Pre-Existing Condition Insurance Plan

(800) 220-7898

[http://www.pciplan.com]

Administered by:

Government Employees Health Association, Inc.

Who may enroll in this Plan:

- You must be a citizen or national of the United States or lawfully present in the United States.
- You must have been uninsured for at least the last six months.
- You must have had a problem getting insurance due to a pre-existing condition in the past six months.

ACCREDITED HEALTH NETWORK

ACCREDITED HEALTH UTILIZATION MANAGEMENT

URAC accreditation: GEHA for Health Network
URAC UM accreditation: InforMed for Health Utilization Management
JCAHO accreditation: Medco for Home Care Pharmacy Dispensing Services

PCIP Plan Options:

- ☐ **Standard Option**
- ☐ **Extended Option**
- ☐ **Health Savings Account (HSA) Option**

The availability and unavailability of membership in the Pre-Existing Condition Insurance Plan (PCIP) and any benefits through the plan are at all times subject to federal law, regulations, and the contract between GEHA and the United States Department of Health and Human Services, and is dependent on continued availability of federal funding.

PCIP Pre-Existing Condition Insurance Plan Administered by GEHA

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Introduction

This brochure describes the benefits of the **Pre-Existing Condition Insurance Plan (PCIP)** – administered by Government Employees Health Association, Inc. (GEHA) under our contract with the United States Department of Health and Human Services (HHS), as authorized by the Affordable Care Act. This Plan is underwritten by the federal government. The address for the PCIP administrative offices is:

PCIP
P.O. Box 300
Independence, Missouri 64051-0300

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. You do not have a right to benefits that were available before your effective date.

Benefits and rates are subject to change. You will receive at least 30 days advance notice before any change is put into effect.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Pre-Existing Condition Insurance Plan premium.

The Office of the Inspector General investigates allegations of fraud, waste, and abuse in the Pre-Existing Condition Insurance Plan.

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 provider, or an authorized Federal Government 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, please complete an online complaint form at http://www.oig.hhs.gov/fraud/hotline. Or, you may send an email report addressed to: hhstips@oig.hhs.gov. If you do not have access to the Internet or if you prefer, you may call 1-800-HHS-TIPS (1-800-447-8477), fax to 1-800-223-8164 or write to Office of Inspector General, Department of Health and Human Services, Attn: Hotline, P.O. Box 23489, Washington, DC 20026.

CONTACT - THE HEALTH CARE FRAUD HOTLINE
www.oig.hhs.gov/fraud/hotline

OR SEND AN EMAIL TO:

hhstips@oig.hhs.gov

OR CALL:

1-800-HHS-TIPS - (1-800-447-8477)
TTY: 1-800-377-4950
Fax: 1-800-233-8164

OR WRITE TO:

Office of the Inspector General Fraud Hotline
Department of Health and Human Services
ATTN: HOTLINE
P.O. Box 23489
Washington, DC 20026

- You can be prosecuted for fraud and the Federal Government may take action against you if you falsify a claim to obtain PCIP benefits or try to obtain services for someone who is not eligible or who is no longer enrolled in the Plan.
- In addition, we want to know about any health coverage that could have been eliminated by an employer due to a pre-existing condition. If you believe your health insurance was eliminated due to your pre-existing condition, please contact PCIP at (800) 220-7898.

Preferred Care Providers

PCIP, through GEHA, has contracted with preferred care providers to assist you with home health services, medical equipment, outpatient therapy, and home infusion therapy. Covered services pre-approved by your PCIP plan and provided by a preferred care provider will be paid at the in-network benefit outlined in the PCIP Benefit Plan Brochure. Some services listed below (*) must be provided by a plan-designated provider. It is important to know that not all services offered by these providers will be covered as medical benefits; some services will be paid as pharmacy benefits. The continued participation of any provider or any service rendered by that provider cannot be guaranteed. In order to obtain the most cost-effective services and assure that services meet medical necessity, PCIP recommends that you call Customer Service at (800) 220-7898 for precertification of any home health care services recommended by any provider prior to receipt of services.

You can choose your own physicians, hospitals, and other health care providers, but you will have less out-of-pocket expense if you choose in-network providers.

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

Services that require precertification and the contact information:

Durable medical equipment*	(800) 220-7898
Hospital – Inpatient care	(800) 242-1025 Fax: 866-315-6314
Inpatient Mental Health/Substance Abuse Care, Residential Treatment Center Care, Intensive Day Treatment Care	(800) 242-1025 Fax: 866-315-6314
Outpatient Mental Health Services: (Psychological Testing, Neuro-Psychological Testing, ECT (Electroconvulsive Therapy)	(800) 220-7898
Radiology MRI, MRA, CAT, PET, Nuclear Cardiology	(866) 879-8317
Skilled Nursing Facility, Long Term Acute Care Facility (LTAC), Inpatient Rehab Facility	(877) 304-4419 Fax: 877-304-4409
Home Skilled Nursing Care, IV therapy*	(800) 220-7898
Therapy Services Physical and Occupational Speech Cardiac or Pulmonary Rehab	 (877) 304-4399 (877) 304-4399 Fax: 877-304-4398 (800) 220-7898
Orthotics and Prosthetics	(800) 220-7898
Hospice care	(800) 220-7898
Transplant care	(800) 220-7898
Nonsurgical cancer treatment	PCIP Provider Portal with link to Eviti or www.Eviti.com. For additional information: (800) 220-7898
^Certain surgeries and procedures	(800) 220-7898
Dialysis services (annual precertification for each dialysis center attended)	(800) 220-7898
Specialty drug benefits*	(800) 220-7898
Preferred provider network	(877) 745-7198
Prescription drug benefits	(800) 427-6145

^Surgeries and procedures requiring precertification:

- ACI (Autologous Cultured Chrondrocytes), also called Genzyme tissue repair (or Carticel) for knee cartilage damage;
- Abdominoplasty/ diastasis recti repair/ panniculectomy;
- Botox injections;
- Breast reconstruction except immediate reconstruction for diagnosis of cancer;
- Coma stimulation;
- Cosmetic procedures including: blepharoplasty or any other type of eyelid surgery, browlift, liposuction, and scar revision;
- Epidural injections;
- Experimental/ investigation surgery or treatment;
- FACET injections;
- Gynecomastia-cosmetic (see mammoplasty);
- Intrathecal pump insertion for pain management (morphine pump, baclofen pump);
- Mammoplasty, reduction (unilateral/ bilateral);
- Mastectomy performed prophylactically;
- Morbid obesity surgeries;
- Multilevel artificial disc replacement;
- Multilevel spinal surgeries;
- Orthognathic surgery (jaw), including TMJ;
- Rhinoplasty-no prior approval for septoplasty;
- Spinal fusion;
- Sympathectomy by thoracoscopy or laproscopy;
- Transplants, except kidney or cornea;
- UPPP Uvulopalatopharyngoplasty; and
- Other surgeries, as identified by the Plan.

Section 1. Facts about this Pre-Existing Condition Insurance Plan (PCIP)

Coverage information

What is PCIP?

In March 2010, Congress passed and President Obama signed the Affordable Care Act-the new health law. The law creates a new program – the Pre-Existing Condition Insurance Plan – to make health coverage available to you if you have been denied health insurance by private insurance companies because of a pre-existing condition.

What is a pre-existing condition?

A pre-existing condition is a condition, disability or illness (either physical or mental) that you have before you enrolled in a health plan.

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 PCIP Program

See www.pcip.gov for enrollment information as well as:

- Information on the PCIP Program;
- A health plan comparison tool; and
- Eligibility.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from the National Finance Center. For information on your premium deductions, you must also contact the National Finance Center:

Pre-Existing Condition Insurance Plan
P. O. Box 60017
New Orleans, LA 70160-0017
Customer Service (866) 717-5826

When benefits and premiums start

If you live in a state where the U.S. Department of Health and Human Services is running the program, you can apply and enroll at anytime you become eligible. Generally, a completed application received **on or before** the 15th of the month will go into effect on the first day of the next month. A completed application received **after** the 15th of the month will go into effect on the first day of the following month.

Enrollee Address Change

If you move, please notify the National Finance Center as soon as possible by:

Phone – call 877-829-9562; or

Mail – send your address change request to:

Pre-Existing Condition Insurance Plan
P. O. Box 60017
New Orleans, LA 70160-0017

Web Account

Register for your web services account at www.PCIPlan.com. Click on Enrollees, then click on Web Services sign in/registration and you'll have access to additional online tools and features, including claims inquiries and your health assessment.

You choose your own user ID number and password, so only you have access to your account information. Just click on the Register button to get started.

When you obtain other coverage

When you receive other health insurance coverage or become Medicare-eligible age, you will no longer be qualified for PCIP.

If premiums aren't paid

If premiums are not received within 30 days, your coverage will end effective the first of the month for which the premium was not received.

If you have limited income and resources, you may be eligible for the Medicaid program in your state. If you are seeking insurance coverage for your child, go to www.insurekidsnow.gov to learn more about children's health insurance in your state.

Section 2. How You Get Care

General features of the Pre-Existing Condition Insurance Plan (PCIP)

We have a Preferred Provider Organization (PPO)

PCIP offers services through a PPO. This means that certain hospitals and other health care providers are "preferred providers". When you use our PPO providers, you will receive covered services at reduced cost. GEHA is solely responsible for the selection of PPO providers in your area. Contact us for the names of PPO providers and to verify their continued participation. You can also go to our Web page, www.pciplan.com. PPO provider listings are available upon request.

We have entered into arrangements with Arizona Foundation for Medical Care; First Health; MedSolutions; OneNet PPO; PPO USA®; and Private Healthcare Systems**;** which are Preferred Providers or networks of hospitals and/or doctors. The doctors and hospitals participating in these networks have agreed to provide services to Plan enrollees. You always have the right to choose a PPO provider or a non-PPO provider for medical treatment. However, if you use a non-PPO provider, your cost-sharing will be higher.

PPO networks are now available in all major metropolitan areas and in most mid-size and rural areas; additional coverage areas will be added throughout the year. Enrollees residing in a PPO network area may look up providers online or request a directory of the PPO providers in their service area. These providers are required to meet licensure and certification standards established by State and Federal authorities, however, inclusion in the network does not represent a guarantee of professional performance nor does it constitute medical advice. To locate a participating provider in your area, call (877) 745-7198 or visit the PCIP Web site at www.pciplan.com. When you phone for an appointment, please remember to verify that the physician is still a PPO provider.

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply. In addition, providers outside the United States will be paid at the PPO level of benefits.

How we pay providers

PCIP will reimburse you or your provider for covered services. We do not typically provide or arrange for health care. You are free to choose your own physicians, hospitals and other health care providers, but you will have less out-of-pocket expense if you choose in-network providers. We reserve the right to audit medical expenses.

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

Never events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use Arizona Foundation for Medical Care or PPO USA® Network preferred providers. This 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 have 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 you nor your PCIP plan will incur costs to correct the medical error.

Preventive care services

Preventive care services rendered by a preferred provider are paid as first dollar coverage.

Annual deductible

You must pay out-of-pocket the annual deductible before the Plan pays benefits for care other than preventive care services.

Lifetime maximum

There are no lifetime maximum limitations in PCIP.

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.

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 health benefits enrollment confirmation letter which you receive from the U.S. Department of Agriculture's National Finance Center (the premium billing and collection vendor).

If you do not receive your ID card within 15 days after the effective date of your enrollment, please call us at (800) 220-7898 or write to us at PCIP, P. O. Box 300, Independence, MO 64051-0300. You may also request replacement cards through our website: www.pciplan.com.

Where you get covered care

You can get care from any "covered provider" or "covered facility." How much we pay – and you pay – depends on the type of covered provider or facility you use. If you use our preferred providers, you will pay less. You will pay less for care furnished by preferred providers even in states other than your own. You can obtain care from any covered provider or covered facility in states that do not participate in the federally administered PCIP program, but providers in those states are not likely to be in the preferred provider network.

- Covered providers

We consider the following to be covered providers when they perform services within the scope of their license or certification:

A licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.). Other covered providers include a chiropractor, nurse midwife, nurse anesthetist, audiologist, dentist, optometrist, licensed clinical social worker, licensed clinical psychologist, licensed professional counselor, licensed marriage and family therapist, podiatrist, speech, physical and occupational therapist, nurse practitioner/clinical specialist, nursing school administered clinic, physician assistant, registered nurse first assistants, certified surgical assistants and Christian Science practitioner.

The term "doctor" includes all of these providers when the services are performed within the scope of their license or certification.

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in the states that are "medically underserved". Currently, the states are: Alabama, Arizona, Idaho, Illinois, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, Oklahoma (beginning January 1, 2011), South Carolina, South Dakota, and Wyoming.

- Covered facilities

Covered facilities include:

- Freestanding ambulatory facility

A facility which is licensed by the state as an ambulatory surgery center or has Medicare certification as an ambulatory surgical center, has permanent facilities and equipment for the primary purpose of performing surgical and/or renal dialysis procedures on an outpatient basis; provides treatment by or under the supervision of doctors and nursing services whenever the patient is in the facility; does not provide inpatient accommodations; and is not, other than incidentally, a facility used as an office or clinic for the private practice of a doctor or other professional.

- Christian Science nursing organization/facilities that are accredited by The Commission for Accreditation of Christian Science Nursing Organization/Facilities Inc.

- Hospice

  A facility which meets all of the following:

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

5) Provides an ongoing quality assurance program.

- Skilled Nursing Facility licensed by the state or Medicare certified if the state does not license these facilities. See limitations on page 49.
- Hospital

1) An institution which is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or

2) A medical institution which is operated pursuant to law, under the supervision of a staff of doctors, and with 24-hour-a-day nursing service, and which is primarily engaged in providing general inpatient care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, all of which facilities must be provided on its premises or have such arrangements by contract or agreement; or

3) An institution which is operated pursuant to law, under the supervision of a staff of doctors and with 24-hour-a-day nursing service and which provides services on the premises for the diagnosis, treatment, and care of persons with mental/substance abuse disorders and has for each patient a written treatment plan which must include diagnostic assessment of the patient and a description of the treatment to be rendered and provides for follow-up assessments by or under the direction of the supervising doctor.

The term hospital does not include a convalescent home or skilled nursing facility, or any institution or part thereof which: a) is used principally as a convalescent facility, nursing facility, or facility for the aged; b) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or c) is operating as a school.

What you must do to get covered care

It depends on the kind of care you want to receive. You can go to any provider you want, but we must approve some care in advance. See pages 5 and 6 for services that require precertification.

- Transitional care

Specialty care: If you have a chronic or disabling condition and lose access to your PPO specialist because we terminate our contract with your specialist for reasons other than for cause, you may be able to continue seeing your specialist and receiving any PPO benefits for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

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

- If you are hospitalized when your enrollment begins

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (800) 220-7898. If you are new to the Pre-Existing Insurance Plan, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

How to get approval for…

- Your inpatient stay, including Skilled Nursing Facility, Long Term Acute Care or Rehabilitation Facility

Precertification (or preauthorization) is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition. Unless we are misled by the information given to us, we won't change our decision on medical necessity.

In most cases, your physician or hospital will take care of precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital whether they have contacted us.

Warning:

We will reduce our benefits for the inpatient hospital stay by $500 if no one contacts us for precertification. If the stay is not medically necessary, we will not pay any benefits.

How to precertify an admission to a hospital, Skilled Nursing Facility, Long Term Care Facility or Rehabilitation Facility

- For medical, surgical services and mental health /substance abuse admissions, you, your representative, your doctor, or your hospital must call InforMed (Medical Management Service – IMMS) before admission. The toll-free number is (800) 242-1025. For admissions to Skilled Nursing Facilities, Long Term Acute Care Facilities, or Rehabilitation Facilities please call OrthoNet to precertify at (877) 304-4419, see pages 54 and 55.
- If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Provide the following information:
  - Enrollee's name and plan identification number;
  - Patient's name, birth date, and phone number;
  - Reason for hospitalization, proposed treatment, or surgery;
  - Name and phone number of admitting doctor;
  - Name of hospital or facility; and
  - Number of planned days of confinement.
- We will then tell the doctor and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your doctor, and the hospital.

Maternity care

You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for the temporary coverage for the 30-day period after the birth.

NICU cases

Confinements of infants in the neonatal care unit at any level must be reported. Alere, in collaboration with PCIP, will review NICU cases, and assign a level of care based on the infant's acuity and consistent with TIOP (March of Dimes report Toward Improving the Outcome of Pregnancy), the 2004 AAP (American Academy of Pediatrics) statement regarding hospital levels of care and NUBC (National Uniform Billing Committee). The facility is notified of the assigned level of care at the time the case is first reviewed and when a change occurs. If the facility bills for a higher level of care than is approved, you will be responsible for the difference between the higher level of care and the lower approved level of care charge.

If your hospital stay needs to be extended:

If your hospital stay – including maternity care – needs to be extended, you, your representative, your doctor or the hospital must ask us to approve the additional days.

What happens when you do not follow the precertification rules

If no one contacts us, we will decide whether the hospital stay was medically necessary.

- If we determine that the stay was medically necessary, we will pay the inpatient charges, less the $500 penalty.
- If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

If we denied the precertification request, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

When we precertified the admission but you remained in the hospital beyond the number of days we approved and did not get the additional days precertified, then:

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

Exceptions:

You do not need precertification in this case:

- You are admitted to a hospital outside the United States.

- Radiology/Imaging procedures precertification

Radiology precertification is the process by which prior to scheduling specific imaging procedures we evaluate the medical necessity of your proposed procedure to ensure the appropriate procedure is being requested for your condition. In most cases your physician will take care of precertification. Because you are still responsible for ensuring that we are asked to precertify your procedure, you should ask your doctor to contact us.

The following outpatient radiology services need to be precertified:

- CT - Computerized Axial Tomography;
- MRI - Magnetic Resonance Imaging;
- MRA - Magnetic Resonance Angiography;
- NC - Nuclear Cardiac Imaging Studies; and
- PET - Positron Emission Tomography.

How to precertify a radiology/imaging procedure:

For outpatient CT, MRI, MRA, NC and PET studies, you, your representative or your doctor must call MedSolutions before scheduling the procedure. The toll free number is (866) 879-8317. Provide the following information: patient's name, plan identification number, and birth date, requested procedure and clinical support for request, name and telephone number of ordering provider, and name of requested imaging facility.

Exceptions:

You do not need precertification in these cases:

- The procedure is performed outside the United States;
- You are an inpatient in a hospital; or
- The procedure is performed as an emergency.

Warning:

We will reduce our benefits for these procedures by $100 if no one contacts us for precertification. If the procedure is not medically necessary, we will not pay any benefits.

How to precertify nonsurgical cancer treatment

To precertify non-surgical cancer treatment (chemotherapy or radiation) in an outpatient setting, your provider should go the PCIP provider portal and follow the link for cancer precertification or visit www.eviti.com and enter your proposed cancer treatment plan. The on-line, real-time Eviti tool allows your provider to select an evidence-based treatment plan and obtain immediate precertification. If part of the treatment will be delivered in the hospital, a treatment plan precertification is required prior to inpatient hospital authorization.

- Other services

Some services require a referral, precertification, or prior authorization. You need to call us at (800) 220-7898 before receiving treatment for care such as:

- Physical, occupational and speech therapy (page 31);
- Home skilled nursing care, IV therapy in the home (pages 12, 35)
- Certain Surgeries and procedures (pages 38-41)
- Transplant services (pages 42-45)
- Hospice (page 49)
- Outpatient dialysis (page 27)
- Orthotics and Prosthetics (page 33)
- Non-surgical cancer treatment (includes chemotherapy and radiologic treatments) (pages 28, 44)
- Surgical treatment of morbid obesity (page 38);
- Certain prescription drugs (pages 28, 29, 56);
- Organ and tissue transplant procedures (pages 42-45);

- Surgical correction of congenital anomalies (page 38);
- Inpatient hospital mental health and substance abuse benefits, inpatient care at residential treatment centers and outpatient intensive day treatment (pages 54-56);
- Psychological testing (pages 53-55);
- Injectable hematopoietic drugs (drugs for anemia, low white blood count);
- Injectable drugs for arthritis, psoriasis or hepatitis; and
- Surgical treatment of hyperhidrosis (benefits will not be approved unless alternative therapies such as botox injections or topical aluminum chloride and pharmacotherapy have been unsuccessful) (see page 39).

Section 3. Your Costs for covered services

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

Cost-sharing

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

Deductible

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

The calendar year deductible is different for each of the three PCIP plan options. If you see in-network providers the deductibles are Standard Option $2,000, Extended Option $1,000 and HSA Option $2,500. After the deductible amount is satisfied for an individual, covered services are payable for that individual.

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

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible. We will base this percentage on either the billed charge or the Plan allowance, whichever is less.

Example: Under any of the federal PCIP options, you pay 40% of our allowance for non-PPO office visits.

If your provider routinely waives your cost

If your provider routinely waives (does not require you to pay) your deductibles or coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

For example, if your physician ordinarily charges $100 for a service but routinely waives your 20% coinsurance, the actual charge is $75. We will pay $60 (80% of the actual charge of $75).

Waivers

In some instances, a provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the contracts that the Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at (800) 220-7898, or write to PCIP, P. O. Box 300, Independence, MO 64051-0300.

Differences between our allowance and the bill

Our "Plan allowance" is the amount we use to calculate our payment for covered services. Fee-for-service plans arrive at their allowances in different ways, so their allowances vary. For more information about how we determine our Plan allowance, see the definition of Plan allowance in Section 13.

Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the provider you use.

- **PPO providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible and coinsurance. Here is an example about coinsurance: You see a PPO physician who charges $150, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, with PCIP, you pay just 20% of our $100 allowance ($20). Because of the agreement, your PPO physician will not bill you for the $50 difference between our allowance and his/her bill.

- **Non-PPO providers**, on the other hand, have no agreement to limit what they will bill you. When you use a non-PPO provider, you will pay your deductible and coinsurance – plus any difference between our allowance and charges on the bill. Here is an example. You see a non-PPO physician who charges $150 and our allowance is again $100. Because you've met your deductible, you are responsible for your coinsurance, so with PCIP you pay 40% of our $100 allowance ($40). Plus, because there is no agreement between the non-PPO physician and us, the physician can bill you for the $50 difference between our allowance and his/her bill.

The following table illustrates the examples of how much you have to pay out-of-pocket, under the PCIP, for services from a PPO physician vs. a non-PPO physician. The table uses our example of a service for which the physician charges $150 and our allowance is $100. The table shows the amount you pay if you have met your calendar year deductible.

EXAMPLE	**PPO physician**	**Non-PPO physician**
Physician's charge	$150	$150
Our allowance	We set it at: 100	We set it at: 100
We pay	80% of our allowance: 80	60% of our allowance: 60
You owe: Coinsurance	20% of our allowance: 20	40% of our allowance: 40
+Difference up to charge?	No: 0	Yes: 50
TOTAL YOU PAY	$20	$90

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

PPO and Non-PPO

The calendar year catastrophic out-of-pocket limit for PPO providers is $5,950 in all three PCIP Plan Options. Once you reach this limit for PPO providers, additional covered PPO charges will be paid at 100%. The out-of-pocket limit for non PPO providers is $7,000. Once you reach this limit for non-PPO providers, additional covered non-PPO charges up to the Plan allowance will be paid at 100%.

Out-of-pocket expenses for this benefit are:

- The calendar year deductible 0 for covered services provided by PPO providers applies to the $5,950 limit and a separate calendar year deductible for covered services provided by non-PPO providers applies to the $7,000 limit;
- The 20% coinsurance you pay for PPO charges under medical services and supplies, surgical and anesthesia services and hospital, facility, ambulance services, mental health and substance abuse services; as well as all pharmacy expenses when in-network and by mail;
- The 40% coinsurance you pay for non-PPO charges under medical services and supplies, surgical and anesthesia services and hospital, facility and ambulance services, mental health and substance abuse services; and
- The $25 copayment for office visits to PPO primary care physicians and specialists.

The following cannot be counted toward catastrophic protection out-of-pocket expenses and you must continue to pay them even after your expenses exceed the limits described above;

- Expenses in excess of our allowable amount or maximum benefit limitations such as the amounts in excess of the chiropractic benefit;
- Expenses paid by the Plan for preventive care including well child care and immunizations;
- The difference between our allowance and the cost of drugs purchased at a non-network pharmacy;

- Non-preferred step therapy drugs are not a covered benefit;
- Any amounts you pay because benefits have been reduced for non-compliance with our cost containment requirements; and
- The difference between the cost of brand and generic multi-source drugs;

If we overpay you

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

Section 4. Pre-Existing Condition Insurance Plan (PCIP) Overview

The Pre-Existing Condition Insurance Plan (PCIP) has three plan options: a Standard Option, an Extended Option and an HSA-qualified High Deductible Health Plan (HDHP). The PCIP benefits are described in this Section. Make sure that you review the benefits that are available.

Please read *"Important things you should keep in mind about these benefits"* at the beginning of each subsection. Also, read the *General Exclusions* in Section 9, they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about PCIP benefits, contact us at (800) 220-7898 or at our Web site at www.pciplan.com.

- **Preventive care**

The Plan covers preventive care services from preferred providers, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., cancer screenings, cardiac screenings, and mammograms), well-child care, and child and adult immunizations. These services are covered at 100% if you use a network provider and the services are described in Section 7. *Preventive care*. Preventive care for children is covered at 100%. Y*ou do not have to meet the deductible before using these services.*

- **Medical coverage**

After you have paid the Plan's deductible, we pay benefits under medical coverage described in Section 8. The Plan typically pays 80% for in-network and 60% for out-of-network medical care.

Covered services include:

- Medical services and supplies provided by physicians and other health care professionals;
- Surgical and anesthesia services provided by physicians and other health care professionals;
- Hospital services; other facility or ambulance services;
- Emergency services/accidents;
- Mental health and substance abuse; and
- Prescription drug benefits.

- **Catastrophic protection for out-of-pocket expenses**

Your annual maximum for out-of-pocket expenses (deductibles and coinsurance) for covered services is limited to $5,950 for in-network/$7,000 out-of-network care. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 3, *Your catastrophic protection out-of-pocket maximum*, and Section 9, for more details.

- **Health education resources and account management tools**

Section 8(a) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

Section 5. Standard and Extended Option Overview

The Pre-Existing Condition Insurance Plan offers a choice of plan options. The Standard and Extended Options are traditional plans, but the HSA Option is an HSA-qualified high deductible health plan. Standard and Extended Option benefit packages are described in Section 8. Make sure that you review the benefits that are available under the option in which you are enrolled. The Standard and Extended Option Section 8 is divided into subsections. Please read *Important things you should keep in mind about these benefits* at the beginning of the subsections. Also read the General exclusions in Section 9, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about Standard and Extended Option benefits, contact us at (800) 220-7898 or at our Web site at www.pciplan.com.

Both options offer:

- Affordable premiums;
- No requirement to choose a single doctor as your primary physician;
- No referral needed to see a specialist;
- Freedom to choose any doctor with extra savings when you see a preferred provider;
- A separate prescription drug deductible to allow prescription coverage sooner;
- Low copays for generic prescription drugs; and
- Preventive Care covered at 100% when you see an in-network provider.

Section 6. HSA Option Overview

You have a choice of plans. The Standard and Extended Options are traditional insurance plans, but one plan is a non-traditional plan. The HSA Option is an HSA-qualified high-deductible health plan (HDHP). This Plan provides comprehensive coverage for high-cost medical events and prescription drugs with a tax-advantaged way to help you build savings for future medical expenses. The HSA Option gives you greater control over how you use your health care benefits. With this Plan, preventive care is covered in full if rendered by preferred providers and a preventive care diagnosis code is indicated. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described on page 24. To take the most advantage of your HDHP, you may want to consider a Health Savings Account (HSA). An HSA is optional. Please read the details below to understand how you might benefit from opening an HSA to work with your health plan.

Health Savings Accounts (HSA)

By law, HSAs are available to individuals enrolled in a high-deductible health plan (HDHP). To be eligible for an HSA, enrollees must not have other health coverage, including coverage through Medicare or a spouse's plan. Enrollees cannot be enrolled in either their own or their spouse's flexible spending account (FSA), unless it's one specifically designed to work with an HSA, and cannot have received VA medical benefits within the last three months.

A health savings account (HSA) is a tax-advantaged medical savings account. You may make tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law. See maximum contribution information on page 20. You can use funds in your HSA to help pay your health plan deductible and any medical expenses you incur after the deductible is met tax-free**.** You own your HSA, so the funds can go with you if you change plans or employment.

Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses. At a minimum, if you cannot make contributions to your HSA ahead of time, or on an ongoing basis, as you have to pay your deductible, it is a good idea to pay for your expenses by first contributing to your HSA account and paying out of the account; this way, you can still receive a tax deduction.

NOTE: It is important to have your HSA open immediately to ensure your expenses are eligible for the tax deduction as soon as you get your insurance plan.

HSA features include:

- Your contributions (money deposited) to the HSA are tax deductible;
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions;
- Your HSA earns tax-free interest;
- You can make tax-free withdrawals for qualified medical (see IRS publication 502 for a complete list of eligible expenses);
- Your unused HSA funds and interest accumulate from year to year;
- It's portable – the HSA is owned by you and is yours to keep, even when you leave the PCIP or retire; and
- When you need it, funds up to the actual HSA balance are available.

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in this PCIP with a Health Savings Account (HSA), and start or become covered by a HCFSA, you will not be qualified to make HSA contributions unless it is a limited FSA specially designed to work with an HSA. You can use a limited health care FSA only for eligible dental and vision expenses. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA.

If you would like more information about an HSA, please contact the HSA Bank™, an FDIC-insured HSA Trustee at P. O. Box 939, Sheboygan, WI 53082-0939, toll-free (877) 247-1325 or www.hsabank.com/pciphsa.

If you have an HSA

- **Eligibility**

You are eligible for an HSA if you have this plan and meet the following HSA eligibility criteria:

- Not covered by any health plan that is not a high deductible health plan (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage);
- Not enrolled in Medicare;
- Not have received VA benefits within the last three months;
- Not covered by your own or your spouse's flexible spending account (FSA); and
- Are not claimed as a dependent on someone else's tax return.

- **Benefits to an HSA**

You may use funds in your HSA to pay all or a portion of the annual deductible, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.

Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, although they are not covered by PCIP.

You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

If you enroll in an HSA, you may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.

You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Pre-Existing Condition Insurance Plan or switch to another plan.

- **Contributions**

All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account on a regular basis or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit, determined by your monthly eligibility for the HDHP. If you contribute, you can claim the amount you contributed for the year as a tax deduction when you file your income taxes. Your HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction).You receive tax advantages in any case. You have until April 15th of the following year to make HSA contributions for the current year.

- **Catch-up contributions**

If you are age 55 or older, the IRS permits you to make additional "catch-up" contributions to your HSA. The allowable catch-up contribution is $1,000. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury Web site at www.ustreas.gov/offices/public-affairs/hsa/.

- **If you die**

You should name a beneficiary for your account in the event of your death. If you do not have a named beneficiary, it becomes part of your taxable estate.

- **Qualified expenses**

You can pay for "qualified medical expenses" as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, LASIK surgery, and some nursing services.

When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA or be qualified for the Pre-Existing Condition Insurance Plan once you are enrolled in Medicare.

For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling (800) 829-3676, or visit the IRS Web site at www.irs.gov and click on "Forms and Publications." Note: Insurance premiums are reimbursable under limited circumstances.

- **Non-qualified expenses**

You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

- **Minimum reimbursements from your HSA**

You can request reimbursement in any amount. Just like a normal bank account, you cannot reimburse yourself for expenses that are greater than the balance in the account.

Section 7. Preventive care

Important things you should keep in mind about these benefits:

- The Plan pays for preventive care services listed in this Section as long as you use a network provider.
- 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.
- You do not need to satisfy the deductible for in-network (PPO) preventive care before coverage begins for this Section.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits only apply when an enrollee uses a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- When you use a PPO hospital, the professionals who provide services to you in a hospital may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers.
- Under medical coverage, you will be responsible for coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- **YOU MUST GET PRECERTIFICATION FOR CERTAIN OUTPATIENT IMAGING PROCEDURES. FAILURE TO DO SO WILL RESULT IN A MINIMUM OF $100 PENALTY**.

Benefits description	You pay
Preventive care, adult	**Standard, Extended and HSA Options**
- Professional services, such as: Age and gender appropriate preventive medical examination	PPO: Nothing Non-PPO: Covered under medical coverage subject to deductible
- Routine screenings, limited to: - Total blood cholesterol screenings - Chlamydial infection - Colorectal cancer screening, including Annual coverage of one fecal occult blood test for enrollees age 40 and older Sigmoidoscopy (surgeon and facility charges) Colonoscopy (surgeon and facility charges) - Prostate cancer screening Annual coverage of one PSA (Prostate Specific Antigen) test for men age 40 and older - Routine Pap test Annual coverage of one Pap smear for women age 18 and older - Routine mammogram Mammograms for diagnostic and/or routine screening - Osteoporosis screening Bone density tests for routine screening for women 65 or older or women 60 or older who are at increased risk - Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	PPO: Nothing Non-PPO: Covered under medical coverage subject to deductible

Preventive care, adult – continued on next page

Preventive care, adult *(continued)*	**You pay**
Not covered: - *Professional fees for automated lab tests* - *Separate charges of anesthesiologist for colonoscopy and upper endoscopy procedures, except for high-risk patients or patients over 60 years of age*	*All charges*
Preventive care, children	
For enrollees who are under age 18: - Well-child care charges for routine office visit examinations and lab screenings	PPO: Nothing Non-PPO: Covered under medical coverage subject to deductible
- Childhood immunizations recommended by the American Academy of Pediatrics	PPO: Nothing Non-PPO: Covered under medical coverage subject to deductible
Not covered: - *Professional fees for automated lab tests*	*All charges*

Section 8 (a). Medical services and supplies provided by physicians and other healthcare professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is $2,000 for In-Network and $3,000 for Out-of-Network under the Standard Option. The calendar year deductible is $1,000 for In-Network and $1,500 for Out-of-Network under the Extended Option. The calendar year deductible is $2,500 for In-Network and $3,000 for Out-of-Network under the HSA Option. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- When you use a PPO hospital, the professionals who provide services to you in a hospital may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers.
- **YOU MUST GET PRECERTIFICATION FOR CERTAIN OUTPATIENT IMAGING PROCEDURES. FAILURE TO DO SO WILL RESULT IN A MINIMUM OF $100 PENALTY.**

Benefits Description	You pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does *not* apply.		
Diagnostic and treatment services	**Standard and Extended Options**	**HSA Option**
Professional services of physicians - In physician's office - Routine physical examinations - Office medical consultations - Second surgical opinions	PPO: $25 copayment (No deductible) Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: $25 copay for office visits Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
- Emergency room physician care (non-accidental injury) - During a hospital stay - At home - Professional services of a physician at an urgent care facility	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Lab, X-ray and other diagnostic tests		
Tests, such as: - Blood tests - Urinalysis - Non-routine Pap tests - Pathology - X-rays, Ultrasound - Non-routine mammograms CAT Scans/MRI (outpatient requires precertification) - Double contrast barium enemas - Electrocardiogram and EEG	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges.

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

Lab, X-ray and other diagnostic tests *(continued)*	**You pay**	
	Standard and Extended Options	**HSA Option**
Not covered: - *Professional fees for automated lab tests*	*All charges*	*All charges*
Maternity care		
Complete maternity (obstetrical) care, such as: - Prenatal care - Delivery - Postnatal care - Physician care such as sonograms Note: Here are some things to keep in mind: - You do not need to precertify your normal delivery; however extended stays will require precertification. - You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary, but you must precertify. - PCIP will cover a newborn natural child born to a mother who is a PCIP member at the time of delivery, from the moment of that child's birth and for the next 30 days of that child's life. Coverage for any newborn natural child of a PCIP covered mother shall terminate at the end of that 30-day period, unless a separate PCIP enrollment application for the newborn is approved and enrolled with an effective date prior to the end of the temporary 30-day period after birth. - We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See *Hospital benefits* and *Surgery benefits*.	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Here are some things to keep in mind continued: - Approved fetal monitors, skilled nursing services, intravenous/infusion therapy, and injections are covered the same as other medical benefits for diagnostic and treatment services. Note: Maternity care expenses incurred by an enrollee serving as a surrogate mother are not covered by the Plan. Expenses of the newborn child are not covered under this or any other benefit in a surrogate mother situation.	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Maternity care – continued on next page

Maternity care *(continued)*	**You pay**	
	Standard and Extended Options	**HSA Option**
Not covered: - *Home uterine monitoring devices, unless preauthorized by our Medical Director* - *Charges 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 rape or incest* - *Charges for services and supplies incurred after termination of coverage* - *Maternity care expenses incurred by an enrollee serving as a surrogate mother are not covered by the Plan. Expenses of the newborn child are not covered under this or any other benefit in a surrogate mother situation.*	*All charges*	*All charges*
Family planning		
A range of voluntary family planning services, limited to: - Voluntary sterilizations (see *Surgical procedures*) - Surgically implanted contraceptives - Injectable contraceptive drugs (such as Depo provera) - Intrauterine devices (IUDs) - Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: - *Reversal of voluntary surgical sterilizations* - *Genetic counseling* - *Preimplantation genetic diagnosis (PGD)* - *Expenses for sperm collection and storage*	*All charges*	*All charges*
- Diagnosis and treatment of infertility except as shown under *Infertility services - Not covered:*	PPO: All charges Non-PPO: All charges	PPO: All charges Non-PPO: All charges
Infertility services		

Not covered:
- *Diagnosis and treatment of infertility*
- *Infertility services after voluntary sterilizations*
- *Fertility drugs*
- *Preimplantation genetic diagnosis (PGD)*
- *Assisted reproductive technology (ART) procedures, such as:*
  - *artificial insemination*
  - *in vitro fertilization*
  - *embryo transfer and gamete intrafallopian transfer (GIFT)*
  - *intravaginal insemination (IVI)*
  - *intracervical insemination (ICI)*
  - *intrauterine insemination (IUI)*
- *Services and supplies related to ART procedures*
- *Cost of donor sperm*
- *Cost of donor egg*
	All charges	*All charges*

Allergy care	You pay	
	Standard and Extended Options	HSA Option
- Testing and treatment, including materials (such as allergy serum) - Allergy testing is limited to $500 per calendar year - Allergy injections	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: - *Clinical ecology and environmental medicine* - *Provocative food testing and sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies		
- Outpatient cardiac or pulmonary rehabilitation - Chemotherapy and radiation therapy (precertification required) Note: High-dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under *Surgical and anesthesia services provided by physicians and other health care professionals.* - Dialysis – for non-Medicare eligible enrollees, hemodialysis and peritoneal (annual precertification required for each dialysis unit where services are provided) - Intravenous (IV)/Infusion Therapy in a provider's office. - Respiratory and inhalation therapies Note: Some medications required for treatment therapies may be available through Medco Pharmacy (mail order) or a Medco participating pharmacy. Medications obtained from these sources are covered under the *Prescription drug benefits, page 56*. Note: Please refer to *Specialty drug benefit, pages 28-29,* for benefits which apply to some categories of prescription drug treatment.	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount Dialysis provider designated by the Plan as a Medicare certified facility: 20% of the Plan allowance (must be precertified) All other dialysis providers: All charges	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount Dialysis provider designated by the Plan as a Medicare certified facility: 20% of the Plan allowance (must be precertified) All other dialysis providers: All charges
Not covered: - *Chelating therapy except for acute arsenic, gold or lead poisoning* - *Maintenance cardiac rehabilitation* - *Topical hyperbaric oxygen therapy* - *Prolotherapy* - *Dialysis (hemodialysis and peritoneal dialysis in non-Medicare certified facility)*	*All charges*	*All charges*

Specialty drug benefits	You pay	
	Standard and Extended Options	HSA Option
Specialty medications are those used to treat some severe, chronic medical conditions and are usually administered by injection or infusion including, but not limited to, those in the following categories: See ***Prescription drug benefits, page 56,*** for additional pharmacy related information. - Hemophilia factor products such as Helixate FS, Recombinate; - Blood growth factors such as Aranesp, Leukine, Neupogen, Procrit, Promacta; - Medications for hyperparathyroidism such as Sensipar; - Growth Hormone medications such as Genotropin, Humatrope, Nutropin; - Immunoglobulin preparations such as Gammagard, Gammar-P, Vivaglobin; - Psoriasis medications such as Amevive; - Multiple Sclerosis medications such as Avonex, Betaseron, Rebif, Tysabri, Copaxone; - Hepatitis medications such as Intron A, Pegasys, Peg-Intron, Copegus, Rebetol, Ribavirin, Ribapak, Ribasphere; - Rheumatoid arthritis medications such as Kineret, Orencia, Enbrel and Humira. These drugs may also be indicated for other conditions. - Pulmonary medications such as Synagis (for RSV), Xolair (asthma), Pulmozyme and Tobi/inhaled tobramycin (for cystic fibrosis); - Aldurazyme and Naglazyme to treat Mucopolysaccharidosis; - Cerezyme to treat Gaucher's Disease; - Exjade as a blood modifier to treat iron overload; - Osteoporosis drug such as Forteo; - AIDS/HIV drug such as Fuzeon; - Orfadin for Hereditary Tyrosinemia; - Acromegaly drugs such as Octreotide and Sandostatin; - Pulmonary hypertension drugs such as Remodulin, Flolan, Tracleer and Vantavis, Letairis and Revatio; - Osteo-arthritis medications such as Synvisc, Supartz, Orthovisc, Hyalgan, Euflexxa; - Ophthalmic medications such as Lucentis (for macular degeneration); - Cancer medications such as Afinitor, Gleevec, Hycamtin, Nexavar, Revlimid, Sprycel, Sutent, Tarceva, Tasigna, Temodar, Thalomid, Tykerb and Zolinza; - Kuvan for Phenylketonuria (PKU); - Cystadane for Homocystinuria; and - Xenazine for Huntington's chorea.	Medications dispensed by Medco Accredo Specialty Pharmacies (for up to a 30-day supply) Generic: 25% with maximum of $150 Formulary brands: 25% with maximum of $150 Non-formulary brands: 50% with maximum $300 Medications dispensed by Medco/Accredo Specialty Pharmacies (for up to a 90-day supply) Generic: 25% with maximum of $350 Formulary brands: 25% with maximum of $350 Non-formulary brands: 50% with maximum of $500 Multi-source brand: If you choose a brand name drug for which a generic drug exists, you will pay the generic co-pay and the difference between the cost of the brand name drug and the cost of the generic drug, unless your physician has provided clinical necessity for the brand name drug which will require preauthorization. When brand name drugs are approved over generic, your cost will be based on the brand name drug. Only the generic co-pay will apply to your deductible and out-of-pocket maximum. The difference between the cost of the brand name drug and the generic will not be applied to the deductible or annual out-of-pocket maximum.	Medications dispensed by Medco Accredo Specialty Pharmacies (for up to a 30-day supply) Generic: 25% with maximum of $150 Formulary brands: 25% with maximum of $150 Non-formulary brands: 50% with maximum $300 Medications dispensed by Medco/Accredo Specialty Pharmacies (for up to a 90-day supply) Generic: 25% with maximum of $350 Formulary brands: 25% with maximum of $350 Non-formulary brands: 50% with maximum of $500 Multi-source brand: If you choose a brand name drug for which a generic drug exists, you will pay the generic co-pay and the difference between the cost of the brand name drug and the cost of the generic drug, unless your physician has provided clinical necessity for the brand name drug which will require preauthorization. When brand name drugs are approved over generic, your cost will be based on the brand name drug. Only the generic co-pay will apply to your deductible and out-of-pocket maximum. The difference between the cost of the brand name drug and the generic will not be applied to the deductible or annual out-of-pocket maximum.

Specialty drug benefits – continued on next page

Specialty drug benefits *(continued)*	**You pay**	
	Standard and Extended Options	**HSA Option**
Drugs in these categories are subject to the *Specialty drug benefits*. The medication examples provided above are not all inclusive. Call our customer service department at (800) 220-7898 to determine if other medications not listed apply to this benefit. Note: Under the Standard and Extended Options, you receive prescription benefits after just meeting the prescription deductible. Some medications require pre-certification or preferred drug step therapy rules apply.	**Medications dispensed by other sources including physician offices, home health agencies, outpatient hospitals:** PPO: $300 copayment per prescription fill and 20% of the Plan allowance Non-PPO: $300 copayment per prescription fill and 40% of the Plan allowance The $300 copayment per prescription fill does not apply to the out-of-pocket maximum or your deductible. Note: A separate copayment applies per prescription fill up to a 30-day supply	**Medications dispensed by other sources including physician offices, home health agencies, outpatient hospitals:** PPO: $300 copayment per prescription fill and 20% of the Plan allowance Non-PPO: $300 copayment per prescription fill and 40% of the Plan allowance The $300 copayment per prescription fill does not apply to the out-of-pocket maximum or your deductible. Note: A separate copayment applies per prescription fill up to a 30-day supply

Specialty drug benefits – continued on next page

Specialty drug benefits *(continued)*	**You pay**	
	Standard and Extended Options	**HSA Option**
Non-Specialty Pharmacy retail purchase If Medco Specialty Pharmacies are not used and you purchase medications in the above categories through a retail pharmacy, you must submit your claim to: Medco P.O. Box 14711 Lexington, KY 40512 Reimbursement will be based on PCIP's costs had you used the Specialty Pharmacies. You must submit original drug receipts. Note: For specialty drugs purchased through the physician's office, home health agency, outpatient hospital, or non-participating retailer, the $300 copayment will not apply to the deductible or out-of-pocket maximum.	**Non-Specialty Pharmacy retail (for up to a 30-day supply)** Generic- $300 copayment per prescription fill and 25% of the cost of the drug. Formulary brands- $300 copayment per prescription filled and 25% of the cost of the drug. Non-formulary brands- $300 copayment per prescription fill and 50% of the cost of the drug. Multi-source brand: If you choose a brand name drug for which a generic drug exists, you will pay the generic co-pay and the difference between the cost of the brand name drug and the cost of the generic drug, unless your physician has provided clinical necessity for the brand name drug which will require preauthorization. When brand name drugs are approved over generic, your cost will be based on the brand name drug. Only the generic co-pay will apply to your deductible and out-of-pocket maximum. The difference between the cost of the brand name drug and the generic will not be applied to the deductible or annual out-of-pocket maximum. If you choose to purchase your specialty medication at a pharmacy other than Medco/Accredo, reimbursement will be based on the Plan's cost had you used the Specialty Pharmacy. The $300 copay plus any difference between our allowance and the cost of the drug will not be applied to the deductibles or out-of-pocket maximums for each 30-day supply.	**Non-Specialty Pharmacy retail (for up to a 30-day supply)** Generic- $300 copayment per prescription fill and 25% of the cost of the drug. Formulary brands- $300 copayment per prescription filled and 25% of the cost of the drug. Non-formulary brands- $300 copayment per prescription fill and 50% of the cost of the drug. Multi-source brand: If you choose a brand name drug for which a generic drug exists, you will pay the generic co-pay and the difference between the cost of the brand name drug and the cost of the generic drug, unless your physician has provided clinical necessity for the brand name drug which will require preauthorization. When brand name drugs are approved over generic, your cost will be based on the brand name drug. Only the generic co-pay will apply to your deductible and out-of-pocket maximum. The difference between the cost of the brand name drug and the generic will not be applied to the deductible or annual out-of-pocket maximum. If you choose to purchase your specialty medication at a pharmacy other than Medco/Accredo, reimbursement will be based on the Plan's cost had you used the Specialty Pharmacy. The $300 copay plus any difference between our allowance and the cost of the drug will not be applied to the deductibles or out-of-pocket maximums for each 30-day supply.

Physical and occupational therapies	You pay	
	Standard and Extended Options	**HSA Option**

- 60 visits per calendar year for the combined services of the following: (One visit is two hours or less of physical or occupational therapy.)
  - qualified physical therapists and
  - qualified occupational therapists
All physical and occupational therapy visits require preauthorization. Please make an evaluation visit then contact OrthoNet by phone at (877) 304-4399 or fax to (877) 304-4398 a copy of the evaluation to OrthoNet. Authorizations will be provided in blocks of time and progress reviewed prior to additional authorizations.
Authorizations for physical and occupational therapy are based on medical necessity. In order to make individual-specific authorization decisions, OrthoNet will review the treating provider's evaluation; including diagnosis, duration of enrollee's symptoms (chronic vs. acute), nature or severity of symptoms, timeframes for anticipated recovery or clinical milestones, measurements of joint motion or from standardized tools specific to the condition or affected body part (Simple Shoulder Test, HSS Knee Score, Oswestry, and DASH), and rehab potential. OrthoNet's on-going therapy management is concurrent and based on progress made in therapy.
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 and when a physician:
  - orders the care
  - identifies the specific professional skills the patient requires and the medical necessity for skilled services
  - indicates the length of time the services are needed
	PPO: 20% of the Plan allowance
	Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
		PPO: 20% of the Plan allowance
		Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Not covered: - *Exercise programs* - *Long-term rehabilitative therapy* - *Hot and cold packs* - *Physical and occupational therapy we have not precertified*	*All charges*	*All charges*
Speech therapy		

- 30 visits per calendar year for the services of a qualified speech therapist: (One visit is two hours or less of speech therapy.)
Note: We only cover speech therapy when a physician:
  - orders the care
  - identifies the specific professional skills the patient requires and the medical necessity for skilled services
  - indicates the length of time the services are needed
	PPO: 20% of the Plan allowance
	Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
		PPO: 20% of the Plan allowance
		Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Speech therapy – continued on next page

Speech therapy *(continued)*	**You pay**	
	Standard and Extended Options	**HSA Option**
All speech therapy visits require preauthorization. Please make an evaluation visit, then contact OrthoNet by phone at (877) 304-4399 or fax to (877) 304-4398 a copy of the evaluation to OrthoNet. Authorizations will be provided in blocks of time and progress reviewed prior to additional authorizations. To precertify speech therapy in Georgia contact Coventry at (800) 470-2004. In North and South Carolina contact WellPath at (800) 708-9355. In Pennsylvania contact HAPA at (800) 755-1135. Authorization for speech therapy is based on medical necessity. In order to make individual-specific authorization decisions, OrthoNet will review the treating provider's evaluation; including diagnosis, duration of enrollee's symptoms, nature or severity of symptoms, timeframes for anticipated recovery or clinical milestones, and rehab potential. OrthoNet's on-going therapy management is concurrent and based on progress made in therapy. Note: When you receive medically necessary speech therapy on an outpatient basis from a qualified speech therapist at a skilled nursing facility, your therapy is covered up to Plan limits.	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: - *Computer devices to assist with communications* - *Computer programs of any type, including but not limited to those to assist with speech therapy* - *Speech therapy we have not precertified*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)		
- Diagnostic hearing tests performed by a M.D., D.O. or audiologist	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: - *Hearing aids, testing and examinations for them*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)		
First pair of contact lenses or standard ocular implant lenses if required to correct an impairment existing after intraocular surgery or accidental injury	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Vision services – continued on next page

Vision services (testing, treatment, and supplies) *(continued)*	**You pay**	
	Standard and Extended Options	**HSA Option**
Not covered: - *Computer programs of any type, including but not limited to those to assist with vision therapy* - *Vision therapy* - *Eyeglasses or contact lenses and examinations for them except as shown above* - *Radial keratotomy and other refractive surgery* - *Special multifocal ocular implant lenses*	*All charges*	*All charges*
Foot care		
- Routine foot care only when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	PPO: $25 copay for office visits to primary care physicians and specialists plus 20% of the Plan allowance for other services performed during the visit Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: $25 copay for office visits to primary care physicians and specialists plus 20% of the Plan allowance for other services performed during the visit Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: - *Cutting, trimming of toenails or removal of corns, calluses, or similar routine treatment of conditions of the* foot, except as stated above	*All charges*	*All charges*
Orthopedic and prosthetic devices		
- 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 *Surgical and anesthesia services provided by physicians and other health care professionals*; for coverage of the surgery to insert the device. Note: We will pay only for the cost of the standard item. Coverage for specialty items such as bionics is limited to the cost of the standard item.	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: - *Orthopedic and corrective shoes* - *Arch supports* - *Foot orthotics* - *Heel pads and heel cups* - *Diabetic shoes* - *Bioelectric, computer programmed prosthetic devices*	*All charges*	*All charges*

Durable medical equipment (DME)	You pay	
	Standard and Extended Options	**HSA Option**
Durable medical equipment (DME) is equipment and supplies that: - Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury) - Are medically necessary - Are primarily and customarily used only for a medical purpose - Are generally useful only to a person with an illness or injury - Are designed for prolonged use - Serve a specific therapeutic purpose in the treatment of an illness or injury We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: - Oxygen - Dialysis equipment - Hospital beds - Wheelchairs - Crutches - Walkers All durable medical equipment, rental or purchased requires precertification. Note: Call us at (800) 220-7898 as soon as your physician prescribes this equipment. We assist you in finding an approved designated health care provider to deliver durable medical equipment for rental or purchase at discounted rates and will tell you more about this service when you call. Note: We will pay only for the cost of the standard item. Coverage for specialty equipment such as all-terrain wheelchairs is limited to the cost of the standard equipment.	Provider designated by the Plan as your DME provider: 20% of the Plan allowance (must be precertified) All other providers: *All charges*	Provider designated by the Plan as your DME provider: 20% of the Plan allowance (must be precertified) All other providers: *All charges*
Not covered: - *Computer devices to assist with communications* - *Computer programs of any type* - *Air purifiers, air conditioners, heating pads, cold therapy units, whirlpool bathing equipment, sun and heat lamps, exercise devices (even if ordered by a doctor), and other equipment that does not meet the definition of durable medical equipment* - *Lifts, such as seat, chair or van lifts* - *Wigs* - *Bone stimulators except for established non-union fractures* - *Services and supplies not obtained from a plan designated provider* - *Services and supplies that are not precertified*	*All charges*	*All charges*

Skilled nursing care	You pay	
	Standard and Extended Options	HSA Option
25 in-home visits per calendar year, not to exceed one visit up to two hours per day when: - A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services - The attending physician orders the care - The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services - The physician indicates the length of time the services are needed Covered services are based on our review for medical necessity (requires precertification). Note: Call us at (800) 220-7898 as soon as your physician prescribes skilled nursing care. We will assist you in finding an approved designated health care provider for skilled nursing care at discounted rates and will tell you more about this service when you call. Please refer to the Specialty drug benefits for information on benefits for home infusion therapies.	Provider designated by the Plan as your skilled nursing care provider: 20% of the Plan allowance (must be precertified) All other providers: *All Charges*	Provider designated by the Plan as your skilled nursing care provider: 20% of the Plan allowance (must be precertified) All other providers: *All charges*
Not covered: - *Nursing care requested by, or for the convenience of, the patient or the patient's family* - *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* - *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* - *Custodial care* - *Services or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption* - *Inpatient private duty nursing* - *Skilled nursing care not obtained from designated providers.*	*All charges*	*All charges*
Chiropractic		
Chiropractic services limited to: - 12 visits per calendar year for manipulation of the spine - X-rays, used to detect and determine nerve interferences due to spinal subluxations or misalignments - $25 per calendar year for chiropractic X-rays	PPO and Non-PPO: All charges in excess of $20 per visit All charges in excess of $25 for X-rays of the spine Note: Visits and charges exceeding these amounts are not applied toward the calendar year deductible.	PPO and Non-PPO: All charges in excess of $20 per visit All charges in excess of $25 for X-rays of the spine Note: Visits and charges exceeding these amounts are not applied toward the calendar year deductible.

Chiropractic - continued on next page

Chiropractic *(continued)*	**You pay**	
	Standard and Extended Options	**HSA Option**
Chiropractic services limited to: Note: No other benefits for the services of a chiropractor are covered under any other provision of this Plan. In medically underserved areas, services of a chiropractor that are listed above are subject to the stated limitations. In medically underserved areas, services of a chiropractor that are within the scope of his/her license and are not listed above are eligible for regular Plan benefits.	PPO and Non-PPO: All charges in excess of $20 per visit All charges in excess of $25 for X-rays of the spine Note: Visits and charges exceeding these amounts are not applied toward the calendar year deductible.	PPO and Non-PPO: All charges in excess of $20 per visit All charges in excess of $25 for X-rays of the spine Note: Visits and charges exceeding these amounts are not applied toward the calendar year deductible.
Not covered: - *Any treatment not specifically listed as covered* - *Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application*	*All charges*	*All charges*
Alternative treatments		
Acupuncture: - Benefits are limited to 20 procedures per calendar year for medically necessary acupuncture treatments if performed by a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.) Christian Science Practitioners: - Benefits are limited to 50 sessions per calendar year - Christian Science Facilities: - Nursing care and room and board in a facility accredited by the Commission for Accreditation of Christian Science Nursing Organizations up to 30 days per year.	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: - *All other alternative treatments, including clinical ecology and environmental medicine* - *Any treatment not specifically listed as covered* - *Naturopathic services* - *(Note: Benefits of certain alternative treatment providers may be covered in medically underserved areas; see page 9.)*	*All charges*	*All charges*
Educational classes and programs		
Coverage is limited to: - Smoking Cessation – We cover counseling sessions for smoking cessation including proactive telephone counseling, group counseling and individual counseling. Benefits are payable for up to two attempts per year, with up to four counseling sessions per attempt.	PPO: $25 copay Non-PPO: 40% and any difference between our Plan allowance and the billed amount	PPO: $25 copay Non-PPO: 40% and any difference between our Plan allowance and the billed amount

Educational classes and programs - continued on next page

Educational classes and programs *(continued)*	**You pay**	
	Standard and Extended Options	**HSA Option**
Coverage is limited to: *(continued)* - In addition, we cover over-the-counter and prescription smoking cessation drugs approved by the FDA. The quantity of drugs reimbursed will be subject to recommended courses of treatment.	PPO: $25 copay Non-PPO: 40% and any difference between our Plan allowance and the billed amount	PPO: $25 copay Non-PPO: 40% and any difference between our Plan allowance and the billed amount
- Diabetes Education – Provided by Certified Diabetes Educators or physician through a program certified by the American Diabetes Association up to $250 per person, per calendar year	PPO: All charges in excess of $250 (No deductible) Non-PPO: All charges in excess of $250 (No deductible)	PPO: All charges in excess of $250 (No deductible) Non-PPO: All charges in excess of $250 (No deductible)

Section 8(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.
- The calendar year deductible is $2,000 for In-Network and $3,000 for Out-of-Network under the Standard Option. The calendar year deductible is $1,000 for In-Network and $1,500 for Out-of-Network under the Extended Option. The calendar year deductible is $2,500 for In-Network and $3,000 for Out-of-Network under the HSA Option. The calendar year deductible applies to all benefits in this Section. Non-covered charges and charges in excess of the Plan allowable do not count towards the deductible.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care.
- When you use a PPO hospital, the professionals who provide services to you in a hospital may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers.
- **YOU MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.**

Benefits Description	You pay After the calendar year deductible…	
Note: The calendar year deductible applies to all benefits in this Section.		
Surgical procedures	**Standard and Extended Options**	**HSA Option**

A comprehensive range of services, such as:
- 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 - limited to children under the age of 18 unless there is a functional deficit (see *Reconstructive surgery*)
- Surgical treatment of obesity (bariatric surgery) is covered only if:
  - eligible enrollee is 18 or over
  - clinical records support a body mass index of 40 or greater (or 35-40 when there is a co-morbid condition such as life-threatening cardiopulmonary problems or severe diabetes mellitus) for a period of six months
  - documentation of failure to lower the body mass index by a medically supervised program within the last twelve months of diet and exercise of at least six months duration
	PPO: 20% of the Plan allowance
	Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
		PPO: 20% of the Plan allowance
		Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures continued on next page

Surgical procedures *(continued)*	**You pay**	
	Standard and Extended Options	**HSA Option**

A comprehensive range of services - *continued*
 	
Note: Benefits are payable only for bariatric surgery which meets the above criteria and is performed at centers certified as "well qualified" by Centers for Medicare and Medicaid Services (CMS). Bariatric surgery must be precertified.
- Insertion of internal prosthetic devices (see Section 8(a) *Orthopedic and prosthetic devices* for device coverage information)
- Voluntary sterilization (e.g., Tubal ligation, Vasectomy)
- Surgically implanted contraceptives
- Intrauterine devices (IUDs)
- Treatment of burns
- Assistant surgeons are covered up to 20% of our allowance for the surgeon's charge for procedures when it is medically necessary to have an assistant surgeon. Registered nurse first assistants and certified surgical assistants are covered up to 15% of our allowance for the surgeon's charge for the procedure if medically necessary to have an assistant surgeon.
 	
Note: Post-operative care is considered to be included in the fee charged for a surgical procedure by a doctor. Any additional fees charged by a doctor are not covered unless such charge is for an unrelated condition.
 	
When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are:
- For the primary procedure based on:
  - Full Plan allowance
- For the secondary and subsequent procedures based on:
  - One-half of the Plan allowance
 	
Note: Multiple or bilateral surgical procedures performed through the same incision are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.
	PPO: 20% of the Plan allowance
	
	Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
		PPO: 20% of the Plan allowance
		
		Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Not covered: - *Reversal of voluntary sterilization* - *Services of a standby physician or surgeon* - *Routine treatment of conditions of the foot; see Foot care* - *Surgical treatment of hyperhidrosis unless alternative therapies such as botox injections or topical aluminum chloride and pharmacotherapy have been unsuccessful*	*All charges*	*All charges*

Reconstructive surgery	You pay	
	Standard and Extended Options	**HSA Option**

- Surgery to correct a functional defect
- Surgery to correct a condition caused by injury or illness if:
  - the condition produced a major effect on your 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 – limited to children under the age of 18 unless there is a functional deficit. Examples of congenital anomalies are: cleft lip; cleft palate; birth marks; and webbed fingers and toes.
- All stages of breast reconstruction surgery following a mastectomy, such as:
  - surgery to produce a symmetrical appearance of breasts
  - treatment of any physical complications, such as lymphedemas
  - breast prostheses; and surgical bras and replacements (see Section 8(a) *Orthopedic and Prosthetic devices* for coverage)
Note: We pay for internal breast prostheses as hospital benefits if billed by a hospital. If included with the surgeon's bill, surgery benefits will apply.
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.
	PPO: 20% of the Plan allowance
	Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
		PPO: 20% of the Plan allowance
		Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Not covered: - *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 if repair is initiated promptly or as soon as the enrollee's condition permits* - *Surgeries related to sex transformation or sexual dysfunction* - Surgeries to correct congenital *anomalies for individuals age 18 and older unless there is a functional deficit* - *Charges for photographs to document physical conditions*	*All charges*	*All charges*
Oral and maxillofacial surgery		
Oral surgical procedures, limited to: - Reduction of fractures of the jaws or facial bones - Surgical correction of cleft lip, cleft palate - Excision of cysts and incision of abscesses unrelated to tooth structure - Extraction of impacted (unerupted or partially erupted) teeth	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Oral and maxillofacial procedures continued on next page

Oral and maxillofacial surgery *(continued)*	**You pay**	
	Standard and Extended Options	**HSA Option**

Oral surgical procedures, limited to: *(continued)*
- Alveoloplasty, partial or radical removal of the lower jaw with bone graft
- Excision of tori, tumors, leukoplakia, premalignant and malignant lesions, and biopsy of hard and soft oral tissues
- Open reduction of dislocations and excision, manipulation, aspiration or injection of temporomandibular joints
- Removal of foreign body, skin, subcutaneous areolar tissue, reaction-producing foreign bodies in the musculoskeletal system and salivary stones and incision/excision of salivary glands and ducts
- Repair of traumatic wounds
- Incision of the sinus and repair of oral fistulas
- Surgical treatment of trigeminal neuralgia
- Repair of accidental injury to sound natural teeth such as: expenses for X-rays, drugs, crowns, bridgework, inlays and dentures. Masticating (biting or chewing) incidents are not considered to be accidental injuries. Accidental dental injury is covered at 100% for charges incurred within 72 hours of an accident (see page 51).
- Orthognathic surgery for the following conditions:
  - severe sleep apnea only after conservative treatment of sleep apnea has failed
  - cleft palate and Pierre Robin Syndrome
  - Orthognathic surgery for any other condition is not covered
- Other oral surgery procedures that do not involve the teeth or their supporting structures
	PPO: 20% of the Plan allowance
	
	Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
		PPO: 20% of the Plan allowance
		
		Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Not Covered: - *Oral implants and transplants* - *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* - *Orthodontic treatment* - *Any oral or maxillofacial surgery not specifically listed as covered* - *Orthognathic surgery, except as outlined above for severe sleep apnea, cleft palate and Pierre Robin Syndrome (even if necessary because of TMJ dysfunction or disorder)* - *Repair of accidental injury to teeth*	*All charges*	*All charges*

Organ/tissue transplants	You pay	
	Standard and Extended Options	HSA Option

Solid organ transplants limited to:
- Cornea
- Heart
- Heart/lung
- Intestinal transplants
  - Small intestine
  - Small intestine with the liver
  - Small intestine with multiple organs, such as the liver, stomach, and pancreas
- Kidney
- Liver
- Single, double or lobar lung
- Pancreas
Blood or marrow stem cell transplants limited to the stages of the following diagnoses (medical necessity is considered satisfied if the patient meets the staging description).
- Allogeneic transplants for
  - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia
  - Advanced Hodgkin's lymphoma
  - Advanced non-Hodgkin's
  - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)
  - Marrow Failure and Related Disorders (i.e., Fanconi's, PNH, pure red cell aplasia)
  - Chronic myelogenous leukemia
  - Hemoglobinopathy
  - Myelodysplasia/Myelodysplastic syndromes
  - Severe combined immunodeficiency
  - Severe or very severe aplastic anemia
  - Amyloidosis
  - Paroxysmal Nocturnal Hemoglobinuria
- Autologous transplants for
  - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia
  - Advanced Hodgkin's lymphoma
  - Advanced non-Hodgkin's lymphoma
  - Neuroblastoma
  - Amyloidosis
- Autologous tandem transplants for
  - Multiple myeloma (de novo and treated)
  - Recurrent germ cell tumors (including testicular cancer)
  - Denovo myeloma
	PPO: 20% of the Plan allowance
	
	Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
		PPO: 20% of the Plan allowance
		
		Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	**You pay**	
	Standard and Extended Options	**HSA Option**

Blood or marrow stem cell transplants for:
- Allogeneic transplants for
  - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)
  - Advanced neuroblastoma
  - Infantile malignant osteopetrosis
- Autologous transplants for
  - Multiple myeloma
  - Testicular, mediastinal, retroperitoneal and ovarian germ cell tumors,
  - Breast cancer
  - Epithelial ovarian cancer
  - Waldenstrom's macroglobulinemia
Mini-transplants (non-myeloablative, reduced intensity conditioning) for Covered transplants. Subject to medical necessity:
Tandem transplants for covered transplants: Subject to medical necessity.
We will cover donor search testing services for up to four potential donors for bone marrow or stem cell transplants.
	PPO: 20% of the Plan allowance
	Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
		PPO: 20% of the Plan allowance
		Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Note: We cover related medical and hospital expenses of the donor when we cover the recipient. Note: All allowable charges incurred for a surgical transplant, whether incurred by the recipient or donor will be considered expenses of the recipient and will be covered the same as for any other illness or injury subject to the limits stated below. This benefit applies only if the recipient is covered by us and if the donor's expenses are not otherwise covered.		
Transportation Benefit - We will also provide up to $10,000 per covered transplant for transportation (mileage or airfare) to a Plan Designated Facility and reasonable temporary living expenses (i.e., lodging and meals) for the recipient and one other individual (or in the case of a minor, two other individuals), if the recipient lives more than 100 miles from the designated transplant facility. - Transportation benefits are payable for follow-up care up to one year following the transplant. The transportation benefit is not available for cornea or kidney transplants. You must contact the Plan for what are considered reasonable and temporary living expenses.	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	**You pay**	
	Standard and Extended Options	**HSA Option**
Limited Benefits - The process for preauthorizing organ transplants is more extensive than the normal precertification process. Before your initial evaluation as a potential candidate for a transplant procedure, you or your doctor must contact the Plan's Medical Director so we can arrange to review the clinical results of the evaluation and determine if the proposed procedure meets our definition of "medically necessary" and is on the list of covered transplants. Coverage for the transplant must be authorized in advance, in writing by our Medical Director. (Cornea and kidney transplants do not require preauthorization by the Plan's Medical Director.)		
- We will pay for a second transplant evaluation recommended by a physician qualified to perform the transplant, if: the transplant diagnosis is covered and the physician is not associated or in practice with the physician who recommended and will perform the organ transplant. A third transplant evaluation is covered only if the second evaluation does not confirm the initial evaluation. - The transplant must be performed at a Plan-designated organ transplant facility to receive maximum benefits. GEHA uses a defined transplant network, which may be different than the Preferred Provider Network. - If benefits are limited to $100,000 per transplant, included in the maximum are all charges for hospital, medical and surgical care incurred while the patient is hospitalized for a covered transplant surgery and subsequent complications related to the transplant. Outpatient expenses for chemotherapy and any process of obtaining stem cells or bone marrow associated with bone marrow transplant (stem cell support) are included in benefits limit of $100,000 per transplant. Tandem bone marrow transplants approved as one treatment protocol are limited to $100,000 when not performed at a Plan Designated Facility. All treatment within 120 days following the transplant are subject to the $100,000 limit except expenses for aftercare such as outpatient prescription drugs are not a part of the $100,000 limit.	PPO: $25 copayment to primary care physicians and specialists. Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount If prior approval is not obtained or a Plan-designated organ transplant facility is not used, our allowance will be limited for hospital and surgery expenses up to a maximum of $100,000 per transplant. If we cannot refer an enrollee in need of a transplant to a designated facility, the $100,000 maximum will not apply.	PPO: $25 copayment to primary care physicians and specialists. Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount If prior approval is not obtained or a Plan-designated organ transplant facility is not used, our allowance will be limited for hospital and surgery expenses up to a maximum of $100,000 per transplant. If we cannot refer an enrollee in need of a transplant to a designated facility, the $100,000 maximum will not apply.
- Chemotherapy and procedures related to bone marrow transplantation must be performed only at a Plan-designated organ transplant facility to receive maximum benefits. - Simultaneous transplants such as kidney/pancreas, heart/lung, heart/liver are considered as one transplant procedure and are limited to $100,000 when not performed at a Plan-designated organ transplant facility.	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Organ/tissue transplants *(continued)*	**You pay**	
	Standard and Extended Options	**HSA Option**
Not covered: - *Services or supplies for or related to surgical transplant procedures (including administration of high-dose chemotherapy) for artificial or human organ/tissue transplants not listed as specifically covered* - *Donor screening tests and donor search expenses, except those listed above* - *Expenses for sperm collection and storage*	*All charges*	*All charges*
Anesthesia		
Professional fees for the administration of anesthesia in: - Hospital (inpatient) - Hospital outpatient department - Ambulatory surgical center - Office	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits
Not covered: - *Separate charges of anesthesiologist for colonoscopy and upper endoscopy procedures, except for high risk patients or patients over 60 years of age*	*All charges*	*All charges*

Section 8(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.
- The calendar year deductible is $2,000 for In-Network and $3,000 for Out-of-Network under the Standard Option. The calendar year deductible is $1,000 for In-Network and $1,500 for Out-of-Network under the Extended Option. The calendar year deductible is $2,500 for In-Network and $3,000 for Out-of-Network under the HSA Option. The calendar year deductible applies to all benefits in this Section. Non-covered charges and charges in excess of the Plan allowable do not count towards the deductible.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- 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.
- When you use a PPO hospital, the professionals who provide services to you in a hospital may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers.
- Charges billed by a facility for implantable devices, surgical hardware, etc., are subject to the Plan allowance which is based on the provider's cost plus a reasonable handling fee. Providers are encouraged to notify us on admission to determine benefits payable.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.**

Benefits Description	You pay	
Inpatient hospital	**Standard and Extended Options**	**HSA Option**
Room and board, such as: - Ward, semiprivate, or intensive care accommodations - General nursing care - Meals and special diets Note: We only cover a private room if we determine it to be medically necessary. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. The remaining balance is not a covered expense. If the hospital only has private rooms, we will cover the private room rate. Note: When the hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges. Other hospital services and supplies, such as: - Operating, recovery 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.	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Inpatient hospital - continued on next page

Inpatient hospital *(continued)*	**You pay**	
	Standard and Extended Options	**HSA Option**
Note: We base payment on whether the facility or a health-care professional bills for the services or supplies. For example, when the hospital bills for its nurse anesthetists' services, we pay Hospital benefits and when the anesthesiologist bills, we pay Surgery benefits.		
Maternity care – inpatient hospital Room and board, such as: - Ward, semiprivate, or intensive care accommodations - General nursing care - Meals and special diets Note: Here are some things to keep in mind: - You do not need to precertify your normal delivery; however extended stays will require precertification. - You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary, but you must precertify. Other hospital services and supplies, such as: - Delivery room, recovery, and other treatment rooms - Prescribed drugs and medicines - Diagnostic laboratory tests and X-rays - Blood or blood plasma, if not donated or replaced - Dressings 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 (Note: Calendar year deductible applies.) - PCIP will cover a newborn natural child to a mother who is a PCIP enrollee at the time of delivery, from the moment of that child's birth and for the next 30 days of that child's life. Coverage for any newborn natural child shall terminate at the end of that 30-day period, unless s separate PCIP enrollment application for the newborn is approved and enrolled with an effective date prior to the end of the temporary 30-day period after birth.	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: - *Any part of a hospital admission that is not medically necessary (see definition), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting.* - *Custodial care; see definition*		

Inpatient hospital - continued on next page

Inpatient hospital *(continued)*	**You pay**	
	Standard and Extended Options	**HSA Option**
Not covered: (continued) - *Non-covered facilities, such as nursing homes, schools* - *Personal comfort items, such as telephone, television, barber services, guest meals and beds* - *Private nursing care* - *Maternity care expenses incurred by an enrollee serving as a surrogate mother are not covered by the Plan. Expenses of the newborn child are not covered under this or any other benefit in a surrogate mother situation.*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center		
- 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 or blood plasma, if not donated or replaced - Pre-surgical testing - Dressings, splints, casts, and sterile tray services - Anesthetics and anesthesia service - Cardiac or pulmonary rehabilitation Note: Please refer to *Specialty drug benefits* for information on benefits for Specialty Pharmacy medications dispensed by hospitals. 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.	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: - *Maintenance cardiac rehabilitation*	*All charges*	*All charges*
Maternity Care – Outpatient Hospital - Delivery room, recovery, and other treatment rooms - Prescribed drugs and medicines - Diagnostic laboratory tests and X-rays, and pathology services - Administration of blood, blood plasma, and other biologicals - Blood or blood plasma, if not donated or replaced - Pre-surgical testing - Dressings and sterile tray services - Medical supplies, including oxygen - Anesthetics and anesthesia service	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Outpatient hospital or ambulatory surgical center - continued on next page

Outpatient hospital or ambulatory surgical center *(continued)*	**You pay**	
	Standard and Extended Options	**HSA Option**
Maternity care – outpatient hospital *(continued)* Note: Maternity care expenses incurred by an enrollee serving as a surrogate mother are not covered by this Plan. Expenses of the newborn child are not covered under this or any other benefit in a surrogate mother situation.		
Extended care benefits/skilled nursing care facility benefits		
- Inpatient confinement at a Skilled Nursing Facility for the first 14 days following transfer from acute inpatient confinement when skilled care is still required. Benefits limited to $700 per day. No other benefits are payable for inpatient skilled nursing facility charges (requires precertification).	Charges in excess of $700 per day. All charges after 14 days	Charges in excess of $700 per day. All charges after 14 days
Hospice care		
Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan-approved independent hospice administration. - We pay up to $15,000 for hospice care provided in an outpatient setting or for room, board, and care while receiving hospice care in an inpatient setting. Services may include a combination of inpatient and outpatient care up to a maximum of $15,000. These benefits paid if the hospice care program begins after a person's primary doctor certifies terminal illness and life expectancy of six months or less and any services or inpatient hospice stay that is part of the program is: - Provided while the person is covered by this Plan - Ordered by the supervising doctor - Charged by the hospice care program - Provided within six months from the date the person entered or re-entered (after a period of remission) a hospice care program Remission is the halt or actual reduction in the progression of illness resulting in discharge from a hospice care program with no further expenses incurred. A readmission within three months of a prior discharge is considered as the same period of care. A new period begins after three months from a prior discharge with maximum benefits available.	PPO: Nothing up to the Plan limits (calendar year deductible applies) Non-PPO: Nothing up to the Plan limits (calendar year deductible applies)	PPO: Nothing up to the Plan limits (calendar year deductible applies) Non-PPO: Nothing up to the Plan limits (calendar year deductible applies)
Not covered: - *Charges incurred during a period of remission, charges incurred for treatment of a sickness or injury of an enrollee that are covered under another plan provision, charges incurred for services rendered by a close relative, bereavement counseling, funeral arrangements, pastoral counseling, financial or legal counseling, homemaker or caretaker services*	*All charges*	*All charges*

Ambulance – accidental injury	**You pay**	
	Standard and Extended Options	**HSA Option**
Local ambulance service (within 100 miles) to the first hospital where treated, from that hospital to the next nearest one if necessary treatment is unavailable or unsuitable at the first hospital, then to either the home (if ambulance transport is medically necessary) or other medical facility (if required for the patient to receive necessary treatment and if ambulance transport is medically necessary).	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Air ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation. Air ambulance will not be covered if transport is beyond the nearest available suitable facility, but is requested by patient or physician for continuity of care or other reasons.	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: - *Transportation by ambulance is not covered when the patient does not require the assistance of medically trained personnel and can be safely transferred (or transported) by other means*	*All charges*	*All charges*

Section 8(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.
- The calendar year deductible is $2,000 for In-Network and $3,000 for Out-of-Network under the Standard Option. The calendar year deductible is $1,000 for In-Network and $1,500 for Out-of-Network under the Extended Option. The calendar year deductible is $2,500 for In-Network and $3,000 for Out-of-Network under the HSA Option. The calendar year deductible applies to all benefits in this Section. Non-covered charges and charges in excess of the Plan allowable do not count towards the deductible.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- When you use a PPO hospital, the professionals who provide services to you in a hospital may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers.

What is an accidental injury?

An accidental injury is a bodily injury sustained solely through violent, external, and accidental means, such as broken bones, animal bites, and poisonings.

Benefits Description	You pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does *not* apply.		
Accidental injury	**Standard and Extended Options**	**HSA Option**
We cover: - Treatment outside a hospital or in the outpatient/emergency room department of a hospital or urgent care facility - Related outpatient physician care Note: Emergency room charges associated directly with an inpatient admission are considered “Other charges” under inpatient hospital benefits.	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Medical emergency		
- Outpatient medical or surgical services and supplies billed by a hospital, for emergency room treatment or outpatient medical or surgical services and supplies billed by an urgent care facility. Note: We pay hospital benefits if you are admitted.	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Ambulance	You pay	
	Standard and Extended Options	HSA Option
- Local ambulance service (within 100 miles) to the first hospital where treated, from that hospital to the next nearest one if necessary treatment is unavailable or unsuitable at the first hospital, then to either the home (if ambulance transport is medically necessary) or other medical facility (if required for the patient to receive necessary treatment and if ambulance transport is medically necessary). - Air ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation. Air ambulance will not be covered if transport is beyond the nearest available suitable facility, but is requested by patient or physician for continuity of care or other reasons.	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: - *Transportation by ambulance is not covered when the patient does not require the assistance of medically trained personnel and can be safely transferred (or transported) by other means*	*All charges*	*All charges*

Section 8(e). Mental health and substance abuse benefits

The enrollee may choose to get care In-Network or Out-of-Network. When the enrollee receives In-Network care, the enrollee must get the Plan's approval for services and follow an approved treatment plan. If the enrollee gets the Plan's approval for services, cost sharing and limitations for In-Network 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, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is $2,000 for In-Network and $3,000 for Out-of-Network under the Standard Option. The calendar year deductible is $1,000 for In-Network and $1,500 for Out-of-Network under the Extended Option. The calendar year deductible is $2,500 for In-Network and $3,000 for Out-of-Network under the HSA Option. The calendar year deductible applies to all benefits in this Section. Non-covered charges and charges in excess of the Plan allowable do not count towards the deductible.
- **YOU MUST GET PREAUTHORIZATION FOR INPATIENT HOSPITAL SERVICES, INPATIENT RESIDENTIAL TREATMENT CENTERS AND OUTPATIENT INTENSIVE DAY TREATMENT. Failure to do so will result in a minimum of $500 penalty. See the instructions after the benefits descriptions below.**

Benefits Description	You pay After the calendar year deductible…	
Professional services	**Standard and Extended Options**	**HSA Option**
All diagnostic and treatment services contained in a treatment plan that the Plan approves. The treatment plan may include services, drugs, and supplies described elsewhere n this brochure. Note: In-Network benefits are payable only when the Plan determines the care is clinically appropriate to treat the enrollee's condition and only when the enrollee receives the care as part of a treatment plan that the Plan approves.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions	Your cost-sharing responsibilities are no greater than for other illnesses or conditions
- Individual or group therapy by psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. - Medication management	PPO: $25 copayment per office visit to primary care physicians and specialists Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: $25 copayment per office visit to primary care physicians and specialists Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
- Psychological tests (requires precertification) - Inpatient professional fees - Diagnostic tests - Laboratory tests to monitor the effect of drugs prescribed for your condition - Electroconvulsive therapy	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Inpatient hospital and inpatient residential treatment centers	You pay	
	Standard and Extended Options	HSA Option
All diagnostic and treatment services contained in a treatment plan that the Plan approves. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: In-Network benefits are payable only when the Plan determines the care is clinically appropriate to treat the enrollee's condition and only when the enrollee receives the care as part of a treatment plan that the Plan approves.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions	Your cost-sharing responsibilities are no greater than for other illnesses or conditions
Room and board, such as: - Ward, semiprivate, or intensive care accommodations - General nursing care - Meals and special diets Note: We only cover a private room if we determine it to be medically necessary. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. The remaining balance is not a covered expense. If the hospital only has private rooms, we will cover the private room rate. Note: When the hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount
Outpatient hospital		
All diagnostic and treatment services contained in treatment plan that the Plan approves. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions	Your cost-sharing responsibilities are no greater than for other illnesses or conditions
- Services such as partial hospitalization or Intensive Day Treatment Programs	Your cost-sharing responsibilities are no greater than for other illnesses or conditions	Your cost-sharing responsibilities are no greater than for other illnesses or conditions
Emergency room – non-accidental injury		
- Outpatient services and supplies billed by a hospital for emergency room treatment Note: We pay Hospital benefits if you are admitted.	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan allowance Non-PPO: 40% of the Plan allowance and any difference between our allowance and the billed amount

Mental health and substance abuse	You pay	
	Standard and Extended Options	HSA Option
Not covered: - *Services by pastoral, marital, drug/alcohol and other counselors including therapy for sexual problems* - *Treatment for learning disabilities and mental retardation* - *Telephone therapy* - *Travel time to the enrollee's home to conduct therapy* - *Services rendered or billed by schools, or halfway houses or members of their staffs* - *Marriage counseling* - *Services that are not medically necessary*	*All charges*	*All charges*

Precertification

To be eligible to receive full benefits for mental health and substance abuse, you must follow the authorization process:

- You must call InforMed at (800) 242-1025 to receive authorization for inpatient care and outpatient intensive day treatment. They will authorize any covered treatment.
- You should call our Medical Management Department (800) 220-7898 to precertify benefits for psychological testing. Psychological testing claims will be denied if we determine the testing is not medically necessary.

If you do not obtain precertification for inpatient care and outpatient intensive day treatment, we will decide whether the stay was medically necessary. If we determine the stay was medically necessary, we will pay the services less the $500 penalty. If we determine that it was not medically necessary, we will only pay for any covered services that are otherwise payable on an outpatient basis. If you remain in the hospital beyond the days we approved and did not get the additional days precertified, we will pay inpatient benefits for the part of the admission that was medically necessary.

Section 8(f). Prescription drug benefits

Important things you should keep in mind about these benefits and features you should be aware of:

- We cover prescribed drugs and medications, as described in the chart beginning on page 60.
- 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.
- All PCIP Plan Options will have the same drug coverage, prior authorization and preferred drug step therapy rules and the same specialty retail lock-out benefit.
- Enrollees in all Plan Options will pay the cost difference between brand drugs and their generic, plus the generic copay.
- All PCIP Plan Options will use the standard preferred Prescriptions incentive formulary.
- All PCIP Plan Options will have the same vaccine coverage with the same age limitations with no copay.
- Accumulators (deductibles, OOP) are based on calendar years and restart each January 1st. Enrollees that join PCIP mid-year must satisfy the full benefit deductibles and OOPs for that plan option.
- Allowable deductibles, copayments and coinsurance for generics and formulary brand prescription drugs in all three plan options will be applied to the annual in-network deductible and the annual out-of-pocket $5,950 maximum. Allowable deductibles, copayments and coinsurance for non-formulary brand prescription drugs for all three plan options will be applied to the annual non-PPO deductible and the annual $7,000 out-of-pocket maximum.
- Items not applied to either of the out-of-pocket maximums include the difference between the cost of the generic and brand multi-source drugs, which are brand drugs for which the patent protection has expired and as a result generic drugs are available and the drug is available from multiple sources, the coinsurance for retail drugs after the first two fills, and non-preferred step therapy medication coinsurance of 100%.
- Under your medical coverage, you will be responsible for your coinsurance amounts for eligible medical and prescription expenses.
- Medications to treat some severe and chronic medical conditions are not available at Medco participating retail pharmacies but are available through Medco Specialty Drug program. See *Specialty drug benefits* for the categories of drugs in this program.
- Based on manufacturer's and FDA guidelines, the use of a certain medication may be limited as to its quantity, total dose, duration of therapy, age, gender or specific diagnosis. Since the prescription does not usually explain the reason the provider prescribed a medication, the requirement of any of these limits and/or prior authorization to confirm the intent of the prescriber may be appropriate.
- Some medications must be approved by the PCIP Administrator and/or Medco before you may purchase them.
- When a claim is submitted for online processing or direct reimbursement of a compound medication, the pricing is based on the contractual discounts plus a professional fee and any applicable sales tax. Recent regulations require a change in processing for compounds. The new standards, required by the Health Information Portability and Accountability Act HIPAA, will require pharmacies to submit all ingredients in a compound prescription as part of the claim for both online claims and paper claim submissions. Pharmacies will begin using the new standards as early as January 1, 2011; pharmacies may convert to the new standards at various times throughout the year and must be converted by the end of 2011.

- Each new enrollee will receive a description of our prescription drug program, a combined prescription drug/plan identification card, and a mail order form, questionnaire, and reply envelope.
- As part of our administration of prescription drug benefits, we may disclose information about your prescription drug utilization, including names of your prescribing physicians, to any treating physician or dispensing pharmacies.
- To help increase awareness, the Plan participates in programs to encourage the prescribing of generics and lower cost alternative preferred brand drugs. These programs may produce savings to you. These programs include generic drug awareness communications or prior approval. These programs include therapeutic classes such as, but not limited to, Proton Pump Inhibitors (PPIs) used for ulcers or reflux, Selective Serotonin Reuptake Inhibitors (SSRIs) for depression, bisphosphonates used to treat osteoporosis, nasal corticosteroids used for allergies, triptans used to treat migraine headaches, and Angiotensin Receptor Blockers (ARBs) used to treat hypertension and cardiac conditions, and sedative hypnotics to treat insomnia. When a prescription for the non-preferred drug in one of these classes is entered at retail or mail, the pharmacist receives a message to call the physician to discuss dispensing a lower cost preferred brand or generic alternative. If the physician believes the non-preferred drug is medically necessary, a coverage review process is available for them. At mail service, a coverage review is automatically initiated. At a retail pharmacy, the pharmacist, member, or physician would need to contact Medco to initiate the coverage review. The coverage review process includes a clinical criterion that has been approved by Medco's P&T Committee to evaluate the physician's response. If the review is approved, the non-preferred drug will be covered which means the standard generic, formulary or non-formulary copay will apply. If the coverage review is denied, you have the option to appeal the decision by contacting Medco or pay the cost of the non-preferred drug.
- **Who can write your prescription:** A licensed physician or a licensed dentist must write the prescription (physician assistants and nurse practitioners can prescribe in select states as state law allows). For Medco Pharmacy (mail order) prescriptions, the physician must be licensed in the United States. In addition, your mailing address must be within the United States or include an APO address.
- **Where you can obtain them**: You may fill the prescription at a participating network retail pharmacy, a non-network pharmacy, or through Medco Pharmacy. We pay a higher level of benefits when you use a network pharmacy. For medications you may take on a regular, long-term basis we pay a higher level of benefits through Medco Mail Order Pharmacy.

Covered medications and supplies

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

- Drugs and medicines (including those administered during a non-covered admission or in a non-covered facility) that by Federal Law of the United States require a physician's prescription for their purchase, except those listed as *Not covered;*
- Insulin;
- Needles and syringes for the administration of covered medications;
- Contraceptive drugs; and
- Ostomy supplies (please include the manufacturer's product number to ensure accurate fill of the product).

You can go to a participating retail pharmacy to receive certain vaccinations. Influenza vaccine is commonly administered by retail pharmacies. Other vaccines, such as those for pneumococcal pneumonia (Pneumovax), varicella (Zostavax) and hepatitis B (Heptavax), may also be available through retail pharmacies.

You will be able to identify participating vaccine pharmacies by calling (800) 427-6145 or by visiting www.pciplan.com or www.medco.com.

Note: A generic equivalent will be dispensed unless you or your physician specifies that the prescription be dispensed as written, when a Federally-approved generic drug is available unless substitution is prohibited by state law.

Prescription drug benefits – continued on next page

Prescription drug benefits *(continued)*

PCIP – three-tier drug benefit

- We divide prescription drugs into three categories or tiers: generic, formulary brands and non-formulary brands. When an approved generic equivalent is available, that is the drug you will receive, unless you or your physician specifies that the prescription must be filled as written. When an approved generic equivalent is not available, you will pay the appropriate copayment. If an approved generic equivalent is available, but you or your physician specifies that the prescription must be filled as written, you will pay the generic copayment plus the difference in the cost of the generic drug and the brand name multi-source drug unless your physician has provided clinical necessity for the brand name drug which will require preauthorization.
- **Generic drugs** are chemically and therapeutically equivalent to the corresponding brand drug, but are available at a lower price. Equivalent generic products for brand name medications become available after a patent and other exclusivity rights for the brand expire. The Food and Drug Administration must approve all generic versions of a drug and assure that they meet strict standards for quality, strength and purity. The FDA requires that generic equivalent medications contain the same active ingredients and be equivalent in strength and dosage to brand name drugs. The main difference between a generic and its brand name drug is the cost of the product.
- **Formulary brands** are brand name drugs that are preferred by the plan. Preferred status is based on an assessment of an independent committee of practicing physicians and a pharmacist to help ensure the formulary is medically sound and supports patient's health.
- Non-formulary brands are brand name drugs that are not preferred by the plan. Your physician may prescribe a non-formulary medication. If your physician feels that a non-formulary medication is needed for your care, it is available for a higher copay than formulary medications.

Medco incentive formulary

Your prescription drug program includes an incentive "formulary" feature with lower copayments for medications included on the formulary and higher copayments for medications that are not included on the formulary. The Medco Drug Formulary is a list of selected FDA approved prescription medications reviewed by an independent group of distinguished health care professionals. Prescription drugs are subjected to rigorous clinical analysis from the standpoint of efficacy, safety, side effects, drug-to-drug interactions, dosage and cost-benefit in determining whether they are included or excluded from the formulary.

A formulary is a list of commonly prescribed medications from which your physician may choose to prescribe. The formulary is designed to inform you and your physician about quality medications that, when prescribed in place of other non-formulary medications, can help contain the increasing cost of prescription drug coverage without sacrificing quality. In many therapeutic categories, there are several drugs of similar effectiveness. Many doctors are often unaware of the significant variations in price among these similar drugs and, as a result, their prescribing decisions often do not consider cost. However, when the cost difference is brought to their attention, doctors will frequently prescribe the less costly medications.

Your physicians will be contacted to discuss their prescribing decision. No change in the medication prescribed will be made without your physicians' approval. Compliance with this formulary list is voluntary and in general there is no financial penalty for obtaining drugs not on the formulary list.

Occasionally there may be exceptions, for additional details refer to page 64, *Important things you should keep in mind about these benefits and features you should be aware of.*

Any rebates or savings received by the Plan on the cost of drugs purchased under this Plan from drug manufacturers are credited to the health plan and are used to reduce health care costs.

Patient safety

PCIP has several programs to promote patient safety. Through these programs, we work to ensure safe and appropriate quantities of medication are being dispensed. The result is improved care and safety for our enrollees. Patient safety programs include:

- Prior approval – Approval must be obtained for certain prescription drugs and supplies before providing benefits for them.
- Quantity allowances – Specific allowances are in place for certain medications, based on manufacturer and FDA recommended guidelines.
- Pharmacy utilization – PCIP reserves the right to maximize your quality of care as it relates to the utilization of pharmacies.

PCIP will participate in other approved managed care programs, as deemed necessary, to insure patient safety.

Prescription drug benefits – continued on next page

Prescription drug benefits *(continued)*

How to use Medco network pharmacies (retail)

You may fill your prescription at any participating retail pharmacy. For the names of participating pharmacies, call (800) 427-6145 or go to www.pciplan.com and click on the Medco link or visit www.medco.com. To receive maximum savings you must present your card at the time of each purchase, and your enrollment information must be current and correct. In most cases, you simply present the card together with the prescription to the pharmacist. Each purchase is limited to a 30-day supply. Any prescription purchased twice at retail, regardless of the quantity purchased is considered maintenance medication. We pay a higher level of benefits for maintenance medication through Medco Pharmacy (mail order).

Refills cannot be obtained until 75% **of the drug has been used. Refills for maintenance medications are not considered new prescriptions except when the doctor changes the strength or 180 days has elapsed since the previous purchase. As part of the administration of the prescription drug program, we reserve the right to maximize your quality of care as it relates to the utilization of pharmacies. Some medications may require prior approval by Medco or PCIP.**

How to use Medco network pharmacies (mail order)

Through this service, you may receive up to a 90-day supply of maintenance medications for drugs which require a prescription, ostomy supplies, diabetic supplies and insulin, syringes and needles for covered injectable medications, and oral contraceptives. Some medications may not be available in a 90-day supply from Medco even though the prescription is for 90 days. Even though insulin, syringes, diabetic supplies and ostomy supplies do not require a physician's prescription, to obtain through Medco Pharmacy, you should obtain a prescription (including the product number for ostomy and insulin pump supplies) from your physician for a 90-day supply.

Some medications may require approval by Medco or PCIP. Not all drugs are available through Medco Pharmacy. In order to use Medco Pharmacy, your prescriptions must be written by a physician licensed in the United States. In addition, your mailing address must be within the United States or include an APO address.

Each enrollee will receive a kit that includes a brochure describing the Medco Pharmacy service, an order form, a questionnaire, and a return envelope.

To order new prescriptions, ask your doctor to prescribe needed medication for up to a 90-day supply, plus refills, if appropriate. Complete the Health, Allergy, & Medication Questionnaire the first time you order through this service. Complete the information on the Ordering Medication Form; enclose your prescription and the correct copayment.

Mail to: Medco
P.O. Box 30493
Tampa, FL 33630-3493

Fax: Or you can ask your physician to fax your prescriptions to Medco. To do this, provide your doctor with your ID number (located on your ID card) and ask him or her to call (888) 327-9791 for instructions on how to use Medco's fax service.

You should receive your medication within 14 days from the date you mail your prescription. You will also receive reorder instructions. If you have any questions or need an emergency consultation with a registered pharmacist, you may call Medco toll-free at (800) 427-6145 available 24 hours a day, 7 days a week except Thanksgiving and Christmas. Forms necessary for refills will be provided each time you receive a supply of medication from the service.

Electronic transmission: Or you can ask your physician to transmit your prescriptions electronically to Medco.

Refilling your medication: to be sure you never run short of your prescription medication, you should re-order on or after the refill date indicated on the refill slip or when you have approximately 14 days of medication left.

To order by phone: Call Member Services at (800) 427-6145. Have your refill slip with the prescription information ready.

To order by mail: Simply mail your refill slip and copayment in the return envelope.

To order online: Go to http://www.pcip.com then click on the link to Medco, or go to http://www.medco.com.

Prescription drug benefits – continued on next page

Prescription drug benefits *(continued)*

Benefits Description	**Note:** ***The calendar year medical deductible does not apply to RX benefits for the Standard and Extended Option Plans.***	
Standard Option – three-tier drug benefit		
Prescription drugs:	**Formulary You pay**	**Non-Formulary You pay**
Rx deductible	$500	$750
Retail – up to a 30-day supply each fill		
Generic – First two fills	$4	$4
Generic – 3rd fill & after	Greater of $4 or 50%	Greater of $4 or 50%
Brand – First two fills	$40	$80
Brand – 3rd fill & after	Greater of $40 or 50%	All charges
Specialty	25%, $150 max	50%, $300 max
Mail order – 90-day supply		
Generic	$10	$10
Brand	$100	$200
Specialty	25%, $350 max	50%, $500 max
Extended Option – three-tier drug benefit		
Prescription drugs:	**Formulary You pay**	**Non-Formulary You pay**
Rx deductible	$250	$375
Retail – up to a 30-day supply each fill		
Generic – First two fills	$4	$4
Generic – 3rd fill & after	Greater of $4 or 50%	Greater of $4 or 50%
Brand – First two fills	$30	$60
Brand – 3rd fill & after	Greater of $30 or 50%	All charges
Specialty	25%, $150 max	50%, $300 max
Mail order – 90-day supply		
Generic	$10	$10
Brand	$75	$150
Specialty	25%, $350 max	50%, $500 max

Prescription drug benefits *(continued)*

HSA Option – three-tier drug benefit		
Prescription drugs:	**Formulary You pay**	**Non-Formulary You pay**
Rx deductible	N/A	N/A
Retail – up to a 30-day supply each fill		
Generic – First two fills	$4	$4
Generic – 3rd fill & after	Greater of $4 or 50%	Greater of $4 or 50%
Brand – First two fills	$30	$60
Brand – 3rd fill & after	Greater of $30 or 50%	All charges
Specialty	25%, $150 max	50%, $300 max
Mail order – 90-day supply		
Generic	$10	$10
Brand	$75	$150
Specialty	25%, $350 max	50%, $500 max

Section 8(g). Special features

Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. - 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. - Under the provisions of our flexible benefits option, we may determine that services or treatments that otherwise have no out-of-network benefit may be covered for a limited time period following your initial enrollment, if you agree to have your care transitioned to a preferred provider. - 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	TDD service is available at (800) 821-4833 for enrollees who are hearing impaired.
High risk pregnancies	To participate in our enhanced maternity program, call (800) 220-7898 at any time as soon as you think you may be pregnant. Early participation in the program guarantees you ongoing communication with a registered nurse throughout the pregnancy. Complimentary educational materials include the book “From Here to Maternity”.
HEALTH ADVICE LINE	Have a health question or concern? Registered nurses provide answers to your health questions 24 hours a day, 7 days a week. Call toll-free (888) 257-4342 for health information and counseling. This program is voluntary and confidential.
Health information library	When you call the HEALTH ADVICE LINE number, you can choose to listen to recorded messages on more than 1,000 health topics. You will receive a pamphlet with instructions for using this service.
Health assessment	Our online Health Assessment (or paper assessment, for those without computer access) can help you evaluate your health risks and identify transition of care needs. Upon completion, you will receive a personalized health report. If completed within 90-days of enrollment, you are eligible for a $50 gift card. To access the on-line assessment, go to www.PCIPlan.com and click on Health Assessment. If no computer access, contact PCIP customer service and request a paper assessment.
Health education resources	Visit our website at www.pciplan.com for information on: - General health topics; - Links to health care news; - Cancer and other specific diseases; - Drugs/medication interactions; - Kids health; - Patient safety information; and - Several helpful website links.

Special features - continued on next page

Special features *(continued)*	
Consumer choice information	- You may choose any provider. However, you will receive discounts when you see a network provider. Provider information is available online at www.pciplan.com. - Pricing information for prescription drugs is available at www.medco.com. - Link to online pharmacy through Medco at www.medco.com. - Educational materials on the topics of HSA and PCIP are available at www.pciplan.com.

Section 9. 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 the benefit Sections of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies for 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; sexual dysfunction or sexual inadequacy;
- Services, drugs, or supplies you receive from a provider or facility barred from the Health and Human Services (HHS) programs;
- Services or supplies for which no charge would be made if the covered individual had no health insurance coverage;
- Services, drugs, or supplies you receive without charge while in active military service;
- Services or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption;
- Services or supplies furnished or billed by a noncovered facility;
- Services or supplies for cosmetic purposes;
- Surgery to correct congenital anomalies for individuals age 18 and older unless there is a functional deficit;
- Services or supplies not specifically listed as covered;
- Services or supplies not reasonably necessary for the diagnosis or treatment of an illness or injury, except for routine physical examinations and immunizations;
- Dental benefits, except as described on page 40-41;
- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copay or coinsurance, we will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges which the enrollee or Plan has no legal obligation to pay and Never event policies (see page 73) or State premium taxes however applied;
- Charges in excess of the "Plan allowance" as defined on pages 73 and 74;
- Biofeedback, educational, recreational or milieu therapy, either in or out of a hospital;
- Inpatient private duty nursing;
- Stand-by physicians and surgeons;
- Clinical ecology and environmental medicine;
- Chelation therapy except for acute arsenic, gold, or lead poisoning;
- Treatment for impotency, even if there is an organic cause for impotency. (Exclusion applies to medical/surgical treatment as well as prescription drugs);
- Treatment other than surgery of temporomandibular joint dysfunction and disorders (TMJ);
- Computer devices to assist with communications;
- Surgical treatment of hyperhidrosis unless alternative therapies such as botox injections or topical aluminum chloride and pharmacotherapy have been unsuccessful;
- Computer programs of any type, including but not limited to those to assist with vision therapy or speech therapy;
- Weight loss programs;
- Home test kits including but not limited to HIV and drug home test kits;
- Telephone consultations; or
- Genetic testing and counseling.

Section 10. Filing a claim for covered services

How to claim benefits

To obtain claim forms, claims filing advice or answers about our benefits, contact us at (800) 220-7898, or at our Web site at www.pciplan.com.

In most cases, providers and facilities file claims for you. Your physician must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form.

Mail to: PCIP
P.O. Box 300
Independence, MO 64051-0300

For claims questions and assistance, call us at (800) 220-7898.

When you must file a claim -- such as for services you received overseas or when another group health plan is primary -- submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

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

In addition:

- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse and should include nursing notes.
- Claims for rental or purchase of durable medical equipment; home skilled nursing, home IV therapy, home PT, OT, ST require precertification.
- Claims for prescription drugs and supplies that are not purchased through the prescription drug program must include receipts that show the prescription number, name of drug or supply, prescribing physician's name, date, and charge. A copy of the physician's script must be included with prescription drugs purchased outside the United States.
- To control administrative costs, we will not issue benefit checks that do not exceed $1.

Records

Keep a record of your medical expenses, as deductibles and maximum allowances apply. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

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. Once we pay benefits, there is a six month limitation on the re-issuance of uncashed checks.

Overseas claims

For covered services you receive in hospitals outside the United States and Puerto Rico and performed by physicians outside the United States, send itemized bills that include an English translation. A copy of the physician's script must be included with prescription drugs purchased outside the United States. Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred. If possible, include a receipt showing the exchange rate on the date the claimed services were performed.

Covered providers outside the United States will be paid at the PPO level of benefits. All overseas claims, including prescription drug reimbursement, should be submitted to: PCIP, Foreign Claims Department, P.O. Box 300, Independence, MO 64051-0300.

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 11. The disputed claims process

Follow this Pre-Existing Condition Insurance Plan disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for precertification/prior approval required by Section 2. Disagreements between you and the PCIP fiduciary regarding the administration of an HSA are not subject to the disputed claims process.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision (unless you can show that you were prevented by circumstances beyond your control from making the request within this time limit); and b) Send your request to us at: PCIP, P.O. Box 300, Independence, MO 64051-0300; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' statements, operative reports, itemized bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision quicker.
2	We have 30 days from the date we receive your request to: a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or b) Write to you and maintain our denial – go to step 4; or c) 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	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. PCIP may extend the 60-day time limit if you were not notified of the time limit or were prevented by circumstances beyond your control from submitting the additional information. We will write to you with our decision.
4	If you do not agree with our decision, you may ask the U.S. Office of Personnel Management (OPM) to review it. You must write to OPM within: - 90 days after the date of our letter upholding our initial decision; or - 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or - 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, PCIP Appeals, Room 3415, 1900 E. Street, NW, Washington, DC 20415-3620.

The disputed claims process *(continued)*

	Send OPM the following information: - A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; - Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; - Copies of all letters you sent to us about the claim; - Copies of all letters we sent to you about the claim; and - Your daytime phone number and the best time to call. - Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision quicker. 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.
5	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 following 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 precertification/prior approval, then call us at (800) 220-7898 and we will expedite our review; or

b) We denied your initial request for care or precertification/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.

Section 12. When others are responsible for your medical care

When other Government agencies are responsible for your care

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

When others are responsible for injuries

If PCIP pays benefits for an illness or injury for which you are later compensated or reimbursed from another source, you must refund PCIP from any recovery you obtain. All PCIP benefit payments in these circumstances are conditional, and remain subject to our contractual benefit limitations, exclusions, and maximums. By accepting these conditional benefits, you agree to the following:

- The covered person or his/her legal representative must contact the Subrogation Unit for the Plan at (800) 220-7898, Ext. 5503 or 5735 as soon after the incident as possible and provide all requested information, including prompt disclosure of the terms of all settlements, judgments, or reimbursements. The covered person must sign any releases PCIP requires to obtain information about his/her claim from other sources.
- Include all benefits paid by PCIP in any claim for compensation you assert against any tortfeasor, insurer, or other party for the injury or illness, and assign all proceeds recovered from any party, including your own and/or other insurance, to PCIP for up to the amount of the benefits paid.
- When benefits are payable under the Plan in relation to the illness or injury, PCIP may, at its option:
    - Subrogate, that is, take over the covered person's right to receive payments from other parties. The covered person or his/her legal representative will transfer to PCIP any rights he or she may have to take legal action arising from the illness or injury to recover any sums paid on behalf of the covered person; or
    - Enforce its right to seek reimbursement, which it recovers from the covered person or his/her legal representative, for any benefits paid from any payment the covered person is entitled to receive from other parties.

  You must cooperate in doing what is reasonably necessary to assist us, and you must not take any action that may prejudice our rights to recover reimbursement.
- Reimburse PCIP on a first priority basis, in full up to the amount of benefits paid, out of any settlements, judgments, and/or recoveries that you obtain from any source, no matter how characterized, i.e., as "pain and suffering". PCIP enforces this right of reimbursement by asserting a lien against any and all recoveries received, including first party Medpay, Personal Injury Protection, No-Fault coverage, Third-Party, and Uninsured and Underinsured coverage. PCIP's lien consists of the total benefits paid to diagnose or treat the illness or injury. PCIP's lien applies first, regardless of the "make whole" and "common fund" doctrines. No reduction of PCIP's lien can occur without our written consent, including reduction for attorney fees and costs.
- Sign a Reimbursement Agreement if asked by PCIP to do so. However, a Reimbursement Agreement is not necessary to enforce our lien. We may delay processing of your claims until we receive a signed Reimbursement Agreement or Assignment of the proceeds of a claim.

  PCIP's lien extends to all related expenses incurred prior to the settlement or judgment date, even if those expenses were not submitted to PCIP for payment at the time you reimbursed PCIP. The lien remains the enrollee's obligation until it is satisfied in full. Failure to refund PCIP or cooperate with our reimbursement efforts may result in an overpayment that can be collected from you.

Workers' compensation

We do not cover services that:

- You need because of a workplace-related illness or injury.
- A similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under Worker's Compensation (WC) or similar laws.

Once Worker's Compensation pays its maximum benefits for your treatment, we will cover your care.

Clinical trials

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

- 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 condition, whether the patient is in a clinical trial or receiving standard therapy. These costs are covered by this Plan.
- 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. This Plan does not cover these costs.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials, and this Plan does not cover these costs.

Section 13. Definitions of terms we use in this brochure

Admission

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

Affordable Care Act

The Patient Protection and Affordable Care Act, Public Law 111-148.

Benefits

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

Clinical trials cost categories

Cost categories:

- 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 condition, whether the patient is in a clinical trial or receiving standard therapy;
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care; or
- 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.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. (see pages 14 and 15)

Congenital anomaly

A condition existing at or from birth which is a significant deviation from the common form or norm. For purposes of this Plan, congenital anomalies include cleft lips, cleft palates, birthmarks, webbed fingers or toes and other conditions that the Plan may determine to be congenital anomalies. Surgical correction of congenital anomalies is limited to children under the age of 18 unless there is a functional deficit. In no event will the term congenital anomaly include conditions relating to teeth or intra-oral structures supporting the teeth.

Copayment

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

Cosmetic

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

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.

Coverage termination

Any person who is confined in a hospital or other institution for care or treatment on the day enrollment is terminated from coverage (for reason other than non-payment of premium) in this program 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 enrollment.

Covered services

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

Custodial care

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

- Personal care such as help in: walking; getting in and out of bed, bathing, eating by spoon, tube or gastrostomy, exercise, dressing;
- Homemaking, such as preparing meals or special diets;
- Moving the patient;
- Acting as companion or sitter;
- Supervising medication that can usually be self administered; or
- Treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

The Carrier determines which services is custodial care. (Custodial care that lasts 90 days or more is sometimes known as long-term care.)

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 14)

Durable medical equipment

Equipment and supplies that:

- Are prescribed by your attending doctor;
- Are medically necessary;
- Are primarily and customarily used only for a medical purpose;
- Are generally useful only to a person with an illness or injury;
- Are designed for prolonged use; and
- Serve a specific therapeutic purpose in the treatment of an illness or injury.

Effective date

The date the benefits described in this brochure are effective:

- January 1 for continuing enrollments; or
- For new enrollees during the calendar year, the effective date of enrollment as determined by the National Finance Center.

Enrollee

An individual receiving coverage from a qualified high-risk pool established under Section 1101 of the Affordable Care Act of 2010, as determined by the Department of Health and Human Services.

Expense

An expense is “incurred” on the date the service or supply is furnished.

Experimental or investigational services

A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device, or biological product is experimental or investigational if: 1) reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

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

Determination of experimental/investigational status may require review of appropriate Government publications such as those of the National Institute of Health, National Cancer Institute, Agency for Health Care Policy and Research, Food and Drug Administration, and National Library of Medicine. Independent evaluation and opinion by Board Certified Physicians who are professors, associate professors, or assistant professors of medicine at recognized United States Medical Schools may be obtained for their expertise in subspecialty areas.

Infertility

The inability to conceive after a year of unprotected intercourse or the inability to carry a pregnancy to term.

Intensive day treatment

Outpatient treatment of mental conditions or substance abuse rendered at and billed by a facility which is accredited under the Hospital Accreditation Program of the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) or is licensed by the state as an outpatient day treatment program.

Medical necessity

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

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

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

Mental health/ substance abuse

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

Never event policies

Federal or State policies that bar health care providers from charging patients for care that is attributable to certain avoidable errors, such as wrong site surgery**.**

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. We determine our Plan allowance as follows:

For PPO providers:

Our PPO allowances are negotiated with each provider who participates in the network. PPO allowances may be based on a standard reduction or on a negotiated fee schedule. For these allowances, the PPO provider has agreed to accept the negotiated reduction and you are not responsible for this discounted amount. In these instances, the benefit paid plus your coinsurance equals payment in full.

For non-PPO providers:

To determine our non-PPO Plan allowance, we must first be provided an itemized bill that includes your diagnosis, the services or supplies you received, and the provider's charge for each, using the same types of standard codes, descriptions and other information required for processing by public health care plans. If we are not provided the itemization of the services or supplies you received, we will assume they were equivalent to the level and extent of services and supplies typically provided by the providers or facilities most commonly used to treat other Plan enrollees with the same principal diagnosis as yours. We will base these equivalent services on claims submitted to the Plan by providers in the same geographic region or a combination of similar geographic regions across the United States.

Based on the itemization of services or supplies you received, we will determine the amount of the maximum non-PPO Plan allowance by applying the following rules, in order:

1. We consult standard industry guides, such as national databases of prevailing health care charges from Ingenix, Fair Health or another identified data source, that are available for our use in a given state or geographic area. After the data supplier removes outliers from the claim data they collect, they group the remaining data by percentiles. We use the 70th percentile. This means that out of every 100 reports remaining after outliers were removed, 30 charges billed may be more, but 70 charges will be the allowed amount or less.

2. For services or supplies obtained in a state or geographic area where the above data source is unavailable for our use, and also for dialysis centers, our non-PPO Plan allowance is two times the Medicare participating provider allowance for the service or supply in the geographic area in which it was performed or obtained. This Medicare-based allowance is not used for those services where Medicare sets a fixed national payment amount that does not vary geographically (such as blood draws). Medicare fee schedule information for physician services may be obtained at www.cms.hhs.gov/PFSlookup/.

3. Some Plan allowances may be submitted to medical consultants who recommend allowances based on standard industry relative value guidelines. For services or supplies for which Medicare does not provide an allowance amount, we may use the current fee schedule used by the federal Office of Workers Compensation (OWCP). OWCP fee schedule information may be obtained at www.dol.gov/owcp/regs/feeschedule/fee.htm. For services or supplies that do not have a value currently established by public health care plans such as Medicare or Medicaid, or for implantable devices and surgical hardware, we may use medical consultants to determine an appropriate allowance. We may also conduct independent studies to determine the usual cost of a service or supply in a geographic area, or to establish allowances for services or supplies provided outside the United States.

Non-PPO Plan allowance amounts determined according to these guidelines include, but are not limited to, ambulatory surgery centers, dialysis centers, surgery, doctor's services, physical therapy, occupational therapy, speech therapy, lab testing and X-ray expenses, implantable devices and surgical hardware. For more information about the source of the data we are currently using you may call us at (877) 745-7198.

Plan allowance for prescription drugs is determined using Average Wholesale Price or other industry-standard reference price data.

Charges for some Plan allowances are stated in this brochure. These include limited benefits such as chiropractic care.

If we negotiate a reduced fee amount on an individual claim for services or supplies which is lower than the Plan allowance, covered benefits will be limited to the negotiated amount. Your coinsurance will be based on the reduced fee amount. If you choose to use a provider other than the one we negotiated a reduction with, you will be responsible for the difference in these amounts.

To estimate our maximum Plan allowance for a non-PPO provider before you receive services from them, call us at (877) 745-7198.

Plan designated facility

These are special facilities that are not just participating providers, but designated preferred facilities for treatment by PCIP. In some cases such as transplants, coverage limitations are placed unless performed at these preferred facilities.

Precertification/ Preauthorization

The requirement that certain covered services or medications must be pre-approved by your PCIP plan or their designated representative.

Primary care physician

For purposes of the office visit copayment for primary care physicians are individual doctors (M.D. or D.O.) whose medical practice is limited to family/general practice, internal medicine, pediatrics/adolescent medicine, obstetrics/gynecology (OB/Gyn), psychiatrists, licensed clinical psychologists, licensed clinical social worker, licensed professional counselors or licensed marriage and family therapists. Doctors listed in provider directories or advertisements under any other medical specialty or sub-specialty area (such as internal medicine doctors also listed under cardiology, or pediatric sub-specialties such as pediatric allergy) are considered specialists, not primary care physicians. Chiropractors, eye doctors and audiologists are not considered primary care physicians.

Qualified high-risk pool

A program which provides coverage in accordance with the requirements of Section 1101 of the Affordable Care Act of 2010, as determined by the Department of Health and Human Services.

Service area	The geographic area encompassing an entire state or states in which a qualified high-risk pool furnishes benefits.
The Plan	The benefit plan pursuant to the Affordable Care Act administered by GEHA as the Third-Party Administrator.
Us/We	"Us" and "we" refer to "the Plan".
You	"You" refers to the enrollee.

Index

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

PCIP
Pre-Existing Condition Insurance Plan
Administered by GEHA

NOTICE OF PRIVACY PRACTICES
Effective August 1, 2010

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.PLEASE REVIEW IT CAREFULLY

PURPOSE OF THE NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is about individual privacy, and throughout this document, "you" means the patient who is insured by PCIP. You should read this document carefully as the covered individual under the plan. It describes how we may use and disclose your protected health information for purposes of treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services, or payment for health care services. A copy of this Notice of Privacy Practices is available at our website, www.pciplan.com or by calling our Customer Service Department at 1-800-220-7898 and requesting that a copy be sent to you in the mail.

OUR LEGAL DUTIES REGARDING PROTECTED HEALTH INFORMATION

We are required to follow the terms of this Notice of Privacy Practices. We understand that medical information about you and your health is personal. We are committed to protecting health information about you. We create a record of the health care claims processed for administration purposes, and this notice applies to all of the records we maintain. Your personal doctor, health care provider, or hospital may have different policies or notices regarding their use and disclosure of your protected health information created at their location.

We are required by law to:
- Ensure protected health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices regarding your protected health information; and
- Follow the terms of the notice that is currently in effect.

REVISION OF THE NOTICE OF PRIVACY PRACTICES

We reserve the right to change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time, including information created or received prior to the effective date of the notice revision.

We are required to promptly revise and distribute a revised Notice of Privacy Practices to you whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in the notice. Except when required by law, a material change to any term of this notice will be implemented upon the effective date of the notice in which the material change is reflected. When the Notice of Privacy Practices has been revised, the revision will also be available at our website, www.pciplan.com or by calling our Customer Service Department at 1-800-220-7898 and requesting that a revised copy be sent to you in the mail.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways we may use and disclose your health information without your authorization. For each category of use or disclosure, an explanation follows to explain what we mean and to present some examples. Not every use or disclosure in a category will be listed.

Treatment: We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your health information. For example, we may disclose your protected health information to a home health agency that provides care to you in order to manage and ensure the quality of your care.

Payment: We may use and disclose protected health information about you to determine and provide eligibility for benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility, to coordinate coverage, or to obtain premiums. For example, we may use health information in the form of your medical history from your health care provider to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether a treatment is covered. We may disclose information to another entity to assist with the subrogation of claims.

Health Care Operations: We may use or disclose your protected health information for other PCIP operations as needed. These uses and disclosures are necessary to administer PCIP, including quality assessment, customer service, legal and auditing functions, business planning and development, and general administrative activities. We may share your protected health information as necessary with third party "business associates" that assist us in performing these various activities. Some examples would be for the provision of mental health and substance abuse benefits and managed care operations (including, but not limited to the preferred provider networks and the prescription drug managed care program). Whenever an arrangement between PCIP and a business associate involves the use or disclosure of your protected health information, we will have a written contract with the business associate that contains terms to ensure that the business associate protects the privacy of your health information to the same extent as is set forth in this Notice of Privacy Practices.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

OPM and HHS: Enrollment information is received from the National Finance Center (NFC), and the information is shared with OPM and HHS, as necessary, to reconcile enrollment discrepancies. Additional information is shared between OPM, HHS and GEHA, including information in regard to fraud and abuse investigations and the disputed claim process. All claim data will be shared with OPM, who maintains a health claim data warehouse.

Personal Representatives: A person is your personal representative only if they have authority by law to act on your behalf in making decisions related to health care. They then must be given the same consideration as you and we may disclose your protected health information to them. We may require your personal representative to produce evidence of his/her authority to act on your behalf. We may not recognize him/her if we have a reasonable belief that treating such person as your personal representative could endanger you and we decide that it is not in your best interest to treat them as your personal representative. In addition, in the event of your death, an executor, administrator, or other person authorized under the law to act on behalf of you or your estate will be treated as your personal representative.

You may also be a personal representative by law for another individual in your family, such as a minor child or an incapacitated adult. Minor children may have some rights as specified in state consent laws that relate directly to minors.

Individuals Involved in Your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care or payment related to your health care. If you are not present, we may disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. In the same way, we may also disclose your medical information in the event of your incapacity or in an emergency. Additionally, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care, of your location, general condition, or death. We may also use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and coordinate uses and disclosures to family or other individuals involved in your health care.

OTHER PERMITTED OR REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION, OR OPPORTUNITY TO OBJECT

We may also use and disclose your protected health information in the following situations without your authorization. These situations include the following:

Required By Law: We may use or disclose your protected health information to the extent that federal, state, or local law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes as follows:
- To a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability, including, but not limited to, reporting of vital statistics, the conduct of public health surveillance, public health investigations, and public health interventions, and if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority;
- To a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect; or
- If authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition;

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information to a governmental authority or agency authorized to receive such information, if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Legal Proceedings: We may disclose protected health information during any judicial or administrative proceeding, in response to an order of a court, or administrative tribunal, if such disclosure is expressly authorized by order. We may disclose protected health information in response to a subpoena, discovery request or other lawful process, if the party seeking the information satisfactorily assures us that reasonable efforts have been made to either notify you of the request or obtain a protective order.

Law Enforcement: We may disclose protected health information for law enforcement purposes. These law enforcement purposes include:
- Legal orders, warrants, subpoenas, or summons;
- Information for identifying and locating a suspect, fugitive, material witness, or missing person;
- Circumstances pertaining to victims of a crime;
- Suspicion that death occurred as a result of criminal conduct; or
- Crime occurring on a PCIP premise;

Decedents: Protected health information may be disclosed to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.

Threats to Health or Safety: Under applicable federal and state laws, we may disclose your protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel as follows:
- For activities deemed necessary by appropriate military command authorities; or
- To foreign military authorities if you are a member of that foreign military services.

We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose health information to comply with laws relating to worker's compensation or other similar programs established by law.

Inmates or Those in Lawful Custody: If you are an inmate of a correctional institution or under the custody of a law enforcement official, your protected health information may be disclosed to the correctional institution or to the law enforcement official. This is required for:
- The provision of health care to you;
- The health and safety of you, other inmates, and officers and employees of the correctional institution;
- The health and safety of any person responsible for transporting inmates, or transferring inmates between facilities; or
- The enforcement of law on the premises of the correctional institution, and the administration and maintenance of safety, security, and order of the correctional institution.

Required Uses and Disclosures: Under the law, we must make disclosures to you or your personal representative upon request. We also must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the law.

AUTHORIZATION FOR OTHER USES AND DISCLOSURES

Uses and disclosures other than those in this notice will be made only with your written authorization. You may revoke an authorization at any time in writing. If you revoke an authorization, it will not affect any action taken or any information released by us prior to receiving and processing your request to revoke the authorization. Please make these requests in writing to our Privacy Officer. Forms are available on our website at www.pciplan.com or may be requested through our Customer Service Department at 1-800-220-7898.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Right to request restrictions: You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. PCIP is not required to agree to a restriction that you may request. If PCIP does agree to the requested restriction, we will advise you in writing, and from that time forward we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment to you or as defined by law. You may revoke a restriction at any time in writing. If you revoke a restriction, it will not affect any action taken toward an individual you previously restricted or any information we refused to release prior to receiving and processing your request to revoke the restriction. We may also terminate our agreement to restriction and would contact you if this situation should occur. Please make these requests in writing to our Privacy Officer. Forms are available on our website at www.pciplan.com or may be requested through our Customer Service Department at 1-800-220-7898.

Right to receive confidential communications: We will accommodate written reasonable requests to receive communication of protected health information by alternative means or at alternative locations if you provide a clear statement that the disclosure of all or part of that information could endanger you. We will ask you to provide an alternative method of contact or address. We will advise you in writing, and from that time forward, we will contact you by alternative means or location as agreed to in our response. You may revoke a confidential communication at any time in writing. If you revoke a confidential communication, it will not affect any action taken toward an individual you previously restricted or any information we refused to release prior to receiving and processing your request to revoke the confidential communication. Please make these requests in writing to our Privacy Officer. Forms are available on our website at www.pciplan.com or may be requested through our Customer Service Department at 1-800-220-7898.

Right of access to inspect and copy: You may have access upon written request to inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A fee may be charged for copying, postage, and for preparing an explanation or summary of your protected health information upon your request. A "designated record set" contains medical and payment records and any other records that PCIP uses for making decisions about you. You may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. In most cases, we will provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. When a decision to deny access has been made, you may have a right to have this decision reviewed in some circumstances. Please make this request in writing to our Privacy Officer. Forms are available on our website at www.pciplan.com or may be requested through our Customer Service Department at 1-800-220-7898.

Right to amend: You may request in writing an amendment of protected health information about yourself in a designated record set for as long as we maintain this information. A request for amendment may be denied if it is determined that the protected health information or record that is the subject of the request meets any of the following criteria:

- Was not created by PCIP;
- Is not part of the designated record set;
- Would not be available for inspection under access guidelines; or
- Is accurate and complete.

In most cases, we will act upon your request within 60 days. If we deny your request to amend, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please make this request in writing to our Privacy Officer. Forms are available on our website at www.pciplan.com or may be requested through our Customer Service Department at 1-800-220-7898.

Right to receive an accounting of disclosures: You may request in writing to obtain an accounting of disclosures. This right applies to disclosures we have made for purposes not related to treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, to a personal representative, or to any disclosures you have specifically authorized. You have the right to receive an accounting of disclosures that occur after August 1, 2010, and for a specified period of time up to six years. You may request a shorter specific timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. If you request an accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to additional requests. Please make this request in writing to our Privacy Officer. Forms are available on our website at www.pciplan.com or may be requested through our Customer Service Department at 1-800-220-7898.

Right to obtain a copy of this notice: You may obtain a paper copy of this notice upon request or view and print a copy electronically at www.pciplan.com.

COMPLAINTS

If you believe these privacy rights have been violated, you may file a written complaint with PCIP's Privacy Officer, or the Secretary of the Department of Health and Human Services. No retaliation will occur against you for filing a complaint.

CONTACT

You may contact PCIP's Privacy Officer for further information about the complaint process, or for further explanation of this document by mail at PCIP – *administered by GEHA*, Attention: Privacy Officer, P.O. Box 300, Independence, MO, 64051-0438, or by phone at 1-800-220-7898.

Summary of Benefits

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside. If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

	Standard Option		**Extended Option**		**HSA Option**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible type	Separate Medical & Prescription deductibles		Separate Medical & Prescription deductibles		A Combined Medical & Prescription Deductible	
Deductible (medical)	$2,000	$3,000	$1,000	$1,500	$2,500	$3,000
Coinsurance (medical)	20%	40%	20%	40%	20%	40%
Catastrophic (or Out-of-Pocket) Maximum	$5,950	$7,000	$5,950	$7,000	$5,950	$7,000
Inpatient Hospital Services^	20%	40%	20%	40%	20%	40%
Outpatient Surgery	20%	40%	20%	40%	20%	40%
Primary Care Office Visit	$25 copay	40%	$25 copay	40%	$25 copay	40%
Specialty Office Visit	$25 copay	40%	$25 copay	40%	$25 copay	40%
Annual Preventive Care Office Visit	Nothing	40%	Nothing	40%	Nothing	40%
Preventive Care - Other	Nothing	40%	Nothing	40%	Nothing	40%
Emergency Room	20%	40%	20%	40%	20%	40%
Lab - Outpatient	20%	40%	20%	40%	20%	40%
X-Ray^<< & Other Diagnostic Tests	20%	40%	20%	40%	20%	40%
Maternity & Newborn Care*	20%	40%	20%	40%	20%	40%
Therapy Services^:	20%	40%	20%	40%	20%	40%
Durable Medical Equipment (DME)^	20%	All Charges	20%	All Charges	20%	All Charges
Skilled Nursing Facility^**	Benefits limited to $700 day		Benefits limited to $700 day		Benefits limited to $700 day	
Home Health Care – skilled nursing, IV therapy^ (Limited to 25 in-home visits per calendar year)	20%	All charges	20%	All charges	20%	All charges
Hospice (combination inpatient & outpatient)	Benefits limited to $15,000		Benefits limited to $15,000		Benefits limited to $15,000	
Mental Health/Substance Abuse	Same as medical conditions.		Same as medical conditions.		Same as medical conditions.	
Prescription Drugs	**Formulary**	**Non-Formulary**	**Formulary**	**Non-Formulary**	**Formulary**	**Non-Formulary**
Rx Deductible	$500	$750	$250	$375	N/A	N/A
Retail – up to a 30-day supply each fill						
Generic – First two fills	$4	$4	$4	$4	$4	$4
Generic – 3rd fill & after	Greater of $4 or 50%	Greater of $4 or 50%	Greater of $4 or 50%	Greater of $4 or 50%	Greater of $4 or 50%	Greater of $4 or 50%
Brand – First two fills	$40	$80	$30	$60	N/A	N/A
Brand – 3rd fill & after	Greater of $40 or 50%	All Charges	Greater of $30 or 50%	All Charges	Greater of $30 or 50%	All Charges
Specialty	25%, $150 max	50%, $300 max	25%, $150 max	50%, $300max	25%, $150 max	50%, $300max
Mail Order – 90-day supply						
Generic	$10	$10	$10	$10	$10	$10
Brand	$100	$200	$75	$150	$75	$150
Specialty	25%, $350 max	50%, $500max	25%, $350 max	50%, $500max	25%, $350 max	50%, $500max

^ Pre-certification for these services is required. Therapy services include Physical & Occupational (Up to 60 visits/calendar year); Speech (up to 30 visits/calendar year) and Cardiac or Pulmonary Rehab.

« Only certain radiology procedures require pre-certification.

* Care of a newborn during the covered portion of the mother's maternity stay.

** Inpatient stay at a skilled nursing facility is covered for the first 14 days following transfer from acute inpatient stay, when skilled care is still required.

Additional information on prescription coverage:

Under the Standard Option and Extended Option plans, you pay the prescription deductible before the Plan pays benefits. Some medications require pre-certification. For a list of drugs on the formulary, go to www.pciplan.com. Non-preferred step-therapy drugs are not a covered benefit. If you choose a brand-name drug for which a generic drug exists, you will pay the generic co-pay and the difference between the cost of the brand-name drug and the cost of the generic drug, unless your physician has provided clinical necessity for the brand-name drug which will require preauthorization. Only the generic co-pay will apply to your deductible and out-of-pocket maximum. The difference between the cost of the brand-name drug and the generic will not be applied to the deductible or annual out-of-pocket maximum. Specialty medications are those used to treat some severe, chronic medical conditions and are usually administered by injection or infusion.