our definition of infertility in Section 10, are eligible for the following reproductive services once prior approval has been obtained: • Artificial insemination (AI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) - Intravaginal insemination (IVI) Note: We also provide the benefits seen here when these services are billed by an outpatient facility. See Section 5 (f) (Prescription drug benefits) for your cost-shares associated with drugs for covered AI procedures. Note: We cover one year of sperm and egg storage, including procurement procedures, only for individuals facing iatrogenic infertility, once per lifetime. We also provide the benefits seen here when billed by a facility. See Section 3, *Other services*, for prior approval requirements. See Section 10 for our definition of iatrogenic infertility. Note: See other sections in this brochure for benefits associated with any other services performed to diagnose and treat the cause of infertility.	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
Assisted reproductive technologies (ART) – Members who meet our definition of infertility in Section 10 are eligible for ART services, limited to $25,000 paid annually. Note: We also provide the benefits seen here when billed by an outpatient facility. See Section 5(f), *Prescription Drug Benefits*, for your cost-shares and limitations for drugs associated with IVF. Note: The covered AI procedures and associated drugs listed in this section, and the prescription drugs associated with ART procedures are not subject to the $25,000 annual maximum. Note: Prior approval required.	Preferred: 15% of the Plan allowance (deductible applies), and any amount over the $25,000 annual maximum Participating: 35% of the Plan allowance (deductible applies), and any amount over the $25,000 annual maximum Non-participating: 35% of the Plan allowance, (deductible applies), plus any difference between our allowance and the billed amount, and any amount over the $25,000 annual maximum	All charges
Not covered: • *All related donor expenses including but not limited to the cost of donor sperm or oocytes* • *Fallopian tube ligations and vasectomy reversals* • *Services determined to be not medically necessary* • *Other services, supplies, or drugs provided to individuals not enrolled in this Plan, including surrogates*	*All charges*	*All charges*

Benefit Description	You Pay	
Allergy Care	**Standard Option**	**Basic Option**
• Allergy testing • Allergy treatment • Sublingual allergy desensitization drugs as licensed by the U.S. FDA Note: See earlier in this section 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 healthcare professional: $35 copayment Preferred specialist: $45 copayment Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.
• Allergy injections Note: See earlier in this section 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 earlier in this section 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 healthcare professional: $35 copayment per multi-dose vial of antigen Preferred specialist: $45 copayment per multi-dose vial of antigen Participating/Non-participating: You pay all charges (except as noted below) Note: For services billed by 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*

Benefit Description	You Pay	
Treatment Therapies	**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. Note: **You must get prior approval for certain radiation therapy treatments.** Please refer to Section 3 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* later in this section. • Outpatient cardiac rehabilitation • Pulmonary rehabilitation therapy • Applied behavior analysis (ABA) for the treatment of an autism spectrum disorder (see prior approval requirements in Section 3) Note: See Section 5(c) for our payment levels for treatment therapies billed for by 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	Preferred primary care provider or other healthcare professional: $35 copayment per visit Preferred specialist: $45 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. Participating/Non-participating: You pay all charges
• Auto-immune infusion medications: Remicade, Renflexis and Inflectra Note: See above for your costs for intravenous (IV)/ infusion therapy - Home IV or infusion therapy.	Preferred: 10% 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 billed amount	Preferred: 15% of the Plan allowance Participating/Non-participating: You pay all charges

Treatment Therapies - continued on next page

Benefit Description	You Pay	
Treatment Therapies (cont.)	**Standard Option**	**Basic Option**
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. • 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.) • Applied behavior analysis (ABA) for the treatment of an autism spectrum disorder (see prior approval requirements in Section 3)	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 Rehabilitation Therapy	**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 healthcare professional: $30 copayment per visit (no deductible) Preferred specialist: $40 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.	Preferred primary care provider or other healthcare professional: $35 copayment per visit Preferred specialist: $45 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. 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.

Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Rehabilitation Therapy - continued on next page

Benefit Description	You Pay	
Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Rehabilitation Therapy (cont.)	**Standard Option**	**Basic Option**
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* • *Equine therapy and hippotherapy (exercise on horseback)* • *Massage therapy*	*All charges*	*All charges*
Hearing Services (Testing, Treatment, and Supplies)	**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 *Orthopedic and Prosthetic Devices* in this section.	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 healthcare professional: $35 copayment per visit Preferred specialist: $45 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. Participating/Non-participating: You pay all charges
Not covered: • *Routine hearing tests* • *Hearing aids (except as described later in this section)*	*All charges*	*All charges*
Vision Services (Testing, Treatment, and Supplies)	**Standard Option**	**Basic Option**
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 21 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 previously described.	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

Benefit Description	You Pay	
Vision Services (Testing, Treatment, and Supplies) (cont.)	**Standard Option**	**Basic Option**
• Eye examinations related to a specific medical condition • Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 21 Note: See Section 5(b), Surgical procedures, for coverage for surgical treatment of amblyopia and strabismus. Note: See earlier in this section for our payment levels for Lab, X-ray, and other diagnostic tests performed or ordered by your provider.	Preferred primary care provider or other healthcare professional: $30 copayment (no deductible) Preferred specialist: $40 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 healthcare professional: $35 copayment per visit Preferred specialist: $45 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. 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 previously described* • *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 above*	*All charges*	*All charges*
Foot Care	**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 healthcare professional: $30 copayment for the office visit (no deductible); 15% of the Plan allowance for all other services (deductible applies) Preferred specialist: $40 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)	Preferred primary care provider or other healthcare professional: $35 copayment per visit Preferred specialist: $45 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. Participating/Non-participating: You pay all charges

Foot Care - continued on next page

Benefit Description	You Pay	
Foot Care (cont.)	**Standard Option**	**Basic Option**
	Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	
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	**Standard Option**	**Basic Option**
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 limited to treatment of erectile dysfunction or as part of an approved plan for gender affirming surgery • Surgical implants 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
• 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 5 calendar years Note: Benefits for hearing aid dispensing fees, fittings, batteries, and repair services are included in the benefit limits described above. Prior approval is required for hearing aids.	Any amount over $2,500 (no deductible)	Any amount over $2,500
• Bone-anchored hearing aids when medically necessary, 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

Orthopedic and Prosthetic Devices - continued on next page

Benefit Description	You Pay	
Orthopedic and Prosthetic Devices (cont.)	**Standard Option**	**Basic Option**
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* • *Over the counter hearing aids, enhancement devices, accessories or supplies (including remote controls and warranty packages), and hearing aids when prior approval was not obtained*	*All charges*	*All charges*
Durable Medical Equipment (DME)	**Standard Option**	**Basic Option**
Durable medical equipment (DME) is equipment and supplies that are: 1. Prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Medically necessary; 3. Primarily and customarily used only for a medical purpose; 4. Generally useful only to a person with an illness or injury; 5. Designed for prolonged use; and 6. Used to 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	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges

Durable Medical Equipment (DME) - continued on next page

Benefit Description	You Pay	
Durable Medical Equipment (DME) (cont.)	**Standard Option**	**Basic Option**
• 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
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 previously described* • *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 above)* • *Equipment for cosmetic purposes* • *Topical Hyperbaric Oxygen Therapy (THBO)* • *Charges associated with separate or extended warranties*	*All charges*	*All charges*
Medical Supplies	**Standard Option**	**Basic Option**
• Medical foods and nutritional supplements when administered by catheter or nasogastric tubes 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, or are enrolled in the FEP Medicare Prescription Drug Program*	*All charges*	*All charges*

Medical Supplies - continued on next page

Benefit Description	You Pay	
Medical Supplies (cont.)	**Standard Option**	**Basic Option**
• *Medical foods administered orally, except as described in Section 5(f)*	*All charges*	*All charges*
Home Health Services	**Standard Option**	**Basic Option**
Home nursing care (skilled) 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: $35 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. 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 described in Section 5(c) under Skilled Nursing Care.* • *Private duty nursing*	*All charges*	*All charges*
Manipulative Treatment	**Standard Option**	**Basic Option**
Manipulative treatment performed by a professional provider, 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. 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: $30 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: $35 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

Manipulative Treatment - continued on next page

Benefit Description	You Pay	
Manipulative Treatment (cont.)	**Standard Option**	**Basic Option**
	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.	
Alternative Treatments	**Standard Option**	**Basic Option**
Acupuncture Note: Acupuncture must be performed and billed by a healthcare 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 *Covered professional providers* in Section 3. Note: When billed by a facility such as the outpatient department of a hospital, you are limited to the number of visits per calendar year listed on this page. See Section 5(c) for your cost-share. Note: See Section 5(b) for our coverage of acupuncture when provided as anesthesia for covered surgery. Note: See earlier in this section 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 healthcare professional: $35 copayment per visit Preferred specialist: $45 copayment per visit Note: Benefits for acupuncture are limited to 12 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	**Standard Option**	**Basic Option**
• Smoking and tobacco cessation treatment - Counseling for smoking and tobacco cessation - 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

Educational Classes and Programs - continued on next page

Benefit Description	You Pay	
Educational Classes and Programs (cont.)	**Standard Option**	**Basic Option**
• Diabetic education Note: See earlier references 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 healthcare professional: $35 copayment per visit Preferred specialist: $45 copayment per visit Participating/Non-participating: You pay all charges
Not covered: • *Educational, or other counseling or training services, or applied behavior analysis (ABA), when performed as part of an educational class or program* • *Premenstrual syndrome (PMS), lactation, headache, eating disorder, and other educational clinics unless described earlier in this section as being covered* • *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*	*All charges*	*All charges*

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare 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 healthcare 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 healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e., hospital, surgical center, etc.).
- **YOU MUST GET PRIOR APPROVAL for the following surgical services: surgery for severe obesity; and surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth, except when care is provided within 72 hours of the accidental injury. Please refer to Section 3 for more information.**
- **YOU MUST GET PRIOR APPROVAL for all organ transplant surgical procedures (except corneal 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.**
- **YOU MUST GET PRIOR APPROVAL for gender affirming surgery. Prior to any gender affirming surgery, your provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and your provider later modifies the plan (including changes to the procedures to be performed or the anticipated dates for the procedures). See Section 3 and later in this section for additional information. If your surgical procedure requires an inpatient admission, YOU MUST ALSO GET PRECERTIFICATION of the inpatient care.**
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage or are enrolled in the FEP Medicare Prescription Drug Program. See Section 5(f) for information about Tier 4 and Tier 5 specialty drug fills from Preferred providers and Preferred pharmacies. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731.
- **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, neonatologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You may be responsible for any difference between our payment and the billed amount. See Section 4, NSA, for information on when you are not responsible for this difference.
  - 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 Section 3 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 Section 3 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, neonatologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You may be responsible for any difference between our payment and the billed amount. See Section 4, NSA, for information on when you are not responsible for this difference.

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 • Assistant surgeons/surgical assistance if required because of the complexity of the surgical 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 Section 5(a). 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 • 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. • **Procedures to treat severe obesity** when you meet the clinical criteria in our medical policy at www.fepblue.org/legal/policies-guidelines for any initial and subsequent surgery (prior approval required).	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 Section 3 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. Participating/Non-participating: You pay all charges

Surgical Procedures - continued on next page

Benefit Description	You Pay	
Surgical Procedures (cont.)	**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.	See prior page	See prior page
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 sexual inadequacy (except surgical placement of penile prostheses to treat erectile dysfunction and gender affirming surgeries specifically listed as covered)* • *Reversal of gender affirming surgery*	*All charges*	*All charges*
Reconstructive Surgery	**Standard Option**	**Basic Option**
• Surgery to correct a functional defect • Surgery to correct a congenital anomaly • 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 Section 3 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.

Reconstructive Surgery - continued on next page

Benefit Description	You Pay	
Reconstructive Surgery (cont.)	**Standard Option**	**Basic Option**
	See previous page	Continued from previous page: 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. Participating/Non-participating: You pay all charges
• **Gender affirming surgical benefits** are limited to the following: - For female to male surgery: mastectomy (including nipple reconstruction), hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty, facial gender affirming surgery (limited to forehead lengthening, cheek augmentation, rhinoplasty, jaw reshaping, chin contouring, Adam's apple enhancement (thyroid cartilage enhancement or implant), pitch lowering masculinization voice surgery, cosmetic fillers, botulinum toxin, fat grafting, and liposuction), electrolysis (hair removal at the covered operative site), and placement of testicular and erectile prosthesis - For male to female surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, labiaplasty, breast augmentation, facial gender affirming surgery (limited to chondrolaryngoplasty, rhinoplasty, contouring or augmentation of the jaw, chin, and forehead; facelift, hair removal and transplantation, pitch raising surgery/Wendler glottoplasty, cosmetic fillers, botulinum toxin, fat grafting and liposuction), and electrolysis (hair removal at the covered operative site) **Note: Prior approval is required for gender affirming surgery.** For more information about prior approval, please refer to Section 3. Note: Benefits are not available for repeat or revision procedures unless they are determined to be medically necessary. Benefits are not available for gender affirming surgery for any condition other than gender dysphoria.	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 Section 3 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: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. Participating/Non-participating: You pay all charges

Reconstructive Surgery - continued on next page

Benefit Description	You Pay	
Reconstructive Surgery (cont.)	**Standard Option**	**Basic Option**
• Gender affirming surgery on an inpatient or outpatient basis is subject to the pre-surgical requirements listed below. **The member must meet all requirements.** - **Prior approval is obtained** - **Member must be at least 16 years of age for mastectomy and 18 years of age for other covered surgeries at the time prior approval is requested and the treatment plan is submitted** - Diagnosis of gender dysphoria by a qualified healthcare professional with well-documented persistent gender incongruence, including documentation that other possible causes of gender incongruence have been excluded - Member must meet the following criteria: • 6 months of continuous hormone therapy appropriate to the member's gender identity (unless medically contraindicated and they are not required for mastectomy) • Documentation of informed consent and fulfillment of the program's criteria for gender affirming surgical treatment • Must have a written psychological assessment from a qualified mental health professional documenting the diagnosis of persistent gender dysphoria with a well-documented persistent gender incongruence between the assigned gender and the experienced/expressed gender or some alternative gender, support of surgical procedure (s), and well-controlled physical and mental health conditions • Surgical treatment plan must include timing, technique, and duration of aftercare	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 Section 3 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: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. 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 sexual dysfunction or sexual inadequacy (except surgical placement of penile prostheses to treat erectile dysfunction)* • *Reversal of gender affirming surgery*	*All charges*	*All charges*

Benefit Description	You Pay	
Oral and Maxillofacial Surgery	**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 to jaws, cheeks, lips, tongue, roof and floor of mouth Note: **Prior approval is required for oral/maxillofacial surgery needed to correct accidental injuries as described above, except when care is provided within 72 hours of the accidental injury.** Please refer to Section 3 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 phone 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 Section 3 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. Participating/Non-participating: You pay all charges
Not covered: • *Oral implants and transplants except for those required to treat accidental injuries as specifically and previously described 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 and previously described 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 and previously described and in Section 5(g)* • *Orthodontic care before, during, or after surgery, except for orthodontia associated with surgery to correct accidental injuries as specifically and previously described and in Section 5(g)*	*All charges*	*All charges*

Benefit Description	You Pay	
Organ and Tissue Transplants	**Standard Option**	**Basic Option**
Solid organ/tissue transplants are subject to medical necessity and experimental/investigational review. For the solid organ transplants listed below, you must obtain prior approval from the Local Plan for the procedures, and you must obtain precertification for the facility. (See precertification and prior approval in Section 3.) • Heart transplant • Heart-lung transplant • Kidney transplant • Liver transplant • Pancreas transplant • Combination liver-kidney transplant • Combination pancreas-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 - Benefits for lung transplantation are limited to double lung transplants for members with end-stage cystic fibrosis. • Implantation of an artificial heart as a bridge to transplant or destination therapy	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

Note: **Solid 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.

Note: 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.

Note: 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 phone number on the back of your ID card.

All the following blood or marrow stem cell transplants - Prior approval is required and 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. See Section 3 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 phone number listed on the back of your ID card for assistance in locating an eligible facility and requesting prior approval for transplant services for the diagnoses as indicated below:

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.

Benefit Description	You Pay	
Organ and Tissue Transplants	**Standard Option**	**Basic Option**
Allogeneic blood or marrow stem cell transplants limited to the diagnoses and stages indicated below: • Acute lymphocytic or myeloid (e.g., AML promyelocytic) leukemia • Blastic plasmacytoid dendritic cell neoplasm • Chronic lymphocytic leukemia (e.g., T cell prolymphocytic leukemia, B cell prolymphocytic leukemia, hairy cell leukemia) • Chronic myeloid leukemia • Hemoglobinopathy (e.g., sickle cell anemia, thalassemia major) • Hodgkin lymphoma • Inherited metabolic disorders: Adrenoleukodystrophy, Globoid cell leukodystrophy (Krabbe's leukodystrophy), Metachromatic leukodystrophy, and Mucopolysaccharidosis type I (Hurler syndrome) • IPEX - immune dysregulation, polyendocrinopathy, enteropathy, X-linked syndrome • Marrow failure (e.g., severe aplastic anemia, Fanconi's anemia, paroxysmal nocturnal hemoglobinuria (PNH), pure red cell aplasia, congenital thrombocytopenia, Dyskeratosis congenita) • MDS/MPN (e.g., chronic myelomonocytic leukemia (CMML)) • Myelodysplastic syndromes (MDS) • Myeloproliferative neoplasms (MPN) (e.g., polycythemia vera, essential thrombocythemia, primary myelofibrosis, Hypereosinophilic syndromes) • Non-Hodgkin lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt lymphoma) • Osteopetrosis • Plasma cell disorders (e.g., multiple myeloma, amyloidosis, plasma cell leukemia, POEMS – (polyneuropathy, organomegaly, endocrinopathy, monoclonal gammopathy, and skin changes syndrome) • Primary immunodeficiencies (e.g., severe combined immunodeficiency, Wiskott-Aldrich syndrome, hemophagocytic disorders, X-linked lymphoproliferative syndrome, severe congenital neutropenia, leukocyte adhesion deficiencies, common variable immunodeficiency, chronic granulomatous disease/phagocytic cell disorders) • Systemic mastocytosis, aggressive	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 and Tissue Transplants - continued on next page

Benefit Description	You Pay	
Organ and Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
Autologous blood or marrow stem cell transplants limited to the diagnoses and stages indicated below: • Acute myeloid leukemia • Autoimmune - limited to: Idiopathic (juvenile) rheumatoid arthritis, multiple sclerosis (treatment-refractory relapsing with high risk of future disability) and Scleroderma/systemic sclerosis • Central nervous system (CNS) embryonal tumors (e.g., atypical teratoid/rhabdoid tumor, primitive neuroectodermal tumors (PNETs), medulloblastoma, pineoblastoma, ependymoblastoma) • Chronic lymphocytic leukemia (e.g., T cell prolymphocytic leukemia, B cell prolymphocytic leukemia, hairy cell leukemia) • Ewing sarcoma • Germ cell tumors (e.g., testicular germ cell tumors) • High-risk or relapsed neuroblastoma • Hodgkin lymphoma • Non-Hodgkin lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt lymphoma) • Osteosarcoma • Plasma cell disorders (e.g., multiple myeloma, amyloidosis, plasma cell leukemia, POEMS – (polyneuropathy, organomegaly, endocrinopathy, monoclonal gammopathy, and skin changes syndrome) • Wilms Tumor	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
Blood or marrow stem cell transplants for the diagnoses below, only when performed as part of a clinical trial that meets the transplant program prior approval criteria and the **requirements** listed in the bullets below. • Allogeneic blood or marrow stem cell transplants for: - Autoimmune - limited to scleroderma/systemic sclerosis, systemic lupus erythematosus, CIDP – (chronic inflammatory demyelinating polyneuropathy), and Idiopathic (Juvenile) rheumatoid arthritis - Breast cancer - Germ Cell Tumors - High-risk or relapsed neuroblastoma - Lysosomal metabolic diseases: e.g., Mucopolysaccharidosis type II (Hunter syndrome); Mucopolysaccharidosis type IV (Morquio syndrome); Mucopolysaccharidosis type VI (Maroteaux-Lamy syndrome), Fabry disease, Gaucher disease	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.

Organ and Tissue Transplants - continued on next page

Benefit Description	You Pay	
Organ and Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
• Continued from previous page: - Renal cell carcinoma - Sarcoma - Ewing sarcoma, rhabdomyosarcoma, soft tissue sarcoma • Autologous blood or marrow stem cell transplants for: - Autoimmune disease - e.g., systemic lupus erythematosus, CIDP (chronic inflammatory demyelinating polyneuropathy), Crohn's disease, Polymyositis-dermatomyositis, rheumatoid arthritis - Glial tumors (e.g., anaplastic astrocytoma, choroid plexus tumors, ependymoma, glioblastoma multiforme) - Sarcoma (e.g., rhabdomyosarcoma, soft tissue sarcoma)	See previous page	Continued from previous page: 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

- Requirements for blood or marrow stem cell transplants covered only under clinical trials:
  - You must contact us at the customer service phone number listed on the back of your ID card to obtain prior approval (see Section 3); and
  - The patient must be properly and lawfully registered in the clinical trial, meeting all the eligibility requirements of the trial; and
  - The clinical trial must be reviewed and approved by the Institutional Review Board 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 http://www.cancer.gov/about-cancer/treatment/clinical-trials. If a non-randomized clinical trial for a blood or marrow stem cell transplant listed above meeting the requirements shown above is not available, we will arrange for the transplant to be provided at an approved transplant facility, if available.

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 Section 9 for our coverage of other costs associated with clinical trials.

Benefit Description	You Pay	
Organ and Tissue Transplants	**Standard Option**	**Basic Option**
Related transplant services: • Extraction or reinfusion of blood or marrow stem cells as part of a covered allogeneic or autologous transplant	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

Organ and Tissue Transplants - continued on next page

Benefit Description	You Pay	
Organ and Tissue Transplants (cont.)	**Standard Option**	**Basic Option**
• 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 in this section 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 in this section • Covered medical and hospital expenses of the donor, when we cover the recipient • Covered services or supplies provided to the recipient • Donor screening tests for 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.	See previous page	Continued from previous page: 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 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 $250 per day copayment ($1,500 maximum) under Basic Option, for the transplant period. See Section 10 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 phone 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)
- Kidney (adult and pediatric)
- Liver (adult and pediatric liver alone; adult only for combination liver-kidney)
- Single or double lung (adult only)

- Blood or marrow stem cell transplants (adult and pediatric) listed in this section
- Related transplant services previously listed

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 companions. If the transplant recipient is age 21 or younger, we pay up to $10,000 for eligible travel costs for the member and companions. Reimbursement is subject to IRS regulations.

Note: You must obtain prior approval for travel benefits (see Section 3).

Note: Benefits for intestinal, pancreas, pediatric lung, and heart-lung transplants are not available through Blue Distinction Centers for Transplants.

Note: See Section 5(c) for our benefits for facility care.

Benefit Description	You Pay	
Organ/Tissue Transplants	**Standard Option**	**Basic Option**
Not covered: • *Any transplant not listed as covered and transplants for any diagnosis not listed as covered* • *Donor screening tests and donor search expenses, including associated travel expenses, except as previously defined* • *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 previously described* • *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*

Benefit Description	You Pay	
Anesthesia	**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	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

Anesthesia - continued on next page

Benefit Description	You Pay	
Anesthesia (cont.)	**Standard Option**	**Basic Option**
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: Anesthesia acupuncture services do not accumulate toward the member's annual maximum. 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
Not covered: • *Anesthesia related to noncovered surgeries or procedures*	*All charges*	*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.
- Note: **Observation services** are billed as outpatient facility care. Benefits for observation services are provided at the outpatient facility benefit levels described in this section. See Section 10, *Definitions*, for more information about these types of services.
- **YOU MUST GET PRIOR APPROVAL for the following services: facility-based sleep studies; surgery for severe obesity; and surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth, except when care is provided within 72 hours of the accidental injury. Please refer to Section 3 for more information.**
- **YOU MUST GET PRIOR APPROVAL for gender affirming surgery. See Section 3 for prior approval and Section 5(b) for the surgical benefit.**
- You should be aware that some Non-preferred (non-PPO) professional providers may provide services in Preferred (PPO) facilities.
- We base payment on whether a facility or a healthcare 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 or facility bills for the service.
- 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.
- Benefits for certain self-injectable drugs are limited to once per lifetime per therapeutic category of drug when obtained from a covered provider other than a pharmacy under the pharmacy benefit. This benefit limitation does not apply if you have primary Medicare Part B coverage or are enrolled in the FEP Medicare Prescription Drug Program. See Section 5(f) for information about Tier 4 and Tier 5 specialty drug fills from Preferred providers and Preferred pharmacies. Medications restricted under this benefit are available on our Specialty Drug List. Visit www.fepblue.org/specialtypharmacy or call us at 888-346-3731.
- **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 Section 3 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 Section 10, *Definitions*, for more information. See later in this section and Section 5(e) for inpatient residential treatment center. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • 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 in this section. See Section 10, *Definitions*, for more information about these types of services. Note: Here are some things to keep in mind: • You do not need to precertify your delivery; see Section 3 for other circumstances, such as extended stays for you or your newborn.	Preferred facilities: $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 facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: $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 $350 per admission copayment for unlimited days and we then provide benefits at 100% of the Plan allowance.	Preferred facilities: $250 per day copayment up to $1,500 per admission for unlimited days Note: Your responsibility for maternity care in a Preferred facility, or birthing center, is limited to a $250 copayment associated with the charges incurred during delivery. Member/Non-member facilities: You pay all charges

Inpatient Hospital - continued on next page

Benefit Description	You Pay	
Inpatient Hospital (cont.)	**Standard Option**	**Basic Option**
• 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 Section 5(a) for other covered maternity services. Note: See Section 5(a) 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. Keep reading this section for more information.	Preferred facilities: $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 facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: $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 $350 per admission copayment for unlimited days and we then provide benefits at 100% of the Plan allowance.	Preferred facilities: $250 per day copayment up to $1,500 per admission for unlimited days Note: Your responsibility for maternity care in a Preferred facility, or birthing center, is limited to a $250 copayment associated with the charges incurred during delivery. Member/Non-member facilities: You pay all charges
Not covered: • *Admission to noncovered facilities, such as nursing homes, extended care facilities, schools, or residential treatment centers (except as described later in this section and Section 5(e))* • *Personal comfort items, such as guest meals and beds, phone, television, beauty and barber services* • *Private duty nursing* • *Facility room and board expenses when, in our judgment, an 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* • Care that is 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.	*All charges*	*All charges*

Inpatient Hospital - continued on next page

Benefit Description	You Pay	
Inpatient Hospital (cont.)	**Standard Option**	**Basic Option**
- 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 an inpatient 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 Section 3).	*All charges*	*All charges*
Outpatient Hospital or Ambulatory Surgical Center	**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 • Acupuncture • 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 *Preventive Care, Adult*, in Section 5 (a). 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	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 facilities: $150 copayment per day per facility (except as noted below) Note: You may be responsible for paying a $200 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. Member/Non-member facilities: You pay all charges

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**Standard Option**	**Basic Option**
• Other medical supplies, including oxygen • Surgical implants Notes: • See Section 5(d) for our payment levels for care related to a medical emergency or accidental injury. • See Section 5(a) for our coverage of family planning services. • For our coverage of hospital-based clinic visits, please refer to the professional benefits described in Section 5 (a). • 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 as described later in this section. • 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 Section 5(a) for other included maternity services. • See later in this section for outpatient drugs, medical devices, and durable medical equipment billed for by a facility. • 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.	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 facilities: $150 copayment per day per facility (except as noted below) Note: You may be responsible for paying a $200 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. Member/Non-member facilities: You pay all charges
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 later in this section 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 facilities: $350 copayment for the duration of services (no deductible) Member facilities: $450 copayment for the duration of services, plus 35% of the Plan allowance (no deductible) Non-member facilities: $450 copayment for the duration of services, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred facilities: $250 per day copayment up to $1,500 Member/Non-member facilities: You pay all charges

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**Standard Option**	**Basic Option**
Outpatient **diagnostic testing and treatment services** performed and billed by a facility, limited to: • Angiographies • Bone density tests • CT scans/MRIs/PET scans • Nuclear medicine • Facility-based sleep studies (prior approval is required) • Genetic testing (prior approval is required)	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 facilities: $200 copayment per day per facility Member facilities: $200 copayment per day per facility Non-member facilities: $200 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.
Outpatient **diagnostic testing services** performed and billed by a facility, such as: • Cardiovascular monitoring • EEGs • Home-based/unattended sleep studies • 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 facilities: $40 copayment per day per facility Member facilities: $40 copayment per day per facility Non-member facilities: $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.
Outpatient **treatment and therapy services** performed and billed by a facility, limited to: • Cognitive rehabilitation therapy • Physical, occupational, and speech therapy - Standard Option benefits are limited to a combined total of 75 visits per person per calendar year - Basic Option benefits are limited to a combined total of 50 visits per person per calendar year • Manipulative treatment services - Standard Option benefits are limited to a combined total of 12 visits per person per calendar year - Basic Option benefits are limited to a combined total of 20 visits per person per calendar year	Preferred facilities: $30 copayment per day per facility (no deductible) 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 facilities: $35 copayment per day per facility Member/Non-member facilities: You pay all charges Note: You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care.

Outpatient Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**Standard Option**	**Basic Option**
Outpatient **treatment services** performed and billed by a facility, limited to: • Cardiac rehabilitation • Pulmonary rehabilitation • Applied behavior analysis (ABA) for an autism spectrum disorder (see prior approval requirements in Section 3)	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 facilities: $35 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. Member/Non-member facilities: You pay all charges
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 facilities: 15% of the Plan allowance Member facilities: 15% of the Plan allowance Non-member facilities: 15% of the Plan allowance plus 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.
Outpatient **adult preventive care** performed and billed by a facility, limited to: • Visits/exams for preventive care, screening procedures, and routine immunizations described in Section 5(a) • Cancer screenings listed in Section 5(a) and ultrasound screening for abdominal aortic aneurysm Note: See Section 5(a) for our payment levels for covered preventive care services for children billed for by facilities and performed on an outpatient basis.	See Section 5(a) for our payment levels for covered preventive care services for adults	Preferred facilities: Nothing Member/Non-member facilities: 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 Hospital or Ambulatory Surgical Center - continued on next page

Benefit Description	You Pay	
Outpatient Hospital or Ambulatory Surgical Center (cont.)	**Standard Option**	**Basic Option**
Outpatient **drugs, medical devices, and durable medical equipment** billed for by a facility, such as: • Prescribed drugs • Orthopedic and prosthetic devices • Durable medical equipment • Surgical implants 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. Note: Certain self-injectable drugs are covered only when dispensed by a pharmacy under the pharmacy benefit. These drugs will be covered once per lifetime per therapeutic category of drugs when dispensed by a non-pharmacy-benefit provider. This benefit limitation does not apply if you have primary Medicare Part B coverage, or are enrolled in the Medicare Prescription Drug Program.	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 facilities: 30% of the Plan allowance Note: You may also be responsible for paying a copayment per day per facility for other outpatient services listed in this section. Member/Non-member facilities: You pay all charges
Blue Distinction® Specialty Care	**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 Knee and Hip Replacement, Blue Distinction Center for Spine Surgery, or Blue Distinction Center for Comprehensive Bariatric Surgery. • Bariatric surgeries covered are: - Roux-en-Y gastric bypass - Laparoscopic adjustable gastric banding - Sleeve gastrectomy - Biliopancreatic bypass with duodenal switch • 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 phone number listed on the back of your ID card for assistance.	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

Blue Distinction® Specialty Care - continued on next page

Benefit Description	You Pay	
Blue Distinction® Specialty Care (cont.)	**Standard Option**	**Basic Option**
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. Note: See Section 3 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 specific covered bariatric surgical procedures, when the surgery is performed at a designated Blue Distinction Center for Bariatric Surgery. Outpatient facility services related to specific covered hip and knee replacement or revision surgeries and certain spine surgery procedures, when performed at a designated Blue Distinction Center for hip/knee/spine surgery. Note: You must meet the pre-surgical requirements listed in our medical policies for bariatric surgeries. Note: 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 phone 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 benefits do not apply to other types of outpatient surgical services, even when performed at a Blue Distinction Center. Note: See Section 3 for more information about Blue Distinction Centers.	Blue Distinction Center: $100 per day per facility (no deductible)	Blue Distinction Center: $25 per day per facility
Residential Treatment Center	**Standard Option**	**Basic Option**
Precertification prior to admission is required. We cover inpatient care provided and billed by an RTC when the care is medically necessary for the treatment of a medical, mental health, and/or substance use disorder: • Room and board, such as semiprivate room, nursing care, meals, special diets, ancillary charges, and covered therapy services when billed by the facility. Note: RTC benefits are not available for facilities licensed as a skilled nursing facility, group home, halfway house, or similar type facility.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred facilities: $250 per day copayment up to $1,500 per admission for unlimited days Member/Non-member facilities: You pay all charges

Residential Treatment Center - continued on next page

Benefit Description	You Pay	
Residential Treatment Center (cont.)	**Standard Option**	**Basic Option**
Note: Benefits are not available for noncovered services, including: respite care; outdoor residential programs; services provided outside of the provider's scope of licensure; recreational therapy; educational therapy; educational classes; biofeedback; Outward Bound programs; equine/hippotherapy provided during the approved stay; personal comfort items, such as guest meals and beds, phone, 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. Note: For outpatient residential treatment center services, see Section 5(e).	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred facilities: $250 per day copayment up to $1,500 per admission for unlimited days Member/Non-member facilities: You pay all charges
Extended Care Benefits/Skilled Nursing Care Facility Benefits	**Standard Option**	**Basic Option**
When Medicare Part A is not your primary payor: For members who do not have Medicare Part A, we cover skilled nursing facility (SNF) inpatient care for a maximum of 30 days annually, when the member can be expected to benefit from short-term SNF services with a goal of returning home. Note: Precertification is required prior to admission (including overseas care). Benefits are not available for inpatient SNF care solely for management of tube feedings, for home level dialysis treatment, as an interim transition to long-term care placement, or for any other noncovered services. Note: Inpatient benefits (such as room and board) may not be provided if precertification is not obtained prior to admission (see Section 3).	Preferred facilities: $175 (no deductible) per admission Member facilities: $275 plus 35% of the Plan allowance (no deductible) per admission Non-member facilities: $275 plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment, per admission	All charges
When Medicare Part A is your primary payor: When Medicare Part A is the primary payor (meaning it pays first) and has made a 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. Note: See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c03.pdf for complete Medicare benefit period definition. 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.	Preferred facilities: Nothing (no deductible) Member facilities: Nothing (no deductible) Non-member facilities: Nothing (no deductible) Note: You pay all charges not paid by Medicare after the 30th day.	All charges

Extended Care Benefits/Skilled Nursing Care Facility Benefits - continued on next page

Benefit Description	You Pay	
Extended Care Benefits/Skilled Nursing Care Facility Benefits (cont.)	**Standard Option**	**Basic Option**
Note: See earlier in this section for benefits provided for outpatient physical, occupational, speech, and cognitive rehabilitation therapy, and manipulative treatment services when billed by a skilled nursing facility. See Section 5(f) for benefits for prescription drugs. ***Note: If Medicare Part A is your primary payor, we will only provide benefits if Medicare provided benefits for the admission.***	Preferred facilities: Nothing (no deductible) Member facilities: Nothing (no deductible) Non-member facilities: Nothing (no deductible) Note: You pay all charges not paid by Medicare after the 30th day.	All charges
Not covered: *Phone, television, personal comfort items, such as guest meals and beds, beauty and barber services, recreational outings/trips, stretcher or wheelchair transportation, non-emergent 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, custodial or long term-care (see* Definitions*), and domiciliary care provided because care in the home is not available or is unsuitable*	*All charges*	*All charges*
Hospice Care	**Standard Option**	**Basic Option**
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 the following	See the following
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

Benefit Description	You Pay	
Hospice Care (cont.)	**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 Section 3 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 described here. **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.**	Nothing (no deductible)	Nothing
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: • Advanced care planning (see Section 10) • Dietary counseling • Durable medical equipment rental • Medical social services • Medical supplies • Nursing care • Oxygen therapy • Periodic physician visits • Physical therapy, occupational therapy, and speech therapy related to the terminal medical condition • Prescription drugs and medications • Services of home health aides (certified or licensed, if the state requires it, and provided by the home hospice agency)	See next page	See next page

Hospice Care - continued on next page

Benefit Description	You Pay	
Hospice Care (cont.)	**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. An episode of care is one home hospice treatment plan per calendar year.	Preferred facilities: Nothing (no deductible) Member/Non-member facilities: $450 copayment per episode (no deductible)	Preferred facilities: Nothing Member/Non-member facilities: You pay all charges
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. An episode consists of up to seven consecutive days of continuous care. The member must be enrolled in a home hospice program in order to receive benefits for subsequent continuous home hospice care, and the services must be provided by the home hospice program in which the member is enrolled.	Preferred facilities: Nothing (no deductible) Member facilities: $450 per episode copayment (no deductible) Non-member facilities: $450 per episode copayment, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred facilities: Nothing Member/Non-member facilities: 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 30 consecutive days in a facility licensed as an inpatient hospice facility. 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 facilities: Nothing (no deductible) Member facilities: $450 per admission copayment, plus 35% of the Plan allowance (no deductible) Non-member facilities: $450 per admission copayment, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred facilities: Nothing Member/Non-member facilities: You pay all charges
Not covered: • *Advanced care planning, except when provided as part of a covered hospice care treatment plan* • *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*

Benefit Description	You Pay	
Ambulance	**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. Note: Prior approval is required for all non-emergent air ambulance transport.	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 the Overseas Assistance Center (provided by GeoBlue) by calling 804-673-1678.	$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
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.*	*All charges*	*All charges*

Ambulance - continued on next page

Benefit Description	You Pay	
Ambulance (cont.)	**Standard Option**	**Basic Option**
• *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 Non-preferred (non-PPO) professional providers may provide services in Preferred (PPO) facilities.
- 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. For more information, see Section 4, NSA.
- 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 member, the health of the member and their 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, 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: Nothing (no deductible)	Preferred: Nothing Participating: Nothing Non-participating: Nothing
• **Professional provider services** in the provider's office, including, 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)	Regular benefit levels apply to covered services provided in this setting. See Sections 5(a) and 5(b).
• 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: Nothing (no deductible)	Preferred emergency room: $250 copayment per day per facility Member emergency room: $250 copayment per day per facility Non-member emergency room: $250 copayment per day per facility Note: If you are admitted directly to the hospital from the emergency room, you do not have to pay the $250 emergency room copayment. However, the $250 per day copayment for Preferred inpatient care still applies.
• Urgent care centers, licensed as and permitted to provide emergency services and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider Note: The urgent care center must be licensed as and permitted to provide emergency services in order to receive protections under the NSA. See Section 4 for more information.	Preferred urgent care center: Nothing (no deductible) Participating urgent care center: Nothing (no deductible) Non-participating urgent care center: Nothing (no deductible)	Preferred urgent care center: $35 copayment per visit Participating/Non-participating urgent care center: $35 copayment per visit
• Urgent care centers, not licensed as or permitted to provide emergency services and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider	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

Benefit Description	You Pay	
Accidental Injury (cont.)	**Standard Option**	**Basic Option**
Note: If you are treated by a non-PPO professional provider in a PPO facility, you will only be responsible for your cost-share and will not owe any difference between our allowance and the billed amount. (See Section 4.) 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 previously described 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	**Standard Option**	**Basic Option**
• **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)	Preferred: Nothing Participating: Nothing Non-participating: Nothing
• 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).	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)	Preferred emergency room: $250 copayment per day per facility Member emergency room: $250 copayment per day per facility Non-member emergency room: $250 copayment per day per facility Note: If you are admitted directly to the hospital from the emergency room, you do not have to pay the $250 emergency room copayment. However, the $250 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

Benefit Description	You Pay	
Medical Emergency (cont.)	**Standard Option**	**Basic Option**
• Urgent care centers, licensed as and permitted to provide emergency services and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider Note: The urgent care center must be licensed as and permitted to provide emergency services in order to receive protections under the NSA. See Section 4 for more information. Note: Benefits for crutches, splints, braces, etc. when billed by a provider other than the urgent care center are stated in Section 5(a), *DME.*	Preferred urgent care center: $30 copayment per visit (no deductible) Participating urgent care center: $30 copayment per visit (no deductible) Non-participating urgent care center: $30 copayment per visit (no deductible)	Preferred urgent care center: $35 copayment per visit Participating/Non-participating urgent care center: $35 copayment per visit
• Urgent care centers, not licensed as or permitted to provide emergency services and supplies, including professional providers' services, diagnostic studies, radiology services, laboratory tests and pathology services, when billed by the provider Note: Benefits for crutches, splints, braces, etc. when billed by a provider other than the urgent care center are stated in Section 5(a), *DME.*	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
Not covered: Emergency room professional charges for shift differentials	*All charges*	*All charges*
Ambulance	**Standard Option**	**Basic Option**
See Section 5(c) for complete ambulance benefit and coverage information.	See Section 5(c)	See Section 5(c)

Section 5(e). Mental Health and Substance Use Disorder 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 an acute 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 Section 5(h). Contact us at the phone number listed on the back of your Service Benefit Plan ID card if you have any questions or would like to discuss your healthcare 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.
- Every year, we conduct an analysis of the financial requirements and treatment limitations which apply to this Plan's mental health and substance use disorder benefits in compliance with the federal Mental Health Parity and Addiction Equity Act (the Act), and the Act's implementing regulations. Based on the results of this analysis, we may suggest changes to program benefits to OPM. More information on the Act is available on the following Federal Government websites:
  https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html
  https://www.dol.gov/ebsa/
  www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act
- **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.
- 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 use disorder 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 Section 3 for the exceptions to this requirement.**
  - There is **no calendar year deductible.**
- You should be aware that some Non-preferred (non-PPO) professional providers may provide services in Preferred (PPO) facilities.

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 use disorder 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 use disorder practitioners when acting within the scope of their license • Individual psychotherapy • Group psychotherapy • Pharmacologic (medication) management • Psychological testing • Office visits • Clinic visits • Home visits • Phone consultations and online medical evaluation and management services (telemedicine) 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 use disorder phone number on the back of your ID card. Note: See Sections 5(a) and 5(f) for our coverage of smoking and tobacco cessation treatment. Note: See Section 5(a) for our coverage of mental health visits to treat postpartum depression and depression during pregnancy. Note: We cover outpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers at the levels shown here.	Preferred: $30 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: $35 copayment per visit Participating/Non-participating: You pay all charges
Telehealth professional services for: • Behavioral health counseling • Substance use disorder counseling Note: Refer to Section 5(h), *Wellness and Other Special Features*, for information on telehealth services and how to access our telehealth provider network. Note: Benefits are combined with telehealth services listed in Section 5(a). Note: Copayments are waived for members with Medicare Part B primary.	Preferred Telehealth provider: Nothing (no deductible) for the first 2 visits per calendar year for any covered telehealth service $10 copayment per visit (no deductible) after the 2nd visit Participating/Non-participating: You pay all charges	Preferred Telehealth provider: Nothing for the first 2 visits per calendar year for any covered telehealth service $15 copayment per visit after the 2nd visit Participating/Non-participating: You pay all charges

Professional Services - continued on next page

Benefit Description	You Pay	
Professional Services (cont.)	**Standard Option**	**Basic Option**
• 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	**Standard Option**	**Basic Option**
Inpatient services provided and billed by a hospital or other covered facility • 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 use disorder includes room and board and ancillary charges for confinements in a hospital/treatment facility for rehabilitative treatment of alcoholism or substance use disorder. Note: You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: 35% of the Plan allowance for unlimited days (no deductible), and any remaining balance after our payment	Preferred facilities: $250 per day copayment up to $1,500 per admission for unlimited days Member/Non-member facilities: You pay all charges
Residential Treatment Center	**Standard Option**	**Basic Option**
Precertification prior to admission is required. We cover inpatient care provided and billed by an RTC when the care is medically necessary for the treatment of a medical, mental health, and/or substance use disorder: • Room and board, such as semiprivate room, nursing care, meals, special diets, ancillary charges, and covered therapy services when billed by the facility Note: RTC benefits are not available for facilities licensed as a skilled nursing facility, group home, halfway house, or similar type facility.	Preferred facilities: $350 per admission copayment for unlimited days (no deductible) Member facilities: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member facilities: 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred facilities: $250 per day copayment up to $1,500 per admission for unlimited days Member/Non-member facilities: You pay all charges

Residential Treatment Center - continued on next page

Benefit Description	You Pay	
Residential Treatment Center (cont.)	**Standard Option**	**Basic Option**
Note: Benefits are not available for noncovered services, including: respite care; outdoor residential programs; services provided outside of the provider's scope of practice; recreational therapy; educational therapy; educational classes; biofeedback; Outward Bound programs; hippotherapy/equine therapy provided during the approved stay; personal comfort items, such as guest meals and beds, phone, television, beauty and barber services; custodial or long-term care; and domiciliary care provided because care in the home is not available or is unsuitable. Note: For outpatient residential treatment center services, see the next Section.	Continued from previous page: 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 facilities: $250 per day copayment up to $1,500 per admission for unlimited days Member/Non-member facilities: You pay all charges
Outpatient Hospital or Other Covered Facility	**Standard Option**	**Basic Option**
Outpatient services provided and billed by a covered facility Note: We cover outpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers at the levels shown here. • 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: $35 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 Note: A residential treatment center is a covered facility for outpatient care (see Section 10, Definitions, for more information). We cover inpatient mental health and substance use disorder services or supplies provided and billed by residential treatment centers, other than room and board and inpatient physician care, at the levels shown here.	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)	**Standard Option**	**Basic Option**
• *Educational or other counseling or training services* • *Services performed by a noncovered provider* • *Testing for and treatment of learning disabilities and intellectual disability* • *Inpatient services performed or billed by residential treatment centers, except as described in Sections 5(a) and 5(e)*	*All charges*	*All charges*

Not Covered (Inpatient or Outpatient) - continued on next page

Benefit Description	You Pay	
Not Covered (Inpatient or Outpatient) (cont.)	**Standard Option**	**Basic Option**
• *Services performed or billed by schools, halfway houses, group homes or members of their staffs* *Note: We cover professional services as described in this section when they are provided and billed by a covered professional provider acting within the scope of their 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.)* • *Hippotherapy/equine therapy (exercise on horseback)* • *Light boxes* • *Custodial or long-term care (see* Definitions*)* • *Costs associated with enabling or maintaining providers' telehealth (telemedicine) technologies, non-interactive telecommunication such as email communications, or asynchronous store-and-forward telehealth services*	*All charges*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits for members enrolled in our regular pharmacy program:

- We cover prescription drugs and supplies, as described below and on the following pages for members enrolled in our regular pharmacy drug program.
- If there is no generic drug available, you must pay the brand-name cost-sharing amount when you receive a brand-name drug.
- If there is a generic substitution available and you or your provider requests a brand-name drug, you will be responsible for the applicable tier cost-share plus the difference in the cost of the brand-name and generic drug. If the provider's prescription is for the brand-name drug and indicates "dispense as written," you are responsible only for the applicable tier cost-share.
- 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.
- Benefits for certain self-injectable (self-administered) drugs are provided only when they are dispensed by a pharmacy under the pharmacy benefit. See the Tier 4 and Tier 5 specialty drug fills from a Preferred pharmacy in the following pages.
- Benefits for certain auto-immune infusion medications (limited to Remicade, Renflexis and Inflectra) are covered only when they are obtained from a non-pharmacy provider, such as a physician or facility (hospital or ambulatory surgical center). See *Drugs From Other Sources* in this section for more 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.
- Medication prices vary among different retail pharmacies, the Mail Service Prescription Drug Program, and the Specialty Drug Pharmacy Program. **Review purchasing options for your prescriptions to get the best price.** A drug cost tool is available at www.fepblue.org or call:
  - **Retail Pharmacy Program: 800-624-5060, TTY: 711**
  - **Mail Service Prescription Drug Program: 800-262-7890, TTY: 711**
  - **Specialty Drug Pharmacy Program: 888-346-3731, TTY: 711**
- **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. Keep reading in this section for more information about the PSQM program and see Section 3 for more information about prior approval. Our prior approval process may include step therapy, which requires you to use a generic and/or preferred medication(s) before a non-preferred medication is covered.
- 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 or biosimilar becomes available or if new safety concerns arise. If your drug is moved to a higher tier, your cost-share will increase. If your drug is moved to noncovered, you pay the full cost of the medication. Tier reassignments during the year are not considered benefit changes.
- A pharmacy restriction may be applied for clinically inappropriate use of prescription drugs and supplies.
- The Standard Option and Basic Option formularies both contain a comprehensive list of drugs under all therapeutic categories with two exceptions: some drugs, nutritional supplements and supplies are not covered; we may also exclude certain U.S. FDA-approved drugs when multiple generic equivalents/ alternative medications are available.

- **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.
  - There is no calendar year deductible for the Retail Pharmacy Program, the Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program.
- **Under Basic Option,**
  - **You must use Preferred retail pharmacies or the Specialty Drug Pharmacy Program in order to receive benefits.** Our specialty drug pharmacy is a Preferred pharmacy.
  - The Mail Service Prescription Drug Program is available only to members with primary Medicare Part B coverage.
  - There is **no calendar year deductible.**
  - We use a managed formulary for certain drug classes.

We will send each new enrollee a Plan identification card, which covers pharmacy and medical benefits. 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 pre-addressed reply envelope.

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

- **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/certified provider with prescriptive authority prescribing within their scope of practice 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.

  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.

  Under Standard Option and Basic Option

  Note: Neither the Mail Service Prescription Drug Program nor the Specialty Drug Pharmacy Program will fill your prescription for a drug requiring prior approval 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 unable to be filled and a letter will be mailed to you explaining the prior approval procedures.

  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.

  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.

- **What is covered.**

  Under Basic Option, we use a managed formulary for certain drug classes. 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.

Under Standard Option and Basic Option

Note: Both formularies include lists of preferred drugs that are safe, effective and appropriate for our members, and are available at lower costs than non-preferred drugs. If your physician prescribed a more expensive non-preferred drug for you, we may ask that they prescribe a preferred drug instead; we encourage you to do the same. If you purchase a drug that is not on our preferred drug list, your cost will be higher. Your cooperation with our cost-savings efforts helps keep your premium affordable.

Note: Some drugs, nutritional supplements, and supplies are not covered (see later in this section); we may also exclude certain U. S. FDA-approved drugs when multiple generic equivalents/alternative medications are available. If you purchase a drug, nutritional supplement, or supply that is not covered, you will be responsible for the full cost of the item.

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. Changes to the preferred drug list are not considered benefit changes.

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. 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 call 800-624-5060, TTY: 711, for assistance. Changes to the formulary are not considered benefit changes. 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 U.S. FDA-approved generic equivalent, unless you or your physician specifically requests a brand-name drug and indicates "dispense as written." Keep in mind that **Basic Option members must use Preferred providers in order to receive benefits.** 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. 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 unless otherwise noted. 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.

Under Standard Option and Basic Option

Benefits for Tier 4 and Tier 5 specialty drugs purchased at a 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. 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 of the specialty drug.

Note: Certain drugs such as narcotics may have additional limits or requirements as established by the U.S. FDA or by national scientific or medical practice guidelines (such as Centers for Disease Control and Prevention, American Medical Association, etc.) 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 22, 30, and 90-day supplies of those medications. **In most cases, refills cannot be obtained until 75% of the prescription has been used. Controlled substances cannot be refilled until 80% of the prescription has been used.** Controlled substances are medications that can cause physical and mental dependence, and have restrictions on how they can be filled and refilled. They are regulated and classified by the DEA (Drug Enforcement Administration) based on how likely they are to cause dependence. 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.

Note: Benefits for certain self-injectable (self-administered) drugs are provided only when they are dispensed by a pharmacy under the pharmacy benefit. Medical benefits will be provided for a once-per-lifetime dose per therapeutic category of drugs dispensed by your provider or any non-pharmacy-benefit provider. This benefit limitation does not apply if you have primary Medicare Part B coverage. See later in this section for Tier 4 and Tier 5 specialty drug fills from a Preferred pharmacy.

Note: Benefits for certain auto-immune infusion medications (Remicade, Renflexis and Inflectra) are provided only when obtained by a non-pharmacy provider, such as a physician or facility (hospital or ambulatory surgical center). See *Drugs From Other Sources* in this Section for more information.

Patient Safety and Quality Monitoring (PSQM)

We have a special program to promote patient safety and monitor healthcare 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 – 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 U.S. FDA-approved recommendations, national scientific and generally accepted standards of medical practice guidelines (such as Centers for Disease Control and Prevention, American Medical Association, etc.), 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 800-624-5060, TTY: 711.

Prior Approval

As part of our Patient Safety and Quality Monitoring (PSQM) program, **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 generally accepted standards of medical, dental, or psychiatric practice in the United States. Our prior approval process may include step therapy, which requires you to use a generic and/or preferred medication(s) before a non-preferred medication is covered. **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 800-624-5060, TTY: 711. You can also obtain the list and forms 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.

Note: It is your responsibility to know the prior approval authorization expiration date for your medication. We encourage you to work with your physician to obtain prior approval renewal in advance of the expiration date.

Standard Option Generic Incentive Program

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

- If you switch from one generic drug to another, you will be responsible for your copayment.

Note: The list of eligible generic drug replacements may change and is not considered a benefit change. For the most up-to-date information, please visit www.fepblue.org/en/benefit-plans/coverage/pharmacy/generic-incentive-program or call us using any of the numbers listed at the beginning of this section.

Medical Foods

The Plan covers medical food formulas and enteral nutrition products that are ordered by a healthcare provider and are medically necessary to prevent clinical deterioration in members at nutritional risk.

To receive benefits, products must meet the definition of medical food (See Section 10, Definitions).

Members must be receiving active, regular, and ongoing medical supervision and must be unable to manage the condition by modification of diet alone.

Coverage is provided as follows:

- Inborn errors of amino acid metabolism
- Food allergy with atopic dermatitis, gastrointestinal symptoms, IgE mediation, malabsorption disorder, seizure disorder, failure to thrive, or prematurity, when administered orally and is the sole source (100%) of nutrition. This once per lifetime benefit is limited to one year following the date of the initial prescription or physician order for the medical food (e.g., Neocate, in a formula form or powders mixed to become formulas)
- Medical foods and nutritional supplements when administered by catheter or nasogastric tubes

Note: A prescription and prior approval are required for medical foods provided under the pharmacy benefit. Renewals of the prior authorization are required every benefit year for inborn errors of metabolism and tube feeding.

Note: See Section 5(a), Medical Supplies, for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube under the medical benefit.

Here is how to obtain your prescription drugs and supplies:

- 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 retail pharmacy to request your prescriptions online and delivery, if available.
- For a listing of Preferred retail pharmacies, call the Retail Pharmacy Program at 800-624-5060, TTY: 711, 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: For prescription drugs billed by a skilled nursing facility, nursing home, or extended care facility, we provide benefits as shown below for drugs obtained from a Preferred retail pharmacy, as long as the pharmacy supplying the prescription drugs to the facility is a Preferred pharmacy. See later in this section for benefit information about prescription drugs supplied by Non-preferred retail pharmacies.

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 Medication and Supplies	**Standard Option**	**Basic Option**
Preferred Retail Pharmacies **Covered drugs and supplies, such as:** • Drugs, vitamins and minerals, and nutritional supplements that by Federal law of the United States require a prescription for their purchase • Drugs for the diagnosis and treatment of infertility • Drugs for IVF – limited to 3 cycles annually (prior approval required) Note: Drugs used for IVF must be purchased through the pharmacy drug program and you must meet our definition of infertility. • Drugs associated with covered artificial insemination procedures • Drugs to treat gender dysphoria (gonadotropin releasing hormone (GnRH) antagonists and testosterones) • Contraceptive drugs and devices, limited to: - Diaphragms and contraceptive rings - Injectable contraceptives - Intrauterine devices (IUDs) - Implantable contraceptives - Oral and transdermal contraceptives • Medical foods • Insulin, diabetic test strips, lancets, and tubeless insulin delivery systems (See Section 5(a) for our coverage of insulin pumps with tubes.) • Needles and disposable syringes for the administration of covered medications	Tier 1 (generic drug): $7.50 copayment for each purchase of up to a 30-day supply ($22.50 copayment for a 31 to 90-day supply) (no deductible) Note: You pay a $5 copayment for each purchase of up to a 30-day supply ($15 copayment for a 31 to 90-day supply) 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, as previously described. Tier 2 (preferred brand-name drug): 30% of the Plan allowance for each purchase of up to a 90-day supply (no deductible) Tier 3 (non-preferred brand-name drug): 50% of the Plan allowance for each purchase of up to a 90-day supply (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 1 (generic drug): $15 copayment for each purchase of up to a 30-day supply ($40 copayment for a 31 to 90-day supply) Tier 2 (preferred brand-name drug): $60 copayment for each purchase of up to a 30-day supply ($180 copayment for a 31 to 90-day supply) Tier 3 (non-preferred brand-name drug): 60% of the Plan allowance ($90 minimum) for each purchase of up to a 30-day supply ($250 minimum for a 31 to 90-day supply) Tier 4 (preferred specialty drug): $85 copayment limited to one purchase of up to a 30-day supply Tier 5 (non-preferred specialty drug): $110 copayment limited to one purchase of up to a 30-day supply **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $10 copayment for each purchase of up to a 30-day supply ($30 copayment for a 31 to 90-day supply)

Covered Medication and Supplies - continued on next page

Benefit Description	You Pay	
Covered Medication and Supplies (cont.)	**Standard Option**	**Basic Option**
• Clotting factors and anti-inhibitor complexes for the treatment of hemophilia Note: For a list of the Preferred Network Long-Term Care pharmacies, call 800-624-5060, TTY: 711. 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 800-624-5060, TTY: 711, 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 when purchased from a Preferred retail pharmacy.	Continued from previous page: Tier 5 (non-preferred specialty drug): 30% of the Plan allowance (no deductible), limited to one purchase of up to a 30-day supply	Continued from previous page: Tier 2 (preferred brand-name drug): $50 copayment for each purchase of up to a 30-day supply ($150 copayment for a 31 to 90-day supply) Tier 3 (non-preferred brand-name drug): 50% of the Plan allowance ($60 minimum) for each purchase of up to a 30-day supply ($175 minimum for a 31 to 90-day supply) Tier 4 (preferred specialty drug): $80 copayment limited to one purchase of up to a 30-day supply Tier 5 (non-preferred specialty drug): $100 copayment limited to one purchase of up to a 30-day supply
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 For Standard Option and Basic Option members when Medicare Part B is Primary, 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: You must obtain prior approval for certain drugs before Mail Service will fill your prescription. See Section 3. Note: Not all drugs are available through the Mail Service Prescription Drug Program. There are no specialty drugs available through the Mail Service Program.	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, as previously stated.	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $20 copayment Tier 2 (preferred brand-name drug): $100 copayment Tier 3 (non-preferred brand-name drug): $125 copayment **When Medicare Part B is not primary: No benefits**

Covered Medication and Supplies - continued on next page

Benefit Description	You Pay	
Covered Medication and Supplies (cont.)	**Standard Option**	**Basic Option**
Note: Please keep reading 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 800-262-7890, TTY: 711. 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.	Continued from previous page: Tier 2 (preferred brand-name drug): $90 copayment (no deductible) Tier 3 (non-preferred brand-name drug): $125 copayment (no deductible)	Continued from previous page: 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.
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 phone number below or visit our website, www.fepblue.org. (See Section 10 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. See Section 7 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 31 to 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 888-346-3731, TTY: 711.	Tier 4 (preferred specialty drug): $65 copayment for each purchase of up to a 30-day supply ($185 copayment for a 31 to 90-day supply) (no deductible) Tier 5 (non-preferred specialty drug): $85 copayment for each purchase of up to a 30-day supply ($240 copayment for a 31 to 90-day supply) (no deductible)	Tier 4 (preferred specialty drug): $85 copayment for each purchase of up to a 30-day supply ($235 copayment for a 31 to 90-day supply) Tier 5 (non-preferred specialty drug): $110 copayment for each purchase of up to a 30-day supply ($300 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 4 (preferred specialty drug): $80 copayment for each purchase of up to a 30-day supply ($210 copayment for a 31 to 90-day supply) Tier 5 (non-preferred specialty drug): $100 copayment for each purchase of up to a 30-day supply ($255 copayment for a 31 to 90-day supply)
Asthma Medications **Preferred Retail Pharmacies:** Note: See Section 3 for information about drugs and supplies that require prior approval.	Tier 1 (generic drug): $5 copayment (no deductible) Tier 2 (preferred brand-name drug): 20% of the Plan allowance (no deductible)	Tier 1 (generic drug): $5 copayment for each purchase of up to a 90-day supply Tier 2 (preferred brand-name drug): $35 copayment for each purchase of up to a 30-day supply ($105 copayment for a 31 to 90-day supply)

Covered Medication and Supplies - continued on next page

Benefit Description	You Pay	
Covered Medication and Supplies (cont.)	**Standard Option**	**Basic Option**
Asthma Medications (cont.)		Continued from previous page: **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment Tier 2 (preferred brand-name drug): $30 copayment for each purchase of up to a 30-day supply ($90 copayment for a 31 to 90-day supply)
Mail Service Prescription Drug Program: Note: You must obtain prior approval for certain drugs before Mail Service will fill your prescription. See Section 3. Note: See earlier in this section for Tier 3, 4 and 5 prescription drug benefits.	Tier 1 (generic drug): $5 copayment (no deductible) Tier 2 (preferred brand-name drug): $65 copayment (no deductible)	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment Tier 2 (preferred brand-name drug): $75 copayment
Other Preferred Diabetic Medications, Test Strips, and Supplies **Preferred Retail Pharmacies:**	Tier 2 (preferred diabetic medications and supplies): 20% of the Plan allowance for each purchase of up to a 90-day supply (no deductible) Tier 2 (preferred insulins): $35 copayment for each purchase of up to a 30-day supply ($65 copayment for a 31 to 90-day supply) (no deductible) Non-preferred retail pharmacies: You pay all charges	Tier 2 (preferred diabetic medications and supplies): $35 copayment for each purchase of up to a 30-day supply ($65 copayment for a 31 to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 2 (preferred brand-name drugs): $30 copayment for each purchase of up to a 30-day supply ($60 copayment for a 31 to 90-day supply)
Mail Service Prescription Drug Program: Note: See earlier in this section for Tier 2, 3, 4, and 5 prescription drug benefits. Benefits will be provided for syringes, pens and pen needles and test strips at Tier 2 (diabetic medications and supplies) for Standard Option members, and Basic Option members with primary Medicare Part B, through the Mail Service Prescription Drug Program.	Tier 2 (preferred brand-name drugs): $40 copayment for each purchase of up to a 90-day supply (no deductible)	**When Medicare Part B is primary, you pay the following:** Tier 2 (preferred brand-name drugs): $50 copayment for each purchase of up to a 90-day supply

Covered Medication and Supplies - continued on next page

Benefit Description	You Pay	
Covered Medication and Supplies (cont.)	**Standard Option**	**Basic Option**
Diabetic Meter Program Members with diabetes may obtain one glucose meter kit every 365 days at no cost through our Diabetic Meter Program. To use this program, you must call the phone 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 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.	Nothing for a glucose meter kit ordered through the Diabetic Meter Program	Nothing for a glucose meter kit ordered through the Diabetic Meter Program

FEP MEDICARE PRESCRIPTION DRUG PROGRAM

Important things you should keep in mind about these benefits for members enrolled in our (Medicare Part D), FEP Medicare Prescription Drug Program:

- We cover prescription drugs and supplies, as detailed on the following pages for members enrolled in our FEP Medicare Prescription Drug Program.
- Members with Medicare Part A and/or Part B primary are eligible for the benefits under the FEP Medicare Prescription Drug Program.
- If you were originally group enrolled and chose to disenroll prior to January 1, 2024, you will not be able to rejoin the FEP Medicare Prescription Drug Program until the next enrollment period.
- If you opt-out from the group enrollment or disenroll any time after January 1, 2024, you will not be eligible to re-enroll prior to the next enrollment period.
- For additional information about who is eligible for this program and when, or to dispute your claim, please visit us at www.fepblue.org/medicarerx
- We may provide additional coverage for prescription drugs not included in your Medicare Part D benefit. For more information about your share of the cost or which prescription drugs may or may not be covered, please call 888-338-7737, TTY 711.
- If there is no generic drug available, you must pay the brand-name cost-sharing amount when you receive a brand-name drug.
- Members enrolled in the FEP Medicare Prescription Drug program have no coverage for drugs obtained and/or purchased overseas.
- 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.
- Certain medications may be covered under Medicare Part B or Medicare Part D, depending on the condition being treated.
- 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.
- Medication prices vary among different pharmacies in our network. **Review purchasing options for your prescriptions to get the best price.** A drug cost tool is available at www.fepblue.org/medicarerx or call 888-338-7737, TTY: 711
- **YOU MUST GET PRIOR APPROVAL FOR CERTAIN DRUGS AND SUPPLIES, and prior approval must be renewed periodically.** Our prior approval process may include step therapy, which requires you to use a generic and/or preferred medication(s) before a non-preferred medication is covered.
- 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. If your drug is moved to a higher tier, your cost-share will increase. If your drug is moved to noncovered, you pay the full cost of the medication. Tier reassignments during the year are not considered benefit changes.
- A pharmacy restriction may be applied for clinically inappropriate use of prescription drugs and supplies.
- The Standard Option and Basic Option formularies both contain a comprehensive list of drugs under all therapeutic categories with two exceptions: some drugs, nutritional supplements and supplies are not covered; we may also exclude certain U.S. FDA-approved drugs when multiple generic equivalents/alternative medications are available. See *Not Covered* later in this section for details.

We will send each new enrollee a Plan identification card, which covers pharmacy and medical benefits.

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

- **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/certified provider with prescriptive authority prescribing within their scope of practice must write your prescriptions.
- **Where you can obtain them.**

  Under Standard Option and Basic Option, you may fill prescriptions at a pharmacy that participates in our nationwide network. The network includes retail pharmacies, mail service pharmacies and specialty pharmacies. You may also receive your medication from a long-term care pharmacy when your care is handled in or by a long-term care facility. You will receive a copy of the pharmacy directory, which lists all pharmacies participating in our network, in your enrollment package. You may also go online to our webpage www.fepblue.org/medicaredrugprogram for a complete listing.

  Note: Due to manufacturer restrictions, a small number of specialty drugs used to treat rare or uncommon conditions may be available only through select pharmacies in our network.

- **What is covered.**

  Under Standard Option and Basic Option

  Both formularies include lists of preferred drugs that are safe, effective and appropriate for our members, and are available at lower costs than non-preferred drugs. If you purchase a drug that is not on our preferred drug list, your cost will be higher. Your cooperation with our cost-savings efforts helps keep your premium affordable.

  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 the CVS Caremark National Pharmacy and Therapeutics Committee, a group of physicians and pharmacists who are not employees or agents of, nor have any 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.

  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

  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 call 888-338-7737, TTY: 711, for assistance. Changes to the formulary are not considered benefit changes.

- **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 pharmacy participating in our network, you authorize the pharmacist to substitute any available U.S. FDA-approved generic equivalent, unless you or your physician specifically requests a brand-name drug and indicates “dispense as written.” 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 and Basic 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 pharmacy network.

Under Standard Option and Basic Option

Note: Certain drugs such as narcotics may have additional limits or requirements as established by the U.S. FDA or by national scientific or medical practice guidelines (such as Centers for Disease Control and Prevention, American Medical Association, etc.) 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 22, 30, and 90-day supplies of those medications. In most cases, refills cannot be obtained until 75% of the prescription has been used. Controlled substances cannot be refilled until 80% of the prescription has been used. Controlled substances are medications that can cause physical and mental dependence, and have restrictions on how they can be filled and refilled. They are regulated and classified by the DEA (Drug Enforcement Administration) based on how likely they are to cause dependence. 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

FEP Medicare Prescription Drug Program: 888-338-7737, TTY: 711; or www.fepblue.org/medicarerx

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Prior Approval

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 generally accepted standards of medical, dental, or psychiatric practice in the United States. Our prior approval process may include step therapy, which requires you to use a generic and/or preferred medication(s) before a non-preferred medication is covered. **Prior approval must be renewed periodically.** To obtain a list of these drugs and supplies and to obtain prior approval request forms, call the FEP Medicare Prescription Drug Program 888-338-7737, TTY: 711. You can also obtain the list and forms 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 FEP Medicare Prescription Drug Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.

Note: It is your responsibility to know the prior approval authorization expiration date for your medication. We encourage you to work with your physician to obtain prior approval renewal in advance of the expiration date.

Medical Foods

The Plan covers medical food formulas and enteral nutrition products that are ordered by a healthcare provider, and are medically necessary to prevent clinical deterioration in members at nutritional risk.

To receive benefits, products must meet the definition of medical food (see Section 10, Definitions).

Members must be receiving active, regular, and ongoing medical supervision and must be unable to manage the condition by modification of diet alone.

Coverage is provided as follows:

- Inborn errors of amino acid metabolism
- Food allergy with atopic dermatitis, gastrointestinal symptoms, IgE mediation, malabsorption disorder, seizure disorder, failure to thrive, or prematurity, when administered orally and is the sole source (100%) of nutrition. This once per lifetime benefit is limited to one year following the date of the initial prescription or physician order for the medical food (e.g., Neocate, in a formula form or powders mixed to become formulas)
- Medical foods and nutritional supplements when administered by catheter or nasogastric tubes

Note: A prescription and prior approval are required for medical foods provided under the pharmacy benefit. Renewals of the prior authorization are required every benefit year for inborn errors of metabolism and tube feeding.

Note: See Section 5(a) Medical Supplies for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube under the medical benefit.

Here is how to obtain your Prescription Drugs and Supplies.

- Make sure you have your Plan ID card when you are ready to purchase your prescription.
- Go to any network pharmacy, or
- Visit the website of your retail pharmacy to request your prescriptions online and delivery, if available.

Note: Pharmacies within our network 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: For prescription drugs billed by a skilled nursing facility, nursing home, or extended care facility, we provide benefits as shown on the following pages for drugs obtained from a pharmacy in our network, as long as the pharmacy supplying the prescription drugs to the facility is a network pharmacy.

Catastrophic Maximums

Each individual enrolled in the FEP Medicare Prescription Drug Program has a separate and lower out-of-pocket catastrophic protection maximum for the drugs purchased while covered under this Program.

Under Standard Option, this separate catastrophic maximum is $2,000

Under Basic Option, this separate catastrophic maximum is $3,250.

This amount accumulates toward the out-of-pocket catastrophic protection maximums described in Section 4 for combined medical and drug expenses for those not enrolled under the FEP Medicare Prescription Drug Program.

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	**Standard Option**	**Basic Option**
Retail Pharmacies **Covered drugs and supplies, such as:** • Drugs, vitamins and minerals, and nutritional supplements that by Federal law of the United States require a prescription for their purchase • Drugs for the diagnosis and treatment of infertility • Drugs for IVF – limited to 3 cycles annually (prior approval required) Note: Drugs used for IVF must be purchased through the pharmacy drug program and you must meet our definition of infertility. • Drugs associated with covered artificial insemination procedures • Drugs to treat gender dysphoria (gonadotropin releasing hormone (GnRH) antagonists and testosterones)	Tier 1 (generic drug): $5 copayment for each purchase of up to a 30-day supply ($15 copayment for a 31 to 90-day supply) (no deductible) Tier 2 (preferred brand-name drug): 15% of the Plan allowance for each purchase of up to a 90-day supply (no deductible) Tier 3 (non-preferred brand-name drug): 50% of the Plan allowance for each purchase of up to a 90-day supply (no deductible) Tier 4 (preferred specialty drug): $60 copayment for each purchase of up to a 30-day supply ($170 copayment for a 31 to 90-day supply) (no deductible)	Tier 1 (generic drug): $10 copayment for each purchase of up to a 30-day supply ($30 copayment for a 31 to 90-day supply) Tier 2 (preferred brand-name drug): $45 copayment for each purchase of up to a 30-day supply ($135 copayment for a 31 to 90-day supply) Tier 3 (non-preferred brand-name drug): 50% of the Plan allowance ($60 minimum) for each purchase of up to a 30-day supply ($175 minimum for a 31 to 90-day supply)

Covered Medications and Supplies - continued on next page

Benefit Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
• 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 available forms of generic contraceptives and for brand-name contraceptives that have no generic equivalent or generic alternative when purchased from a network retail pharmacy. • Medical foods • Insulin, diabetic test strips, lancets, and tubeless insulin delivery systems (See Section 5(a) for our coverage of insulin pumps with tubes.) • Needles and disposable syringes for the administration of covered medications • Clotting factors and anti-inhibitor complexes for the treatment of hemophilia Note: For a list of the Network Long-Term Care pharmacies, call 888-338-7737, TTY: 711.	See previous page	Continued from previous page: Tier 4 (preferred specialty drug): $75 copayment for each purchase of up to a 30-day supply; ($195 for 31 to 90-day supply)
Mail Service Prescription Drug Program For members enrolled in the FEP Medicare 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: You must obtain prior approval for certain drugs before Mail Service will fill your prescription. See Section 3. Note: Not all drugs are available through the Mail Service Prescription Drug 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 800-262-7890, TTY: 711.	Tier 1 (generic drug): $5 copayment (no deductible) Tier 2 (preferred brand-name drug): $85 copayment (no deductible) Tier 3 (non-preferred brands): $125 copayment (no deductible) Tier 4 (specialty-drugs): $150 copayment (no deductible)	Tier 1 (generic drug): $15 copayment Tier 2 (preferred brand-name drug): $95 copayment Tier 3 (non-preferred brands): $125 copayment Tier 4 (specialty-drugs): $150 copayment

Covered Medications and Supplies - continued on next page

Benefit Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
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): $5 copayment (no deductible) Tier 2 (preferred brand-name drug): $85 copayment (no deductible) Tier 3 (non-preferred brands): $125 copayment (no deductible) Tier 4 (specialty-drugs): $150 copayment (no deductible)	Tier 1 (generic drug): $15 copayment Tier 2 (preferred brand-name drug): $95 copayment Tier 3 (non-preferred brands): $125 copayment Tier 4 (specialty-drugs): $150 copayment
Asthma Medications **Network Retail Pharmacies:** Note: See Section 3 for information about drugs and supplies that require prior approval.	Tier 1 (generic drug): $5 copayment (no deductible) Tier 2 (preferred brand-name drug): 10% of the Plan allowance (no deductible)	Tier 1 (generic drug): $5 copayment for each purchase of up to a 90-day supply Tier 2 (preferred brand-name drug): $30 copayment for each purchase of up to a 30-day supply ($90 copayment for a 31 to 90-day supply)
Mail Service Prescription Drug Program Note: You must obtain prior approval for certain drugs before Mail Service will fill your prescription. See Section 3. Note: See earlier in this section for Tier 3 and Tier 4 prescription drug benefits	Tier 1 (generic drug): $5 copayment (no deductible) Tier 2 (preferred brand-name drug): $65 copayment (no deductible)	Tier 1 (generic drug): $5 copayment Tier 2 (preferred brand-name drug): $75 copayment
Other Preferred Diabetic Medications, Test Strips, and Supplies **Network Retail Pharmacies:**	Tier 2 (preferred diabetic medications and supplies): 10% of the Plan allowance for each purchase of up to a 90-day supply (no deductible) Tier 2 (preferred insulins): $35 copayment for each purchase of up to a 30-day supply ($65 copayment for a 31 to 90-day supply) (no deductible)	Tier 2 (preferred diabetic medications and supplies): $30 copayment for each purchase of up to a 30-day supply ($60 copayment for a 31 to 90-day supply)
Mail Service Prescription Drug Program: Note: See earlier in this section for Tier 2, 3, and 4 prescription drug benefits. Benefits will be provided for syringes, pens and pen needles and test strips at Tier 2 (diabetic medications and supplies) for those enrolled in the FEP Medicare Prescription Drug Program when obtained through the Mail Service Prescription Drug Program.	Tier 2 (preferred brand-name drug): $40 copayment for each purchase of up to a 90-day supply (no deductible)	Tier 2 (preferred brand-name drugs): $50 copayment for each purchase of up to a 90-day supply

The pharmacy benefits starting here to the end of the section apply to all covered members, unless otherwise noted.

Benefits 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	**Standard Option**	**Basic Option**
Smoking and Tobacco Cessation Medications If you are a covered member, 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, create a Tobacco Cessation Quit Plan using Daily Habits. For more information, see Section 5(h). The Quit Plan is not required for those covered under the FEP Medicare Prescription Drug Program. Note: There may be age restrictions based on U.S. FDA guidelines for these medications. The following medications are covered through this program: • Generic medications available by prescription: - Bupropion ER 150 mg tablet - Bupropion SR 150 mg tablet - Varenicline 0.5 mg tablets - Varenicline 1 mg tablets - Varenicline starting pack • Brand-name medications available by prescription: - 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 Section 5(a) for our coverage of smoking and tobacco cessation treatment, counseling, and classes.	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

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Anti-hypertensive Medications **Preferred Retail Pharmacies:** Note: See Section 3 for information about drugs and supplies that require prior approval. **Mail Service Prescription Drug Program:** Note: You must obtain prior approval for certain drugs before Mail Service will fill your prescription. Note: See earlier in this section for Tier 2, 3, 4, and 5 prescription drug benefits.	Tier 1 (generic drug): $3 copayment (no deductible) Tier 1 (generic drug): $3 copayment (no deductible)	Tier 1 (generic drug): $5 copayment for each purchase of up to a 90-day supply **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $5 copayment
• Over-the-counter (OTC) contraceptive drugs and devices, limited to: - Emergency contraceptive pills - Condoms - Spermicides - Sponges Note: We provide benefits in full for OTC contraceptive drugs and devices when the contraceptives meet U.S. FDA standards for OTC products. To receive benefits, you must use a 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
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. Note: Our vaccine network is a network of Preferred retail pharmacies that have agreements with us to administer one or more routine immunizations. Check with your pharmacy or call our Retail Pharmacy Program at 800-624-5060, TTY: 711, to find out 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.
Metformin and metformin extended release (excluding osmotic and modified release generic drugs) **Preferred Retail Pharmacies:** **Mail Service Prescription Drug Program:**	Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply (no deductible) Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply (no deductible)	Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $1 copayment for each purchase of up to a 90-day supply

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
Medications 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 individuals capable of pregnancy • Low-dose aspirin (81 mg per day) for pregnant members at risk for preeclampsia • Aspirin for men age 45 through 79 and women age 50 through 79 • Generic cholesterol-lowering statin drugs Note: Benefits are not available for acetaminophen, ibuprofen, naproxen, etc. Note: Benefits for these medications are subject to the dispensing limitations described earlier 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/preventive-care-benefits. See Section 5(a) for information about other covered preventive care services.	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 medications 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 800-624-5060, TTY: 711, to request this form. You can also obtain the Coverage Request Form through our website at www.fepblue.org. This is not required if you are covered under the FEP Medicare Prescription Drug Program.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges Mail Service Prescription Drug Program: Nothing (no deductible)	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

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
We cover the first prescription filled for certain **bowel preparation** medications for colorectal cancer screenings with no member cost-share. We also cover certain **antiretroviral therapy** medications for HIV for those at risk but who do not have HIV. You can view the list of covered medications on our website at www.fepblue.org or call 800-624-5060, TTY: 711, for assistance.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges Mail Service Prescription Drug Program: Nothing (no deductible)	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
Opioid Reversal Agents: Tier 1 medications limited to generic naloxone nasal spray and injectable **Preferred Retail Pharmacies:** **Non-preferred Retail Pharmacies:** **Mail Service Prescription Drug Program:** Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a combined 90-day supply through any of our pharmacy programs, all Tier 1 fills thereafter are subject to the corresponding cost-share.	Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year (no deductible) Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost-share. You pay all charges Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year (no deductible)	Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year Note: Once you have purchased amounts of these medications in a calendar year that are equivalent to a 90-day supply combined, all Tier 1 fills thereafter are subject to the corresponding cost-share. You pay all charges **When Medicare Part B is primary, you pay the following:** Tier 1: Nothing for the purchase of up to a 90-day supply per calendar year
Not covered: • *Remicade, Renflexis, and Inflectra are not covered for prescriptions obtained from a retail pharmacy, Mail Service Prescription or through the Specialty Drug Program* • *Medical supplies such as dressings and antiseptics* • *Drugs and supplies for cosmetic purposes* • *Supplies for weight loss* • *Drugs for orthodontic care, dental implants, and periodontal disease* • *Drugs used in conjunction with non-covered assisted reproductive technology (ART) and assisted insemination procedures*	*All charges*	*All charges*

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
• *Drugs used in conjunction with IVF that exceed the covered 3 per year annual cycle limitation described in this section* • *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 or you are enrolled in the FEP Medicare Prescription Drug Program (see Section 5(a))* • *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 previous benefits in this section for our coverage of medications recommended under the Affordable Care Act and for smoking and tobacco cessation medications.* • *Medical foods administered orally are not covered if not obtained at a retail pharmacy or through the Mail Service Prescription Drug Program* *Note: See Section 5(a) for our coverage of medical foods when administered by catheter or nasogastric tube.* • *Products and foods other than liquid formulas or powders mixed to become formulas; foods and formulas readily available in a retail environment and marketed for persons without medical conditions; low-protein modified foods (e.g., pastas, breads, rice, sauces and baking mixes); nutritional supplements, energy products; and similar items* *Note: See Section 5(a) for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube.* • *Infant formula other than previously described in this section and in Section 5(a)* • *Drugs for which prior approval has been denied or not obtained* • *Drugs and supplies related to sexual dysfunction or sexual inadequacy* • *Drugs and covered-drug-related supplies for the treatment of gender dysphoria if not obtained from a retail pharmacy or through the Mail Service Prescription Drug Program or Specialty Drug Pharmacy Program as previously described in this section* • *Drugs purchased through the mail or internet from pharmacies outside the United States by members located in the United States*	*All charges*	*All charges*

Covered Medications and Supplies - continued on next page

Benefits Description	You Pay	
Covered Medications and Supplies (cont.)	**Standard Option**	**Basic Option**
• *Over-the-counter (OTC) contraceptive drugs and devices, except as previously described in this section* • *Drugs used to terminate pregnancy* • *Sublingual allergy desensitization drugs, except as described in Section 5(a)*	*All charges*	*All charges*
Drugs From Other Sources	**Standard Option**	**Basic Option**
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. This includes drugs and supplies covered only under the medical benefit. Note: Prior approval is required for certain high-cost drugs obtained outside one of our pharmacy programs. Contact the customer service number on the back of your ID card or visit us at www.fepblue.org/highcostdrugs for a list of these drugs. See Section 3 for more information on prior approval. 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 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 related to drugs obtained from other sources: - Physician's office – Section 5(a) - Facility (inpatient or outpatient) – Section 5(c) - Hospice agency – Section 5(c) • Please refer to information discussed previously in this section 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 professional provider: 35% of the Plan allowance (deductible applies) Non-participating professional provider: 35% of the Plan allowance (deductible applies) plus any difference between our allowance and the billed amount Member facilities: 35% of the Plan allowance (deductible applies) Non-member facilities: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating professional provider: You pay all charges Non-participating professional provider: You pay all charges Member/Non-member facilities: You pay all charges

Drugs From Other Sources - continued on next page

Benefits Description	You Pay	
Drugs From Other Sources (cont.)	**Standard Option**	**Basic Option**
For members covered under our regular pharmacy drug program: • Auto-immune infusion medications: Remicade, Renflexis and Inflectra Note: Benefits for certain auto-immune infusion medications (limited to Remicade, Renflexis and Inflectra) are covered only when they are obtained by a non-pharmacy provider, such as a physician or facility (hospital or ambulatory surgical center). Members covered under the FEP Medicare Prescription Drug Program may obtain these drugs under their pharmacy benefits.	Preferred: 10% of the Plan allowance (deductible applies) Participating professional provider: 15% of the Plan allowance (deductible applies) Non-participating professional provider: 15% of the Plan allowance (deductible applies) plus any difference between our allowance and the billed amount Member facilities: 15% of the Plan allowance (deductible applies) Non-member facilities: 15% of the Plan allowance (deductible applies), plus any difference between our allowance and billed amount.	Preferred: 15% of the Plan allowance Participating professional provider: You pay all charges Non-participating professional provider: You pay all charges Member/Non-member facilities: You pay 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.**

Benefit Description	You Pay	
Accidental Injury Benefit	**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.	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.	$35 copayment for associated oral evaluations 30% of the Plan allowance for all other care 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 cost-share amounts 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.

Accidental Injury Benefit - continued on next page

Benefit Description	You Pay	
Accidental Injury Benefit (cont.)	**Standard Option**	**Basic Option**
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.	See previous page	See previous page

Dental Benefits

What is Covered

Standard Option dental benefits are presented in the chart on the following page.

Basic Option dental benefits appear later in this section.

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 phone 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 phone 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 page. 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 described on the previous page.

Standard Option Dental Benefits	Standard Option Only		
Covered Service	**We Pay to Age 13**	**We Pay Age 13 and Over**	**You Pay**
Clinical oral evaluations			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).
Periodic oral evaluation *(up to 2 per person per calendar year)*	$12	$8	
Limited oral evaluation	$14	$9	
Comprehensive oral evaluation	$14	$9	
Detailed and extensive oral evaluation	$14	$9	
Diagnostic imaging			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	
Palliative treatment			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).
Palliative treatment of dental pain – minor procedure	$24	$15	
Protective restoration	$24	$15	
Preventive			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).
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 (*up to 2 per person per calendar year*)	$13	$8	
Not covered: Any service not specifically listed above	*Nothing*	*Nothing*	*All charges*

Basic Option Dental Benefits

Under Basic Option, we provide benefits for the services listed below. You pay a $35 copayment for each evaluation, and we pay any balances up to the Maximum Allowable Charge previously described in this section. 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 phone 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 $35 copayment Participating/Non-participating: Nothing	Preferred: $35 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*)	Preferred: All charges in excess of your $35 copayment Participating/Non-participating: Nothing	Preferred: $35 copayment per evaluation Participating/Non-participating: You pay all charges
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)*	Preferred: All charges in excess of your $35 copayment Participating/Non-participating: Nothing	Preferred: $35 copayment per evaluation Participating/Non-participating: You pay all charges
Not covered: Any service not specifically listed above	*Nothing*	*All charges*

Section 5(h). Wellness and Other 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 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 phone, secure email, or live chat. Ask questions and get medical advice. Please keep in mind that benefits for any healthcare 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 healthcare expenses. See the following for more information. • **Daily Habits** – Manage your health proactively by setting and managing health goals, create a plan of care, track your progress, and pursue healthy activities. Daily Habits offers members a combination of guidance, support, and resources. • **Tobacco Cessation Incentive Program** – If you would like to quit smoking, you can participate in this program and receive tobacco cessation products at no charge. Create a Tobacco Cessation Quit Plan using our online coaching tool, Daily Habits. 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 Section 5(f) for more information. Note: There may be age restrictions based on U.S. FDA guidelines for these medications. • **Health Topics and WebMD Videos** offer an extensive variety of educational tools using videos, recorded messages, and colorful online materials that provide up-to-date information about a wide range of health-related topics.
Services for the Deaf and Hearing Impaired	All Blue Cross and Blue Shield Plans provide TTY 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 well-being. For more information, go to www.fepblue.org.
Diabetes Management Program	The Diabetes Management Program is a program to help members with diabetes manage their condition. All members with type 1 and type 2 diabetes, including those for whom Medicare is primary, are eligible for this program. You will receive a free glucose meter and have unlimited test strips and lancets shipped directly to you. Automated reordering is based on your usage. Personalized coaching and support are also provided. The program offers live interventions triggered by acute alerts based on your glucose meter test results. Member support is offered 24/7/365. For more information go to www.fepblue.org/diabetes.
Blue Health Assessment	The **Blue Health Assessment (BHA**) questionnaire is an easy and engaging online health evaluation program which can be completed in 10-20 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 coaching tool, Daily Habits.

	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, both the contract holder and spouse are eligible for the $50 health account. We will send each eligible member a debit card to access their 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 Daily Habits 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, hypertension, 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, 2024**. 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 888-258-3432 toll-free.
Hypertension Management Program	The **Hypertension Management Program** gives members age 18 and older with hypertension (otherwise known as high blood pressure) 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 the contract holder and spouse who meet the following criteria. 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, you will be sent a letter advising you of your eligibility for the free BPM. You are eligible to receive a free BPM every two calendar years. You must follow the directions in the letter, which include taking the letter to your healthcare 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 criteria or for those who obtain a BPM outside of this program. For more information, call us at the phone number on the back of your ID card. See Section 5(f) for information on preferred generic anti-hypertensive medications.
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. 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. All covered adult members, age 18 and over may be eligible for this incentive.

	To qualify for the Pregnancy Care Box, you must be pregnant. Information on the program is available on our website, www.fepblue.org. To qualify for the $75 incentive, you must meet the criteria above for the Pregnancy Care Box and send us a copy of your healthcare provider's medical record that confirms you had a prenatal care visit during the first trimester of your pregnancy. Information that must be included when submitting your medical record can be found on our website, www.fepblue.org/maternity. To receive 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 are limited to two pregnancies per calendar year.
Annual Incentive Limitation	Financial incentives earned through participation in the Blue Health Assessment, personalized goals through Daily Habits and the Pregnancy Care Incentive Program are limited to a total of $420 per person per calendar year for the contract holder and spouse.
Reimbursement Account for Basic Option Members Enrolled in Medicare Part A and Part B	Basic Option members enrolled in Medicare Part A and Part B are eligible to be reimbursed up to $800 per calendar year for their Medicare Part B premium payments. The account is used to reimburse member-paid Medicare Part B premiums. For more information on how to obtain reimbursement, please visit www.fepblue.org/mra or call 888-706-2583.
MyBlue® Customer eService	Visit **MyBlue Customer eService** at www.fepblue.org/myblue or use the fepblue mobile app 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 "View My Claims"; from there you can search claims and select the "EOB" link next to each claim to access your EOB. You can also access EOBs via the fepblue mobile app. Simply link to MyBlue, and click on Claims. • **Opt In or Out of Mailed Paper EOBs** – The Service Benefit Plan offers an environmentally friendly way of accessing your EOBs via www.fepblue.org/myblue. You can opt in or out of receiving mailed paper EOBs by following 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. • **Financial Dashboard** – Log in to MyBlue to access important information in real time, including deductibles, out-of-pocket costs, remaining covered provider visits, medical claims, and pharmacy claims. You also can review your year-to-date summary of completed claims, MyBlue Wellness Card balance, and pharmacy spending throughout the year.
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 healthcare needs, the Service Benefit Plan offers two types of Care Management Programs that provide assistance with the coordination of your care, provide member education and clinical support.

	• **Case Management** provides members who have acute or chronic complex healthcare needs with the services and assistance of a licensed healthcare professional with a nationally recognized case management certification. Case managers may be a registered nurse, licensed social worker, or other licensed healthcare professional practicing within the scope of their license, who may work with you and your providers to assess your healthcare needs, coordinate needed care and available resources, evaluate the outcomes of your care, and support and monitor the progress of the member's treatment plan and healthcare needs. Some members may receive guidance and clinical support for an acute healthcare need while others may benefit from a short-term case management enrollment. Enrollment in case management requires your consent. Members in case management are asked to provide verbal consent prior to enrollment in case management and must provide written consent for case management. • **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, including if you are eligible for enrollment and assistance with enrollment, please contact us at the customer service phone 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 will review the member's healthcare needs and may at our sole discretion, identify a less costly alternative treatment plan for the member. The member (or their healthcare proxy) and provider (s) must cooperate in the process. Case Management Program enrollment is required for eligibility. Prior to the starting date of the alternative treatment plan, members who are eligible to receive services through the flexible benefits option are required to sign and return a written consent for case management and 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. **We must receive the consent for case management and the alternative benefits agreement signed by the member/ healthcare proxy before you receive any services included in the alternative benefits agreement.** • Alternative benefits will be made available for a limited period of time and are subject to our ongoing review. You must cooperate with and participate in the review process. Your provider(s) must submit the information necessary for our reviews. You and/or your healthcare proxy must participate in care conferences and caregiver training as requested by your provider(s) or by us. • We may revoke the alternative benefits agreement immediately at any time, if we discover we were misled by the information given to us by you, your provider, or anyone else involved in your care, or that you are not meeting the terms of the agreement. • If we approve alternative benefits, we do not guarantee that they will be extended beyond the limited time period and/or scope of the alternative benefits agreement 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 at our sole discretion, 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 alternative benefits for the stated time period, unless we are misled by the information given to us or circumstances change. Benefits as stated in this brochure will apply to all services and dates of care not included in the alternative benefits agreement. You or your provider may request an extension of the time period initially approved for alternative benefits, no later than five business days prior to the end of the alternative benefits agreement. We will review the request, including the services proposed as an alternative and the cost of those services, but benefits as stated in this brochure will apply if we do not approve your request. Note: If we deny a request for precertification or prior approval of regular contract benefits, as stated in this brochure, 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).
Telehealth Services	Go to www.fepblue.org/telehealth or call 855-636-1579, TTY: 711, toll free to access on-demand, affordable, high-quality care for adults and children experiencing non-emergency medical issues, including treatment of minor acute conditions, dermatology care, counseling for behavioral health and substance use disorder, and nutritional counseling. Note: This benefit is available only through the contracted telehealth provider network.
The fepblue Mobile Application	Blue Cross and Blue Shield's fepblue mobile application is available for download for both iOS and Android mobile phones. The application provides members with 24/7 access to helpful features, tools and information related to Blue Cross and Blue Shield Service Benefit Plan benefits. Members can log in with their MyBlue® username and password to access personal healthcare information such as benefits, out-of-pocket costs, deductibles (if applicable) and physician visit limits. They can also view claims and approval status, view/share Explanations of Benefits (EOBs), view/share member ID cards, locate in-network providers, and connect with our telehealth services.

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 later in this section 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 healthcare 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 overseas, with the exception of admissions for gender affirming surgery and admissions to residential treatment centers and skilled nursing facilities. Prior approval is required for all non-emergent air ambulance transport services for overseas members (refer to Section (c)). Protections offered under the NSA (see Section 3) do not apply to overseas claims. Members enrolled in the FEP Medicare Prescription Drug Program have no coverage for drugs obtained and/or purchased overseas.

Overseas 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 Overseas 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 Overseas 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 Overseas Assistance Center (provided by GeoBlue), by calling 804-673-1678. Members in the United States, Puerto Rico, or the U.S. Virgin Islands should call 800-699-4337 or email the Overseas Assistance Center at fepoverseas@geo-blue.com. GeoBlue 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.

Hospital and professional provider benefits

For **professional care** you receive overseas, we provide benefits at Preferred benefit levels using either our Overseas Fee Schedule, a customary percentage of the billed charge, or a provider-negotiated discount as our Plan allowance. **The Basic Option requirement to use Preferred providers in order to receive benefits does not apply when you receive overseas care. Standard Option members have no deductible for overseas services.**

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. When the Plan allowance is a provider-negotiated discount, you are only responsible for your coinsurance and/or copayment amounts. You must also pay any charges for noncovered services.

For **inpatient facility care** you receive overseas, we provide benefits at the Preferred level **under both Standard and Basic Options. For Basic Option, there is no member cost-share** for admissions to a DoD facility, or when the Overseas Assistance Center (provided by GeoBlue) has arranged direct billing or acceptance of a guarantee of benefits with the facility. For all other inpatient facility care, Basic Option members are responsible for the per admission copayment. Standard Option members have no cost-share for inpatient facility care.

For **outpatient 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 have no deductible for overseas services.

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 $35 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.

Pharmacy benefits

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 Section 5(f) for more information.

Overseas claims payment

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.

Filing overseas claims

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 1568, Southeastern, PA 19399.
2. Fax: 001-610-293-3529. 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 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@geo-blue.com, or from your Local Plan.

Filing a claim for 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. Timely filing for overseas pharmacy claims is limited to one year from the prescription fill date. 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 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

These benefits are not part of the FEHB contract or premium, and you cannot file an FEHB dispute regarding these benefits. Fees paid 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® – The Blue Cross and Blue Shield Service Benefit Plan presents Blue365, a program that provides easy access to premier health and wellness products and services to help members build a path to live a healthy life. With Blue365, members get access to over 90 handpicked discounts from leading brands and there is no limit to how many deals a member can redeem. Many deals are available and new ones are constantly being added, including:

- Fitness – Get the support you need to achieve your fitness goals with deals on wearable devices, apparel, home gym equipment, virtual workout classes and in-person gym access.
- Healthy Eyes and Ears – Between replacing hearing aids and correcting your vision, caring for your eyes and ears can get expensive quickly. Blue365 provides up to 60% off hearing aids, discounts on LASIK surgery and more.
- Home and Family – Your home and family can influence your mental, physical, emotional, and financial well-being. Blue365 offers discounts on premium vitamins and supplements, pet insurance, fertility services, products for new parents, financial offers, family health and more.
- Nutrition – Blue365 offers a variety of deals that help you eat right. Choose from meal kit subscriptions, chef-prepared entrees, weight management plans and more.
- Personal Care – A little self-care can go a long way toward improving your mental health. Blue365 offers exclusive discounts on skin care products, oral care products, tooth-whitening kits, mindfulness subscriptions and much more.
- Travel – Sometimes a vacation is all you need to escape stress and reset. Blue365 makes family getaways more affordable with discounted access to lodging, car rentals and vacation packages.

Each week, Blue365 members can receive great health and wellness deals via email. With Blue365, there is no paperwork to fill out. Just visit http://www.fepblue.org/blue365 and select Get Started 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.

Discount Drug Program – The Discount Drug Program is available to members not enrolled in the FEP Medicare Prescription Drug Program 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 24%. The program permits you to obtain discounts on several drugs related to dental care, weight loss, hair removal and hair growth, and other miscellaneous health conditions. Please refer to www.fepblue.org/ddp for a full list of discounted drugs, including those that may be added to this list as they are approved by the U.S. Food and Drug Administration (U.S. FDA). To use the program, simply present a valid prescription and your Service Benefit Plan ID card at a Preferred 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 800-624-5060.

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.
- Experimental or investigational procedures, treatments, drugs, or devices (see Section 5(b) 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 and gender affirming surgeries specifically listed as covered).
- Travel expenses except as specifically provided for covered transplants performed in a Blue Distinction Center for Transplant (see Section 5(b)).
- 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, doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare, or state premium taxes however applied. See Section 9.
- Prescriptions, 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 provided 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 or supplies for the treatment of obesity, weight reduction, or dietary control, except for office visits, diagnostic tests, prior approved weight loss drugs covered under the pharmacy program, and procedures and services for the treatment of severe obesity listed in Section 5(b).
- 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 phone.
- 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 *Preventive Care, Child* in Sections 5(a) and 5(c); and certain routine services associated with covered clinical trials (see Section 9).
- Recreational or educational therapy, and any related diagnostic testing, except as provided by a hospital during a covered inpatient stay.
- Applied behavior analysis (ABA) and related services for any condition other than an autism spectrum disorder.
- Applied behavior analysis (ABA) services and related services performed as part of an educational program; or provided in or by a school/educational setting; or provided as a replacement for services that are the responsibility of the educational system.
- 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, meditation techniques, relaxation techniques, movement therapies, and energy therapies.
- Services, drugs, or supplies related to medical marijuana.
- Advanced care planning, except when provided as part of a covered hospice care treatment plan (see Section 5(c)).
- Membership or concierge service fees charged by a healthcare provider.
- Fees associated with copies, forwarding or mailing of records except as specifically described in Section 8.
- Services not specifically listed as covered.
- Services or supplies we are prohibited from covering under the Federal Law.

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 phone 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 provider 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, speech, or cognitive rehabilitation therapy, you must provide a written statement from the provider 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 provider's name, date, and charge. (See Section 7 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 (e.g., medical records) 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 retail 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 retail 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 Section 3).

See the following paragraphs 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 800-624-5060 to request a retail prescription drug claim form to claim benefits. Hearing-impaired members with TTY equipment may call 711. 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 800-262-7890, TTY: 711. 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 phone 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 Section 5(f) 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 888-346-3731, TTY: 711, or you may send your prescription to: BCBS FEP Specialty Drug Pharmacy Program, CVS Specialty, 9310 Southpark Center Loop, Orlando, FL 32819. 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 are most convenient for you. To order refills, call the same phone 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 888-346-3731, TTY: 711, 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 following year after 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 (e.g., diagnosis codes, dates of service, etc.), you must resubmit it within 90 days, or before the timely filing period expires, whichever is later.

Note: Timely filing for overseas pharmacy claims is limited to one year from the prescription fill date.

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

Overseas claims

Please refer to the claims filing information in Section 5(i).

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 healthcare 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% 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 phone 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 healthcare 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 or to make an inquiry 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 call your Plan's customer service representative at the phone number found on your enrollment card, our brochure, or our website (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 phone 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 healthcare 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 their 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.

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, FEHB 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;
- Your daytime phone number and the best time to call; and
- 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 healthcare 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 or notify you of the status of OPM's review 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 phone 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 FEHB 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 family member 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 healthcare 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 healthcare 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 on NAIC rules regarding the coordinating of benefits, visit our website at www.fepblue.org/coordinationofbenefits.

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 processes the benefit, 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 (described later in this section). 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 healthcare 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 or employing 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**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

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 or employing 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 healthcare 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, 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 covered 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 Section 5(b). **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 phone 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 (U.S. FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I enroll in Medicare?" please contact Medicare at 1-800-Medicare 800-633-4227, TTY: 711, or at www.medicare.gov.

- **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 Section 3 for exceptions).

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 phone 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 healthcare 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 (skilled) 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**

If you are enrolled in Medicare Part B, 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 healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227), TTY: 711, 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 Section 3 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 or employing 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		✓*
9) Are a Federal employee receiving 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 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: Participates with Medicare or accepts Medicare assignment for the claim and is in our Preferred network
Then you are responsible for:

Standard Option - your deductibles, coinsurance, and copayments.
Basic Option - your copayments and coinsurance.

If your physician: Participates with Medicare or accepts Medicare assignment and is not in our Preferred network
Then you are responsible for:

Standard Option - your deductibles, coinsurance, and copayments, and any balance up to the Medicare-approved amount.
Basic Option - all charges.

If your physician: Does not participate with Medicare and is in our Preferred network
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.
Then you are responsible for:

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.

If your physician: Does not participate with Medicare and is not in our Preferred network
Then you are responsible for:

Standard Option - your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare-approved amount.
Basic Option - all charges.

If your physician: Opts-out of Medicare via private contract
Then you are responsible for:

Standard Option - your deductibles, coinsurance, copayments, and any balance your physician charges.
Basic Option - your deductibles, coinsurance, copayments, and any balance your physician 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.

Physicians Who Opt-Out of Medicare

A physician may have opted-out of Medicare and may or may not ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. This is different than a Non-participating doctor, and we recommend you ask your physician if they have opted-out of Medicare. Should you visit an opt-out physician, the physician will not be limited to 115% of the Medicare-approved amount. You may be responsible for paying the difference between the billed amount and our regular in-network/out-of-network benefits.

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, you pay nothing for covered charges (see note below for Basic Option).
- If your physician **does not accept** Medicare assignment, 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 Section 3 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.

Please review the following examples illustrating your cost-share liabilities when Medicare is your primary payor **and** your provider is in our network and participates with Medicare compared to what you pay without Medicare. Please do not rely on this chart alone but read all information in this section of the brochure. You can find more information about how our Plan coordinates with Medicare in our *Medicare and You Guide for Federal Employees* available online at www.fepblue.org.

Benefit Description: Deductible
Standard Option You Pay **Without** Medicare: $350-Self, $700-Family
Standard Option You Pay **With** Medicare Parts A & B: $0.00
Basic Option You Pay **Without** Medicare: N/A
Basic Option **With** Medicare Parts A & B: $0.00

Benefit Description: Catastrophic Protection Out-of-Pocket Maximum
Standard Option You Pay **Without** Medicare: $8,000-Self, $16,000-Family
Standard Option You Pay **With** Medicare Parts A & B: $8,000-Self, $16,000-Family
Basic Option You Pay **Without** Medicare: $6,500-Self, $13,000-Family
Basic Option **With** Medicare Parts A & B: $6,500-Self, $13,000-Family

Benefit Description: Part B Premium Reimbursement
Standard Option You Pay **Without** Medicare: N/A
Standard Option You Pay **With** Medicare Parts A & B: N/A
Basic Option You Pay **Without** Medicare: N/A
Basic Option **With** Medicare Parts A & B: $800

Benefit Description: Primary Care Provider
Standard Option You Pay **Without** Medicare: $30
Standard Option You Pay **With** Medicare Parts A & B: $0.00
Basic Option You Pay **Without** Medicare: $35
Basic Option **With** Medicare Parts A & B: $0.00

Benefit Description: Specialist
Standard Option You Pay **Without** Medicare: $40
Standard Option You Pay **With** Medicare Parts A & B: $0.00
Basic Option You Pay **Without** Medicare: $45
Basic Option **With** Medicare Parts A & B: $0.00

Benefit Description: Inpatient Hospital
Standard Option You Pay **Without** Medicare: $450
Standard Option You Pay **With** Medicare Parts A & B: $0.00
Basic Option You Pay **Without** Medicare: $250/day up to $1,500
Basic Option **With** Medicare Parts A & B: $0.00

Benefit Description: Outpatient Hospital
Standard Option You Pay **Without** Medicare: 15% or $30 copayment
Standard Option You Pay **With** Medicare Parts A & B: $0.00
Basic Option You Pay **Without** Medicare: 30% or $35-$500 copayment
Basic Option **With** Medicare Parts A & B: $0.00

Benefit Description: Incentives Offered
Standard Option You Pay **Without** Medicare: N/A
Standard Option You Pay **With** Medicare Parts A & B: N/A
Basic Option You Pay **Without** Medicare: N/A
Basic Option **With** Medicare Parts A & B: N/A

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.

Advanced care planning — Receiving information on the types of life-sustaining treatments that are available, completing advance directives and other standard forms, and/or if you are diagnosed with a terminal illness and making decisions about the care you would want to receive if you become unable to speak for yourself.

Agents — Medications 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 medications 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. Benefits provided under the contract are not assignable by the member to any person without express written approval of the Carrier, and in the absence of such approval, any such assignment shall be void. Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment. OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Please visit www.fepblue.org to obtain a valid authorization form.

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 an ovulating individual, combine them with sperm in the laboratory, and then implant the embryos or donate them to an individual capable of pregnancy.

Biologic drug — A complex drug or product that is manufactured in a living organism, or its components, that is used as a diagnostic, preventive or therapeutic agent.

Biosimilar drug — A U.S. FDA-approved biologic drug, which is considered highly similar to an original brand-name biologic drug, with no clinically meaningful differences from the original biologic drug in terms of safety, purity and potency.

Biosimilar, interchangeable drug — A U.S. FDA-approved biosimilar drug that may be automatically substituted for the original brand-name biologic drug.

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.

Clinical trials — 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 U.S. Food and Drug Administration (U.S. FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

Coinsurance See Section 4.

Concurrent care claims A claim for continuing care or an ongoing course of treatment that is subject to prior approval. See Section 3.

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; ambiguous genitalia; and webbed fingers and toes. Note: Congenital anomalies do not include conditions related to the teeth or intra-oral structures supporting the teeth.

Copayment See Section 4.

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 See Section 4.

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 healthcare 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.

Durable medical equipment Equipment and supplies that are:

1. Prescribed by your physician (i.e., the physician who is treating your illness or injury);
2. Medically necessary;
3. Primarily and customarily used only for a medical purpose;
4. Generally useful only to a person with an illness or injury;
5. Designed for prolonged use; and
6. Used to serve a specific therapeutic purpose in the treatment of an illness or injury.

Experimental or investigational services Experimental or investigational shall mean:

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

2. Reliable evidence shows that the healthcare 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
3. Reliable evidence shows that the consensus of opinion among experts regarding the healthcare 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
4. Reliable evidence shows that the healthcare 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:

1. Published reports and articles in the authoritative medical and scientific literature;
2. 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
3. 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 a U.S. 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 U.S. FDA as interchangeable with your brand-name drug.

Group health coverage — Healthcare 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).

Healthcare professional — A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law. See Section 3 for information about how we determine which healthcare 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 healthcare provider. For more information, visit our website, www.fepblue.org.

Iatrogenic infertility — Infertility caused by a medically necessary medical or surgical intervention used to treat a condition or disease.

Infertility — A disease or condition characterized by the failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse, or a person's inability to reproduce either as a single individual or with their partner without medical intervention, or a licensed physician's findings based on a patient's medical, sexual, and reproductive history, age, and/or diagnostic testing.

Inpatient — You are an inpatient when you are formally admitted to a hospital with a doctor's order.

Note: Inpatient care requires precertification. For some services and procedures prior approval must also be obtained. See Section 3.

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 use disorders. 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 healthcare 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:

1. In accordance with generally accepted standards of medical practice in the United States; and
2. 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
3. Not primarily for the convenience of the patient, physician, or other healthcare 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
4. Not part of or associated with scholastic education or vocational training of the patient; and
5. In the case of inpatient care, able to be provided safely only in the inpatient 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.

Minor acute conditions

Under the telehealth benefit you have on-demand access to care for common, non-emergent conditions. Examples of common conditions include sinus problems, rashes, allergies, cold and flu symptoms, etc.

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.

Outpatient

You are an outpatient if you are getting emergency department services, observation services, outpatient surgery, lab tests, X-rays, or any other hospital services, and the doctor has not written an order to admit you to a hospital as an inpatient. In these cases, you are an outpatient even if you are admitted to a room in the hospital for observation and spend the night at the hospital.

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 healthcare 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 Section 5(g) 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 healthcare 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 Local Plan Allowance. The Local Plan Allowance varies by region and is determined by each Plan. If you would like additional information, or to obtain the current allowed amount, please call the customer service phone number on the back of your ID card. For inpatient stays resulting from medical emergencies or accidental injuries, or for emergency deliveries, our allowance is the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations;
  - For outpatient, non-emergency 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 Local Plan Allowance. This allowance applies to all of the covered services billed by the hospital. If you plan on using a Non-member hospital, or other Non-member facility, for your outpatient procedure, please call us before you receive services at the customer service phone 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 to use our National Doctor and Hospital Finder, or call us at the customer service phone number on the back of your ID card;
- For outpatient services resulting from a medical emergency or accidental injury that are billed by Non-member facilities, our allowance is the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations (minus any amount for noncovered services);
- For non-emergency medical services performed in Preferred hospitals provided by physicians and other covered healthcare professionals identified under the NSA (see Section 4) that do not contract with your local Blue Cross and Blue Shield Plan and cannot balance bill you under this regulation, our allowance is equal to the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations;
- For physicians and other covered healthcare 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 Local Plan Allowance. In the absence of a Medicare participating fee schedule amount or ASP for any service, drug, or supply, our allowance is the Local Plan Allowance. 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 healthcare professionals, and air ambulance providers that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is the lesser of the billed amount or the qualifying payment amount (QPA) determined in accordance with federal laws and regulations;
- 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 the Overseas Assistance Center (provided by GeoBlue), 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, D.C., area, or a customary percent of billed charge, whichever is higher.

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 phone 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. See Section 3.

For more information, see *Differences between our allowance and the bill* in Section 4. For more information about how we pay providers overseas, see Section 5(i).

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, healthcare institutions, and other covered healthcare 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 healthcare 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)); general health panel; basic or comprehensive metabolic panel; fasting lipoprotein profile; urinalysis; CBC; screening for diabetes mellitus, hepatitis B and hepatitis C, and latent tuberculosis; screening for alcohol/substance use disorders; counseling on reducing health risks; screening for depression; screening for chlamydia, syphilis, gonorrhea, HPV, and HIV; screening for intimate partner violence for women of reproductive age; administration and interpretation of a Health Risk Assessment questionnaire; cancer screenings including low-dose CT screening for lung cancer; screening for abdominal aortic aneurysms; osteoporosis screening, as specifically stated in this brochure; and immunizations as licensed by the U.S. Food and Drug Administration (U.S. FDA).

Note: Anesthesia services and pathology services associated with preventive colorectal surgical screenings are also paid as preventive care.

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*.

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).

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.

Telehealth dermatology — Under the telehealth benefit, dermatologic conditions seen and treated include but are not limited to acne, dermatitis, eczema, psoriasis, rosacea, seborrheic keratosis, fungal infections, scabies, suspicious moles, and warts. Members capture important digital images, combine those with the comprehensive questionnaire responses, and send those to the dermatology network without requiring a phone or video interaction.

Telehealth services — Non-emergency services provided by phone or secure online video/messaging for minor acute conditions, dermatology care, behavioral health and substance use disorder counseling, and nutritional counseling. Go to www.fepblue.org/telehealth or call 855-636-1579, TTY: 711, toll free to access this benefit. After your telehealth visit, please follow up with your primary care provider.

Telemedicine services — Services provided by phone or secure online video/messaging for evaluation and management services. This does not include the use of fax machine or email; costs associated with enabling or maintaining providers' telehealth (telemedicine) technologies; or fees for asynchronous services—medical information stored and forwarded to be reviewed at a later time by a physician or healthcare practitioner at a distant site without the patient being present. Providers must perform covered services acting within the scope of their license or certification under applicable state law. Please note, your healthcare provider must know when and where they can treat you. You, in turn, are responsible for accurately identifying to your provider where you are physically located for the service you received through telehealth (telemedicine) technologies. You and your physician must be in the same U.S. State, Territory, or foreign country as required by applicable legislation.

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 phone 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.

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Do not rely only 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.

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Summary of Benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2024

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a decision, please read this FEHB brochure.

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 healthcare professional, you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown below.

You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.fepblue.org/brochure.

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; $30 per office visit for primary care providers and other healthcare professionals $40 per office visit for specialists Non-PPO: 35%* of our allowance	39-45
Medical services provided by physicians: Telehealth services	PPO: Nothing for the first 2 visits per calendar year; after the 2nd visit: $10 copayment per visit Non-PPO: You pay all charges	39, 99
Services provided by a hospital: Inpatient	PPO: $350 per admission Non-PPO: $450 per admission, plus 35% of our allowance	75-77
Services provided by a hospital: Outpatient	PPO: 15%* of our allowance Non-PPO: 35%* of our allowance	77-81
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	90-91
Emergency benefits: 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)	91-92

Standard Option Benefits	You pay	Page
Mental health and substance use disorder treatment	PPO: Regular cost-sharing, such as $30 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	93-97
Prescription drugs	**Retail Pharmacy Program:** • PPO: $7.50 for each purchase of up to a 30-day supply generic ($5.00 for a 30-day supply if you have Medicare Part B primary)/30% of our allowance Preferred brand-name/50% 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 Part B primary)/$90 Preferred brand-name/$125 non-preferred brand-name per prescription; up to a 90-day supply **Specialty Drug Pharmacy Program:** • $65 preferred specialty drug for a purchase of up to a 30-day supply; $85 non-preferred specialty drug for a purchase of up to a 30-day supply	103-107
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	123
Wellness and other special features: Health Tools; Blue Health Assessment; MyBlue® Customer eService; National Doctor and Hospital Finder; Healthy Families; travel benefit/services overseas; Care Management Programs; and Flexible benefits option	See Section 5(h).	125-129
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	• Self Only: Nothing after $6,000 (PPO) or $8,000 (PPO/Non-PPO) per contract per year • Self Plus One: Nothing after $12,000 (PPO) or $16,000 (PPO/Non-PPO) per contract per year • Self and Family: Nothing after $12,000 (PPO) or $16,000 (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.	33-34

Summary of Benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2024

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a decision, please read this FEHB brochure.

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 Section 3. There is no deductible for Basic Option.

You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.fepblue.org/brochure.

Basic Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	PPO: Nothing for preventive care; $35 per office visit for primary care providers and other healthcare professionals; $45 per office visit for specialists Non-PPO: You pay all charges	39-45
Medical services provided by physicians: Telehealth services	PPO: Nothing for the first 2 visits per calendar year after the 2nd visit: $15 copayment per visit Non-PPO: You pay all charges	39, 99
Services provided by a hospital: Inpatient	PPO: $250 per day up to $1,500 per admission Non-PPO: You pay all charges	75-77
Services provided by a hospital: Outpatient	PPO: $150 per day per facility Non-PPO: You pay all charges	77-81
Emergency benefits: Accidental injury	PPO: $35 copayment for urgent care; $250 copayment for emergency room care Non-PPO: $250 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	90-91
Emergency benefits: Medical emergency	Same as for accidental injury	91-92
Mental health and substance use disorder treatment	PPO: Regular cost-sharing, such as $30 office visit copayment; $250 per day up to $1,500 per inpatient admission Non-PPO: You pay all charges	93-97

Basic Option Benefits	You pay	Page
Prescription drugs	**Retail Pharmacy Program:** • PPO: $15 generic/($10 if you have primary Medicare Part B)/$60 Preferred brand-name per prescription ($50 if you have primary Medicare Part B)/60% coinsurance ($90 minimum) for non-preferred brand-name drugs (50% ($60 minimum) if you have primary Medicare Part B) • Non-PPO: You pay all charges **Specialty Drug Pharmacy Program:** • $85 preferred specialty drug for a purchase of up to a 30-day supply; $110 non-preferred specialty drug for a purchase of up to a 30-day supply **Mail Service Prescription Drug Program** (for primary Medicare Part B members only): • $20 generic/$100 Preferred brand-name/$125 non-preferred brand-name per prescription; up to a 90-day supply	103-107
Dental care	PPO: $35 copayment per evaluation (exam, cleaning, and X-rays); most services limited to 2 per year; sealants for children up to age 16; $35 copayment for associated oral evaluations required due to accidental injury; regular benefits for covered oral and maxillofacial surgery Non-PPO: You pay all charges	124
Wellness and other special features: Health Tools; Blue Health Assessment; MyBlue® Customer eService; National Doctor and Hospital Finder; Healthy Families; travel benefit/services overseas; Care Management Programs; and Flexible benefits option	See Section 5(h).	125-129
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	• Self Only: Nothing after $6,500 (PPO) per contract per year • Self Plus One: Nothing after $13,000 (PPO) per contract per year • Self and Family: Nothing after $13,000 (PPO) per contract per year; nothing after $6,500 (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.	33-34

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2024 Rate Information for the Blue Cross and Blue Shield Service Benefit Plan

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

Premiums for Tribal employees are shown under the Monthly Premium Rate 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	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Nationwide					
Standard Option Self Only	104	$271.43	$150.79	$588.10	$326.71
Standard Option Self Plus One	106	$586.50	$336.84	$1,270.75	$729.82
Standard Option Self and Family	105	$646.18	$370.68	$1,400.06	$803.14
Nationwide					
Basic Option Self Only	111	$271.43	$95.74	$588.10	$207.44
Basic Option Self Plus One	113	$586.50	$238.63	$1,270.75	$517.03
Basic Option Self and Family	112	$646.18	$262.60	$1,400.06	$568.96