

BlueCHiP Coordinated Health Plan

<http://www.BCBSRI.com>



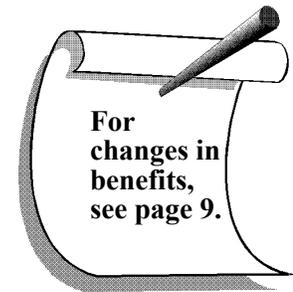
Your Plan for Life.™

2010

An Individual Practice Prepayment Plan (high option) with a Point-of-Service Product

Serving:

Rhode Island and portions of Southeastern Massachusetts



Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.

Enrollment code for this Plan:

DA1 Self Only

DA2 Self and Family

Authorized for distribution by the:



**United States
Office of Personnel Management**

Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>



RI 73-489

**Important Notice from Blue Cross & Blue Shield of Rhode Island About
Our Prescription Drug Coverage and Medicare**

OPM has determined that the Blue Cross & Blue Shield of Rhode Island's (BCBSRI) 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. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit 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 BCBSRI 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 premium will go up at least 1% 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'll 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 (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low-Income Benefits

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

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

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

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Introduction

This brochure describes the benefits of BlueCHiP Coordinated Health Plan (BlueCHiP) from Blue Cross & Blue Shield of Rhode Island under our contract (CS 2328) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Blue Cross & Blue Shield of Rhode Island's administrative offices is:

Blue Cross & Blue Shield of Rhode Island
500 Exchange Street
Providence, RI 02903-2699

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health 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. You do not have a right to benefits that were available before January 1, 2010, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each Plan annually. Benefit changes are effective January 1, 2010, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means Blue Cross & Blue Shield of Rhode Island (BCBSRI).
- 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 first.
- Our brochure and other FEHB Plans' brochures have the same format and similar descriptions to help you compare Plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

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

- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.
- 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 us at (401) 274-3500 from within the State of Rhode Island or toll-free at 1-800-564-0888 from outside Rhode Island and explain the situation.

If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE

(202) 418-3300

OR 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 over age 22 (unless he/she is disabled and incapable of self-support).
- 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.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

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

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:

Exactly what will you be doing?

About how long will it take?

What will happen after surgery?

How can I expect to feel during recovery?

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Never events

Beginning January 1, 2010, you will no longer be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use plan providers. This new policy will help protect you from preventable medical errors and improve the quality of care you receive.

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

We are adopting a benefit payment policy that will encourage hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events". When a Never Event occurs neither your FEHB plan or you will incur cost to correct the medical error.

Visit these Web sites for more information:

- www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this Individual Practice Prepayment Plan

This Plan is an Individual Practice Prepayment Plan. We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory. We give you a choice of enrollment in a High Option.

Individual Practice Payments Plans emphasizes preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an Individual Practice Payment Plan because you prefer the Plan's benefits, not because a particular provider is available. You cannot change Plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General features of our High Option

We have Point-of-Service (POS) benefits

Our Individual Practice Payment Plan offers Point-of-Service (POS) benefits. This means you can receive covered services from a non-participating provider. However, out-of-network benefits may have higher out-of-pocket costs than our in-network benefits.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Your rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB Web site (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: 70 years
- Profit status: Nonprofit

If you want more information about us, call (401) 274-3500 from within Rhode Island or toll-free at 1-800-564-0888 from outside of Rhode Island or write to Blue Cross & Blue Shield of Rhode Island, 500 Exchange Street, Providence, RI 02903. You may also contact us by fax at (401) 459-5089 or visit our Web site at www.BCBSRI.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is: the State of Rhode Island and the following cities and towns in the state of Massachusetts: Acushnet, Attleboro, Bellingham, Blackstone, Dartmouth, Dighton, Fall River, Fairhaven, Foxboro, Franklin, Mansfield, Medway, Mendon, Millville, New Bedford, North Attleboro, Norton, Plainville, Raynham, Rehoboth, Seekonk, Somerset, Swansea, Taunton, Uxbridge, Westport, and Wrentham.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior Plan approval.

If you or a covered family member move outside of our service area, you can enroll in another Plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service Plan or an HMO that has agreements with affiliates in other areas. Blue Cross & Blue Shield of Rhode Island offers the HMO USA Guest Membership Program. To enroll in this program, please contact Customer Service at (401) 274-3500 from within Rhode Island or toll-free at 1-800-564-0888 from outside of Rhode Island. If you or a family member move, you do not have to wait until Open Season to change Plans. Contact your employing or retirement office.

Section 2. How we change for 2010

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

Program-wide Changes

- We have clarified cost categories associated with clinical trials (Section 9, Clinical Trials, page 54; Section 10, Clinical Trails Cost Categories, page 56)

Changes to this Plan

- Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 65.
- There are no benefit changes. The benefits will remain at the 2009 Federal Brochure contract level.

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 must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan 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 us at (401) 274-3500 from within the State of Rhode Island or 1-800-564-0888 from outside of Rhode Island or write to us at Blue Cross & Blue Shield of Rhode Island, 500 Exchange Street, Providence, RI 02903. You may also request replacement cards through our Web site: www.BCBSRI.com.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance, if you use our point-of-service program, you can also get care from non-Plan providers, but it will cost you more.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician (PCP). This decision is important since your primary care physician provides or arranges for most of your health care.

- **Primary care**

Your primary care physician can be a family practitioner, internist, or pediatrician. In addition, some gynecologists (OB/GYN) are also primary care physicians. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see your OB/GYN for annual exams, a Plan ophthalmologist or optometrist for your routine annual eye exam and receive up to twelve (12) chiropractic visits per year without a referral. In addition, you do not need a referral from your primary care physician for mental health or substance abuse services, however you must receive authorization for these services from the Plan’s mental health administrator.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
 - Reduce our service area and you enroll in another FEHB Plan,

you may be able to continue seeing your specialist 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 until the end of your postpartum care, even if it is beyond the 90 days.

• **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

• **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 our Customer Service department immediately at (401) 274-3500 from within Rhode Island or toll free at 1-800-564-0888 from outside of Rhode Island. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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; or
- 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 Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new Plan begin on the effective date of enrollment.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process the Prospective Medical Review. Your physician must obtain Prospective Medical Review for: inpatient admissions, growth hormone therapy/home IV therapy, home physical, speech and occupational therapy, skilled nursing care, inpatient rehabilitation, surgical treatment of morbid obesity, outpatient mental health and substance abuse services require authorization from the Plan's Behavioral Health Administrator. Certain radiology services such as magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computerized axial tomography (CAT or CT scans), positron emission tomography (PET scan), and nuclear cardiac imaging require authorization from the Plan's Radiology Program Administrator.

You may be responsible for payment of these services if they are determined to not be medically necessary.

We continue to recommend that you obtain prior medical review for these same services when utilizing the POS benefit. When utilizing non-Plan participating providers, it is recommended that you advise your provider to contact the Plan for prior medical review in advance of such services to ensure that they will be covered.

Section 4. Your costs for covered services

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

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

Example: When you see your primary care physician you pay a copayment of \$15 per office visit and when you go in the hospital, you pay \$500 per admission.

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.

Deductible A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- The calendar year deductible for Point-of-Service is \$500 per person under High Option. Under a family enrollment for Point-of-Service, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$1,000 under High Option.

Coinsurance Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: In our Plan, you pay 20% of our allowance for infertility services and durable medical equipment. Coinsurance also applies when you use the POS benefit.

Differences between our Plan allowance and the bill BCBSRI rates are privately negotiated with network providers. They are not necessarily the same as the full charge amount.

Your catastrophic protection out-of-pocket maximum After your in-network inpatient copayments per admission reach \$1,000 per person or \$2,000 per family enrollment in any calendar year, you do not have to pay any more for covered inpatient services for that year. There are no other out-of-pocket maximums except as noted under the POS benefit.

Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

When Government facilities bill us Facilities of the Department of Government Veteran Affairs, the Department of Defense and the Indian Health Services 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.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible for services received from participating Plan providers. Please see section 5(i) regarding your Point-of-Service benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Diagnostic and treatment services	High Option
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • At home • Office medical consultations • Second surgical opinion 	\$15 per visit to your primary care physician \$25 per visit to a specialist
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center 	\$50 per visit
Professional services of physicians <ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	Nothing
Lab, X-ray and other diagnostic tests	High Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing

Benefit Description	You pay
Preventive care, adult	High Option
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older • Routine Pap test <p>Note: The office visit copayment applies if test is received on the same day; see <i>Diagnostic and treatment Services</i>, above.</p>	Nothing
<p>Routine mammogram – covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	Nothing
<p>Adult routine immunizations endorsed by Centers for Disease Control and Prevention (CDC):</p> <ul style="list-style-type: none"> • Diphtheria, Tetanus, and Pertussis (Dtap) booster – once every 10 years, ages 19 to 64 (except as provided for under Childhood immunizations), • For ages 65 and older, Tetanus-Diphtheria (Td) booster once every ten years. • Varicella (Chickenpox), ages 19 to 49 years • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older 	Nothing
<p><i>Not covered: Physical exams or immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay
Preventive care, children	High Option
Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: <ul style="list-style-type: none"> - Eye exams through age 17 to determine the need for vision correction - Ear exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22) 	\$15 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i> • <i>Weight reduction programs, including laboratory tests related to programs designed for the purposes of weight reduction.</i> • <i>Examination, evaluations, or services performed solely for educational or developmental purposes.</i> 	<i>All charges</i>
Maternity care	High Option
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 12 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. In addition, coverage of injury or illness or sickness including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities will be covered for the first 31 days of a newborn's life; all care after the first 31 days will be covered only if we cover the infant under a Self or Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. 	\$15 for the initial office visit at Member's PCP, otherwise, \$25 for initial office visit to Specialist; covered in full thereafter.

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	High Option
<ul style="list-style-type: none"> We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	\$15 for the initial office visit at Member's PCP, otherwise, \$25 for initial office visit to Specialist; covered in full thereafter.
<p><i>Not covered:</i></p> <p><i>Routine sonograms to determine fetal age, size or sex.</i></p>	<i>All charges</i>
Family planning	High Option
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> Voluntary sterilization (See Surgical procedures Section 5 (b)) Surgically implanted contraceptives Injectable contraceptive drugs (such as Depo provera) Intrauterine devices (IUDs) Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	Nothing
Medically necessary genetic counseling	\$25 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Reversal of voluntary surgical sterilization</i> <i>Treatment for infertility when the cause of infertility was a previous sterilization.</i> 	<i>All charges</i>
Infertility services	High Option
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> Artificial insemination: <ul style="list-style-type: none"> Intravaginal insemination (IVI) Intracervical insemination (ICI) Intrauterine insemination (IUI) Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> In vitro fertilization Embryo transfer, gamete intra-fallopian transfer (GIFT), and zygote intra-fallopian transfer (ZIFT) Zygote transfer Fertility drugs <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit. Fertility drugs purchased at the pharmacy also have a 20% copayment.</p>	20%

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Freezing (i.e., cryo-preservation) and storage of gametes, sperm, embryos or other specimens for future use • Sperm bank (i.e., storage) • Cost of donor egg • Donor oocytes for non-infertile couples (e.g., member has genetic disorder, HIV + status, etc.) 	All charges
Allergy care	High Option
Testing and treatment	\$25 per office visit
<ul style="list-style-type: none"> • Allergy serum • Allergy injections 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Provocative food testing • Sublingual allergy desensitization 	All charges
Treatment therapies	High Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High-dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 27.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Preauthorization is required for GHT treatment. Benefits for treatment will be continued as long as there has been a satisfactory response to growth hormone of at least 5cm a year after the first year. See <i>Services requiring our prior approval</i> in Section 3.</p>	Nothing
Physical and occupational therapies	High Option
<p>Physical and occupational therapy for services by each of the following:</p> <ul style="list-style-type: none"> • Qualified physical therapists and • Occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. You must show significant improvement within sixty (60) days to receive authorization for additional treatment.</p>	<p>\$25 per office visit</p> <p>\$25 per outpatient visit</p> <p>Nothing per visit during covered inpatient admission</p>

Physical and occupational therapies - continued on next page

Benefit Description	You pay
Physical and occupational therapies (cont.)	High Option
Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to eighteen (18) weeks or thirty-six (36) visits, which ever comes first.	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> • <i>Massage therapy</i> • <i>Recreation therapy</i> 	<i>All charges</i>
Speech therapy	High Option
Speech therapy services by a speech therapist.	\$25 per office visit
Note: You must show significant improvement within sixty (60) days to receive authorization for additional treatment.	\$25 per outpatient visit
	Nothing per visit during covered inpatient admission
Hearing services (testing, treatment, and supplies)	High Option
<ul style="list-style-type: none"> • \$500 limit for routine hearing aids every three years. • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	<p>No co-payment for outer ear hearing aids</p> <p>No co-payment for over-the-ear hearing aids</p> <p>\$25 co-payment for diagnostic hearing exams</p> <p>\$25 co-payment for up to one routine hearing test every year</p>
Vision services (testing, treatment, and supplies)	High Option
One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	Nothing
Annual eye refractions rendered by a Plan ophthalmologist or optometrist	\$25 per office visit
Note: See <i>Preventive care, children</i> for eye exams for children.	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses and after age 17, examinations for them</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges</i>

Benefit Description	You pay
Foot care	High Option
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts.</p>	\$25 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> • <i>All other routine foot care</i> 	<i>All charges</i>
Orthopedic and prosthetic devices	High Option
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose. • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	\$20 per item
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> 	<i>All charges</i>

Benefit Description	You pay
Durable medical equipment (DME)	High Option
<p>We cover rental or purchase durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs (the type of wheelchair we allow will depend on your medical condition); • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. <p>Note: Call us at (401) 274-3500 from within Rhode Island or toll-free at 1-800-564-0888 from outside of Rhode Island as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	\$20 per item
<p>Diabetic supplies including test strips and lancets when from a participating DME supplier</p>	Nothing
<p>Not covered:</p> <ul style="list-style-type: none"> • <i>Equipment that serves as a comfort or convenience item. Electrical or mechanical features, which enhance basic equipment, usually serve a convenience function. Determination of medical necessity should be made regarding the coverage of these features.</i> • <i>Equipment used for environmental control or to enhance the environmental setting or surrounding of an individual should not be considered durable medical equipment. Examples of these include air conditioners, air filters, portable jacuzzi pumps, humidifiers, etc.</i> • <i>Repairs to patient-owned equipment.</i> 	<i>All charges</i>
Home health services	High Option
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> 	<i>All charges</i>

Home health services - continued on next page

Benefit Description	You pay
Home health services (cont.)	High Option
<ul style="list-style-type: none"> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<i>All charges</i>
Chiropractic	High Option
<ul style="list-style-type: none"> • Manipulation of the spine and extremities up to twelve (12) self-referred visits per calendar year • One set of X-rays of the spine every three (3) years 	\$25 per office visit
<p><i>Not covered:</i></p> <p><i>Other imaging studies or laboratory work ordered by a chiropractor</i></p>	<i>All charges</i>
Alternative treatments	High Option
No benefit.	<i>All charges</i>
Educational classes and programs	High Option
<p>Smoking Cessation – Coverage is limited to primary care visits and individual counseling for smoking cessation.</p> <p>Note: Prescription nicotine substitutes, including transdermal patches, are covered under the prescription drug benefit up to a maximum of a three (3) month supply (see Section (5f)). Member must submit proof of being smoke free for a one-year period for reimbursement.</p>	\$15 per office visit
Asthma self-management	Nothing
Diabetes self-management – Diabetes education, when medically necessary and prescribed by a physician, may be provided only by the physician or, upon his or her referral to, an appropriately licensed and state-certified diabetes educator.	\$15 per office visit

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible for services received from participating Plan providers. Please see Section 5(i) regarding your Point of Service benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Surgical procedures	High Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see <i>Reconstructive surgery</i>) • Surgical treatment of morbid obesity (bariatric surgery). The following medical criteria must be met for coverage: <ul style="list-style-type: none"> - Eligible members must be age 18 or over - BMI of 40 or BMI of 35 with significant comorbidities (e.g., cardiovascular including high blood pressure, diabetes, etc.) - Documented failure of weight loss attempts - Obesity present for at least 5 years - No untreated metabolic/endocrine abnormalities - Preauthorization is required • Insertion of internal prosthetic devices. See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information 	<p>\$25 per office visit; Nothing for surgery</p>

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	High Option
<ul style="list-style-type: none"> • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	\$25 per office visit; Nothing for surgery
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Blood storage</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<i>All charges</i>
Reconstructive surgery	High Option
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - The condition produced a major effect on the member's appearance and - The condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - Surgery to produce a symmetrical appearance of breasts; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) <p>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.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> 	<i>All charges</i>

Benefit Description	You pay
Reconstructive surgery (cont.)	High Option
<ul style="list-style-type: none"> • <i>Surgeries related to sex transformation</i> 	<i>All charges</i>
Oral and maxillofacial surgery	High Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Medical or surgical treatment of Temporomandibular Joint Disorder (TMJ) <p>Other surgical procedures that do not involve the teeth or their supporting structures.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> • <i>Dental treatment of TMJ</i> 	<i>All charges</i>
Organ/tissue transplants	High Option
<p>Solid Organ transplants limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs such as the liver, stomach, and pancreas 	Nothing
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses:</p> <ul style="list-style-type: none"> • Allogeneic transplants for 	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Marrow Failure and Related Disorders (i.e., Fanconi's PNH, pure red cell aplasia) - Chronic myelogenous leukemia - Hemoglobinopathies - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Amyloidosis - Paroxysmal Nocturnal Hemoglobinuria • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Neuroblastoma - Amyloidosis • Autologous transplants for <ul style="list-style-type: none"> - Recurrent germ cell tumors (including testicular cancer) - Multiple myeloma - De novo myeloma 	Nothing
Transportation/lodging when performed at a Plan-designated center of excellence	Up to \$5,000
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogenic transplants for <ul style="list-style-type: none"> - Phagocytic/Hemaphagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced neuroblastoma - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Mucopolysaccharidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) 	Nothing

Benefit Description	You pay
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> - Myeloproliferative disorders - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Ependyoblastoma - Ewing's sarcoma - Medulloblastoma - Pineoblastoma - Waldenstrom's macroglobulinemia 	Nothing
Mini-transplants (non myeloblative, reduced intensity conditioning) for covered transplants: Subject to medical necessity	Nothing
Tandem transplants for covered transplants: Subject to medical necessity	Nothing
<p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols for</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) - Hemoglobinopathies - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Myelodysplasia/Myelodysplastic syndromes - Multiple myeloma - Multiple sclerosis • Non myeloablative allogeneic transplants or Reduced intensity conditioning for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Myelodysplasia/myelodysplastic syndromes - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia 	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle Cell disease • Autologous transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) - Small cell lung cancer - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis • National Transplant Program (NTP) - Note: We cover related medical and hospital expenses of the donor when we cover the recipient. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered 	<i>All charges</i>
Anesthesia	High Option
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	Nothing

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.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible for services received from participating Plan providers. Please see Section 5(i) regarding your Point-of-Service benefits.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Inpatient hospital	High Option
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	\$500 per admission \$1,000 individual /\$2,000 family out-of-pocket maximum for admission co-payments per calendar year.
Other inpatient hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Custodial care</i> 	<i>All charges</i>

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	High Option
<ul style="list-style-type: none"> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> 	<i>All charges</i>
Outpatient hospital or ambulatory surgical center	High Option
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	Nothing
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges.</i>
Extended care benefits/Skilled nursing care facility benefits	High Option
<p>Extended care/Skilled nursing facility (SNF) benefit:</p> <ul style="list-style-type: none"> • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by a skilled nursing facility when prescribed by a Plan doctor. 	Nothing
<i>Not covered: Custodial care</i>	<i>All charges.</i>
Hospice care	High Option
<ul style="list-style-type: none"> • Supportive and palliative care for a terminally ill member is covered in the home or hospice facility • Family counseling • Hospice services are provided under the direction of Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six (6) months or less. 	Nothing
Inpatient care	\$500 per admission

Benefit Description	You pay
Hospice care (cont.)	High Option
	\$1,000 individual/\$2,000 family out-of-pocket maximum per calendar year
Outpatient care	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges</i>
Ambulance	High Option
Local professional ambulance service when medically appropriate	Nothing
Air and water ambulance are only covered when medically appropriate and provided in the United States and its territories	All charges over \$3,000 per occurrence

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 about coordinating benefits with other coverage, including with Medicare.

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.

What to do in case of emergency:

Emergencies within our service area

Please call your primary care physician. In extreme emergencies, if you are unable to contact your doctor, call 911 or go to the nearest emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or your family member should notify the Plan within forty-eight (48) hours unless it is not reasonably possible to do so. It is your responsibility to ensure that the Plan has been notified timely.

If you need to be hospitalized, the Plan must be notified within forty-eight (48) hours or on the first working day following your admission, unless it is not reasonably possible to notify the Plan within that timeframe.

To be covered by this Plan, any follow-up care recommended by a non-Plan provider must be approved by a Plan provider except as covered under the POS benefit.

Emergencies outside our service area

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

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

To be covered by this Plan, any follow-up care recommended by a non-Plan provider must be approved by a Plan provider except as covered under the POS benefits.

Benefit Description	You pay
Emergency within our service area	High Option
Emergency care at a doctor's office	\$15 per PCP visit \$25 per Specialist visit
Emergency care at an urgent care center	\$50 per visit
Emergency care in an outpatient hospital facility, including doctors' services	\$100 per visit. If emergency results in an admission to a hospital, the copayment is waived.
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>
Emergency outside our service area	High Option
Emergency care at a doctor's office	\$25 per visit
Emergency care at an urgent care center	\$50 per visit
Emergency care as an outpatient at a hospital, including doctors' services	\$100 per visit. If emergency results in an admission to a hospital, the copayment is waived.
Ambulance	High Option
Professional ambulance service when medically appropriate.	Nothing
Air and water ambulance are only covered when medically appropriate and provided in the United States and its territories Note: See 5(c) for non-emergency service.	<i>All Charges over \$3,000 per occurrence</i>

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

When you get our approval for services and follow a treatment plan we approve, cost-sharing for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions 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 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay
Mental health and substance abuse benefits	High Option
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	\$25 per office visit
Diagnostic tests	Nothing
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization. 	\$500 per admission \$1,000 individual /\$2,000 family out-of-pocket maximum per admission per calendar year
Services in approved alternative care settings such as facility based intensive outpatient treatment, residential treatment	\$25 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services not coordinated through our Administrator</i> • <i>Methadone treatment programs</i> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All Charges.</i>

Preauthorization	To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:
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	<p>Authorization of treatment for inpatient and intensive outpatient mental health conditions and substance abuse may be obtained directly by contacting our Behavioral Health Administrator at 800-544-5977 or 401-276-4052 prior to services being rendered. Our Administrator will determine and authorize the appropriate number of visits and determine the appropriate specialist. A referral from your PCP is not required.</p>
<p>Limitation</p>	<p>We may limit your benefits if you do not obtain a treatment plan.</p> <p>There are no benefit limitations for the following services:</p> <ul style="list-style-type: none"> • Outpatient Mental Health services • Child & Family Intensive Services (CFIT) • Adult intensive Services • Outpatient Chemical Dependency Services • Intensive Outpatient Program • Inpatient Chemical Dependency Services: <ul style="list-style-type: none"> - Detoxification - Rehabilitation (residential and hospital facility)

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy or by mail. Contact Customer Service at (401) 274-3500 from within the State of Rhode Island or 1-800-564-0888 from outside of Rhode Island for more information or to obtain a mail service enrollment form directly log on to www.BCBSRI.com.
- **We use a formulary.** Blue Cross & Blue Shield of Rhode Island uses a drug formulary, which is a listing of quality, cost effective medications that are covered under your prescription drug benefit for a lower co-payment. We cover non-formulary drugs prescribed by a physician; however, you will be responsible for a higher co-payment.
- **These are the dispensing limitations.** Prescription drugs prescribed by a physician will be dispensed for up to a 30-day supply for non-maintenance drugs and maintenance drugs. If there is no generic equivalent available, you will still have to pay the brand name co-payment. A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand or if you specifically ask and sign for a brand name medication.
- **A generic equivalent will be dispensed if it is available,** unless your physician specifically requires a name brand. If you receive a name brand drug when a federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generic drugs cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs. You can save money by using generic drugs. However, you and your physician have the option to request a name brand if a generic option is available.
- **When you do have to file a claim.** You will be required to submit a claim for prescriptions purchased from a non-Plan pharmacy. You will be required to pay the non-Plan pharmacy directly and the Plan will reimburse you once you have submitted the receipt, your name, Plan identification number to Basic Claims Administration, Blue Cross & Blue Shield of Rhode Island, 500 Exchange Street, Providence, RI 02903.

Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications should call our Customer Service Department at 1-800-564-0888.

Benefit Description	You pay
Covered medications and supplies	High Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (contact Customer Service for limitations) • Contraceptive drugs and devices purchased at the pharmacy • Prenatal vitamins 	<p>\$7 per prescription unit or refill for generic drugs</p> <p>\$30 per prescription unit or refill for brand name drugs on the Plan’s formulary</p> <p>\$50 per prescription unit or refill for brand name drugs not listed on the Plan’s formulary</p> <p>Mail order: \$14 for formulary generic; \$60 for formulary brand drugs; \$100 for non-formulary drugs for a 90-day supply</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copayment. In addition, if a brand name drug becomes available as a generic, you will be required to pay the highest copayment.</p>
<ul style="list-style-type: none"> • Diabetic supplies, including test strips and lancets purchased at the pharmacy • Fertility drugs purchased at the pharmacy • Injectable drugs purchased at the pharmacy • Insulin 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Over-the-counter drugs (even if prescribed)</i> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Compound medications not made up of at least one Legend drug</i> • <i>Vitamins (excluding prenatal), nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Drugs and supplies for the purpose of weight reduction</i> • <i>Non-prescription medicines</i> 	<p><i>All charges</i></p>

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 First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Accidental injury benefit	High Option
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury caused by an unexpected or unintentional means and services are received within seventy-two (72) hours of injury.	\$100 per hospital emergency room visit
<p>Only the following services are covered:</p> <ul style="list-style-type: none"> • Extraction of teeth needed to avoid infection of teeth damaged in the injury • Suturing and suture removal • Re-implanting and stabilization of dislodged teeth • Medication received from the provider 	\$25 per office visit
<i>Not covered: Injuries incurred as a result of biting and/or chewing</i>	<i>All charges</i>
Dental benefits	High Option
<i>We have no other dental benefits.</i>	<i>All charges</i>

Section 5(h). Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services for deaf and hearing impaired	For the deaf and hearing impaired, please call our TDD number: 1-888-252-5051.
Reciprocity benefits	When you or a covered member are traveling throughout the United States, and need urgent medical care before you return home, call 1-800-810-BLUE to locate a Blue Cross & Blue Shield traditional provider or log on to www.bcbs.com . In addition, you must contact Customer Service before or after you receive care (within 48 hours) to ensure that your claim is paid appropriately. Please remember to coordinate all follow-up care through your primary care physician.
High risk pregnancies	If you are pregnant, you will be part of our Little Steps prenatal program. Little Steps is designed to work with you and your physician to help you have the healthiest baby possible. Little Steps includes free classes on parenting, newborn care and breast-feeding. The classes are held at participating hospitals throughout Rhode Island. For more information contact Customer Service.
Centers of excellence	To ensure you receive quality care, we selectively choose medical facilities that specialize in various transplants to participate in our network. The facilities are chosen based on the duration of their transplant program, volume of transplants performed each year, patient outcomes, and qualifications of their transplant program medical staff. Each facility is well known and respected throughout the country, and is designated a “Center of Excellence” for its commitment to quality care and positive patient outcomes. By utilizing one of our network facilities, you will receive quality care and can better manage your costs. For more information, contact Customer Service.

Section 5(i). Point-of-Service benefits

Point-of-Service (POS) Benefits

Facts about this Plan's Point-of-Service (POS) option

At your option, you may choose to obtain benefits covered by this Plan from non-Plan doctors and hospitals whenever you need care, except for the benefits listed below under “What is not covered.” Benefits not covered under Point-of-Service must either be received from or arranged by Plan doctors to be covered. When you obtain covered non-emergency medical treatment from a non-Plan doctor without a referral from a Plan doctor, you are subject to the deductibles, coinsurance and maximum benefit stated below.

What is covered

Under the point-of-service benefit, you are covered for medically necessary, covered health services when you self-refer to a non-Plan provider or to a Blue Cross & Blue Shield of Rhode Island provider without a referral from your primary care physician. You may receive medically necessary covered health services listed in this brochure, except for the benefits listed below under “What is not covered.” Once you use the point-of-service benefit, all services associated with the episode of care (e.g., lab, X-ray, hospitalization) will be paid according to your point-of-service benefit. If you choose to use the point-of-service benefit, you will receive a lower allowance than when the standard benefit is utilized.

You are able to self-refer to a non-Plan provider either inside or outside of our service area. You must call Blue Cross & Blue Shield of Rhode Island for authorization for hospitalization.

Plan Authorization

When utilizing the point-of-service benefit, we continue to recommend that you obtain prior medical review for the same services that we recommend you do so under the standard benefit. When utilizing non-Plan participating providers, it is recommended that you advise your provider to contact the Plan for prior medical review in advance of such services to ensure they will be covered.

Deductible

When the point-of-service benefit is utilized, you pay a \$500 deductible per member per calendar year or a \$1000 deductible per family per calendar year for doctor's visits, other outpatient services, and hospital services. The deductible is not reimbursable by the Plan. If you decide to use non-Plan providers or self refer to a Plan provider, this deductible applies to all covered benefits. Copayments under the BCBSRI's point-of-service benefit cannot be used to meet your calendar year deductible.

Coinsurance

Members are able to self-refer to a provider either inside or outside the Service Area. If you self-referral to a provider who does not participate with the BlueCHiP network, but who is part of the Blue Cross & Blue Shield national traditional network (Host Blue), you will only be responsible for your deductible and the 30% coinsurance. To check if the provider participates with this program, please call 1-800-810-BLUE or log on to www.bcbs.com. These providers will file the claim directly. This feature is referred to as the BlueCard program.

If you self-refer to a provider who is neither part of the BlueCHiP network, nor part of the BlueCard program, you will be responsible for any amount over our allowance, in addition to your deductible and coinsurance amount.

When you use the Flex Plan Rider to self-refer for services to participating providers, BCBSRI will pay 70% of our fee schedule based on existing contractual relationships with the provider. BlueCHiP providers cannot charge the member more than the contracted fee.

When you obtain health care services through the BlueCard program outside the BlueCHiP network, you will pay 30% of the amount for the covered services. The amount charged for a covered service is calculated on the lower of:

- The billed charges for your covered health care services, or
- The negotiated price that the on-site Blue Cross &/or Blue Shield Plan (“Host Blue”) passes on to us.

Often, this "negotiated price" will consist of a simple discount, which reflects the actual price paid by the Host Blue. However, sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or under- estimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. If any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above in this section or require a surcharge, we would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

When you receive services from providers that are not contracted with BlueCHiP or a Host Blue Plan, we will pay 70% of the fee schedule, as determined by BlueCHiP. The member is responsible for the remaining balance of the non-network provider's charges if they are greater than the fee schedule. Payment for these services will be made directly to the member. The member is responsible to pay the provider directly for the services.

All payments made by BlueCHiP for services through the point-of-service benefit will be subject to a deductible as outlined above.

Out-of-Pocket Maximum

You are protected by an out-of-pocket maximum of \$5,000 per person per calendar year and \$10,000 per family per calendar year. This includes deductibles and copayments. Charges over the fee allowance cannot be applied to the out-of-pocket maximum.

Emergency Benefits

True, medically necessary emergency care (even if received from a non-participating provider) is always covered as a standard benefit.

What is Not Covered

- Anesthesia consultations
- Chiropractic care
- Diagnostic procedures, such as laboratory tests and x-rays
- Durable Medical Equipment (DME) and medical supplies
- Emergency room visits
- Home health services
- Infertility services
- Mental conditions/substance abuse benefits
- Outpatient physical, speech and occupational therapies, cardiac rehabilitation
- Rehabilitation hospitalizations
- Skilled nursing facility care
- Transplant coverage
- Vision care benefits

How to Obtain Benefits

If you receive services from a non-participating provider, you may be required to pay up front and submit to us for reimbursement. Please call Customer Service at (401) 274-3500 from within the State of Rhode Island or toll free at 1-800-564-0888 from outside of Rhode Island for a claim form. We will provide you with a form within 15 days of your request. Submit the claim to Basic Claims Administration, Blue Cross & Blue Shield of Rhode Island, 500 Exchange Street, Providence, RI 02903 as soon as possible. You must submit a complete claim form by December 31 of the year after the year you received the service. Either we or OPM can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at, (401) 274-3500 from within the State of Rhode Island or toll free at 1-800-564-0888 from outside of Rhode Island or visit our website at www.BCBSRI.com.

Medicare Prepaid Plan

Enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated in page 51, annuitants and former spouses with FEHBP coverage and Medicare Part B may elect to drop their FEHBP coverage and enroll in a Medicare prepaid Plan when one is available in their area. They may then later re-enroll in the FEHB Program. Most federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid Plan but may have to pay for hospital coverage in addition to the Part B premium. Before you join the Plan, ask whether the Plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHBP enrollment and changing to a Medicare prepaid Plan. Contact us at 1-800-505-2583 for information on the Medicare prepaid Plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB Plan, call 1-800-505-2583 for information on the benefits available under the Medicare HMO.

Section 6. General exclusions – things we don't 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 your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** (see specifics regarding transplants).

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Clinical trials extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Clinical trials 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
- 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 sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call us at (401) 274-3500 from within the State of Rhode Island or toll-free at 1-800-564-0888 from outside of Rhode Island.

When you must file a claim – such as for services you receive outside the Plan’s service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member’s name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to: *Basic Claims Administration, 500 Exchange Street, Providence, Rhode Island, 02903*

Other supplies or services

Submit your claims to: *Basic Claims Administration, 500 Exchange Street, Providence, Rhode Island, 02903*

Prescription drugs

Submit your claims to: *Basic Claims Administration, 500 Exchange Street, Providence, Rhode Island, 02903*

Deadline for filing your claim

Send us all of the documents for your claim 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 the claim was submitted as soon as reasonably possible.

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.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3:

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">a) Write to us within 6 months from the date of our decision; andb) Send your request to us at: 500 Exchange Street, Providence, Rhode Island 02903; andc) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andd) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none">a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orb) Write to you and maintain our denial - go to step 4; orc) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request - go to step 3.
3	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">• 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. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none">• A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;• Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;• Copies of all letters you sent to us about the claim;• Copies of all letters we sent to you about the claim; and• Your daytime phone number and the best time to call.

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.

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

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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 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 sue. 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 claim decision. This information will become part of the court record.

You may not sue 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

a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at (401) 274-3500 from within the State of Rhode Island or toll-free at 1-800-564-0888 from outside Rhode Island and we will expedite our review; or

b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Insurance Group 3 at (202) 606-0737 between 8 a.m. and 5 p.m. eastern time.

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

a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at (401) 274-3500 from within the State of Rhode Island or toll-free at 1-800-564-0888 from outside Rhode Island and we will expedite our review; or

b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Insurance Group 3 at (202) 606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

When you have double coverage, one Plan normally pays its benefits in full as the primary payor and the other Plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

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.

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; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- **Part A (Hospital Insurance).** Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) for more information.
- **Part B (Medical Insurance).** Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- **Part C (Medicare Advantage).** You can enroll in a Medicare Advantage Plan to get your Medicare benefits. We offer a Medicare Advantage Plan. Please review the information on coordinating benefits with Medicare Advantage Plans on the next page.
- **Part D (Medicare prescription drug coverage).** There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug Plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). 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. The notice will give you guidance on enrolling in Medicare Part D.

• Should I enroll in Medicare?

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

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't 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 the Medicare Part B coverage.

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

- **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.

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.

If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

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 Original Medicare 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 covered charges. To find out if you need to do something to file your claim, call us at (401) 274-3500 from within Rhode Island or toll-free at 1-800-564-0888 from outside of Rhode Island or see our Web site at www.BCBSRI.com.

We do not waive any costs if the Original Medicare Plan is your primary payor.

- **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.

- **Medicare Advantage (Part C)**

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

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

This Plan and our Medicare Advantage Plan: You may enroll in our Medicare Advantage Plan and also remain enrolled in our FEHB Plan. In this case, we do not waive cost sharing for your FEHB coverage.

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. 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 (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. 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.

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 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.

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

- You 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 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

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental 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, 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.

Coverage Clinical Trials

This health plan covers care for clinical trials according to definitions listed below and as stated on specific pages of this brochure:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy. The Plan covers these costs (Page 56)

- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient’s routine care. The Plan does not cover these costs (Page 56)
- 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. The Plan does not cover these costs (Page 56)

Section 10. Definitions of terms we use in this brochure

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.
Clinical Trials Cost Categories	<p>This health plan covers care for clinical trials according to definitions listed below and as stated on specific pages of this brochure:</p> <ul style="list-style-type: none">• Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient’s cancer, whether the patient is in a clinical trial or is receiving standard therapy (Page 54)• Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient’s routine care (Page 55)• 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 (Page 55)
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 13.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 13.
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	Care we provide benefits for, as described in this brochure.
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 those services. See page 13.
Experimental or investigational service	Experimental or investigational services include any treatment procedure, facility, equipment, drug, device, supply, or service when the service has progressed to limited human application, but has not been recognized as proven effective in clinical medicine. A service is considered experimental or investigational if the Plan determines that one or more of the following circumstances are true: 1) the service is the subject of an ongoing clinical trial or is under study to determine the maximum tolerated dose, toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis; or 2) the prevailing opinion among experts regarding the service is that further studies or clinical trials are necessary; or 3) the current belief in the pertinent specialty of the medical profession in the United States is that the service or supply should not be used for the diagnosis or indications being requested outside of clinical trials or other research settings because it requires further evaluation for that diagnosis or indications.
Group health coverage	A Plan maintained by an employer to provide medical care, directly or indirectly, to employees, ex-employees and their families
Medical necessity	Medical necessity means the health care services provided to treat your illness or injury. The services must: 1) be essential to the diagnosis, treatment, or care of your condition; 2) be commonly and customarily recognized in your provider’s profession as appropriate for you diagnosis; 3) be performed in the most cost-effective manner or at a location providing a less intensive level of care; and 4) not be determined by us to be experimental or investigational.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:

- (a) the amount the provider charges for the service; or
- (b) the maximum amount we pay any provider for that service.

Us/We

Us and We refer to Blue Cross & Blue Shield of Rhode Island (BCBSRI)

You

You refers to the enrollee and each covered family member.

Section 11. 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.

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

See www.opm.gov/insure/health 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 who participate in Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits*, 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; and
- When the next open season for enrollment begins.

We don't 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 and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 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 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 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 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 to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorce, or when your child under age 22 marries.

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.

- **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 and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self 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 and Family coverage in the Blue Cross & 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 and Family 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 and Family in the Blue Cross & Blue Shield Service 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. Contact your employing office for further information.

• **When benefits and premiums start**

The benefits in this brochure are effective 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 2010 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 2009 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.

• **When you retire**

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

When you lose benefits

• **When FEHB coverage ends**

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

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

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

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **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 coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse’s employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM’s Web site, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)** If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (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, if you are a covered dependent child and you turn 22 or marry, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage** You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new Plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB Plans, you may also request a certificate from those Plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; refer to the “TCC and HIPAA” frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

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

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

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

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election of \$5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents, which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **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 dental and vision care expenses for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) 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 Sease held each fall.

Where can I get more information about FSAFEDS?

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

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

Important Information The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

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 Dental plans provide a comprehensive range of services, including all the following:

- 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 24-month waiting period

Vision Insurance 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 at www.opm.gov/insure/vision and www.opm.gov/insure/dental. These sites also provide links to each Plan's website, where you can view detailed information about benefits and preferred providers.

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

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection The Federal Long Term Care Insurance Program (FLTCIP) can help you 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. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of Benefits for Blue Cross & Blue Shield of Rhode Island - 2010

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and 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.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the items is subject to the \$500/\$1,000 calendar year deductible.

High Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copayment: \$15 primary care; \$25 specialist	16
Services provided by a hospital:		
• Inpatient	\$500 per admission copayment	31
• Outpatient	Nothing	32
Emergency benefits:	\$100 per emergency room visit; \$50 per urgent care center visit; \$15 per primary care office visit; \$25 per specialists office visit	34
Mental health and substance abuse treatment:	Regular cost-sharing	36
Prescription drugs:	\$7 for formulary generic drugs; \$30 for formulary brand drugs; \$50 for non-formulary drugs at a participating pharmacy for each 30-day supply	38
Dental care:	No benefit.	40
Vision care:	\$25 per office visit	21
• Annual Eye Exam	Nothing for one pair of eyeglasses to correct impairment directly caused by intraocular surgery; No other benefit for eyeglasses	
• Eyeglasses		
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Protection against catastrophic costs (out-of-pocket maximum):	Nothing for in-network inpatient admissions after \$1000 per person/\$2000 per family per calendar year Some costs do not count toward this protection	13

2010 Rate Information for Blue Cross & Blue Shield of Rhode Island

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

Postal rates apply to career Postal Service employees. Most employees should refer to the Guide to Benefits *for Career United States Postal Service Employees, RI 70-2*, and to the rates shown below.

The rates shown below do not apply to *Postal Service Inspectors, Office of Inspector General (OIG) employees and Postal Service Nurses*. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees (RI 70-2IN)*. Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses (RI 70-2NU)*.

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. Refer to the applicable Guide to Federal Benefits.

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

Rhode Island and portions of Southern Massachusetts.

High Option Self Only	DA1	\$167.61	\$139.93	\$363.16	\$303.18	\$190.89	\$116.65
High Option Self and Family	DA2	\$376.04	\$438.96	\$814.75	\$951.08	\$428.27	\$386.73