Attach Your Logo

Plan name (32 pt)

http://www.planAddress.org **(14 pt)**

2001

A fee-for-service plan with a preferred provider organization

Artwork:

For changes in benefits, see page xx.

Sponsored and administered by: *{insert sponsoring organization name}*

Who may enroll in this Plan: *{plan specific}*

To become a member or associate member: *{plan specific}*

Xxxxxxx
Xxxxxx

If you are a non-postal employee/annuitant, you will automatically become an associate member of *{organization name}* upon enrollment in the *{Plan name}*.

Annuitants (retirees) may *{may not}* enroll in this Plan. *{plan specific}*

Membership dues: $xx per year for an associate membership. *{Organization name}* will bill new associate members for the annual dues when it receives notice of enrollment. *{Organization name}* will also bill continuing associate members for the annual membership. Active and retired Postal Service employee's membership dues vary by *{organization{* local. *{Plan specific}*

Enrollment codes for this Plan:

001 High Option - Self Only
002 High Option - Self and Family
004 Standard Option - Self Only
005 Standard Option - Self and Family

Authorized for distribution by the:

OPM Logo

United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

Federal Employees Health Benefits Program

RI 71-xxx

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Introduction

Sample FFS Benefit Plan
Address
City…

This brochure describes the benefits ***of [Insert plan name]*** under our contract (CS xxxx) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page xx. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means *{insert plan name}*.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this fee-for-service plan

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

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

We also have Preferred Provider Organizations (PPO):

Our fee-for-service plan offers services through a PPO. When you use our PPO providers, you will receive covered services at reduced cost. Contact us for the names of PPO providers and to verify their continued participation. You can also go to our web page, which you can reach through the FEHB web site, www.opm.gov/reitre. Do not call OPM or your agency for our provider directory.

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.

We also have Point-of-Service (POS) benefits:

Our fee-for-service plan offers POS benefits. This means you can get better benefits at less cost by signing up with us for the POS program, selecting a contracted primary care physician (PCP), and letting the PCP manage your care. We offer the POS program in the following areas: *{insert Plan specific info}.*

How we pay providers

{Plan specific – describe Patient Bill of Rights requirements re explaining how you pay}

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, which allows you to get information about your health plan, its networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

{Insert here the PBR information that you wish to include in the brochure, such as:}

- *{explain compliance and licensing requirements}*
- Years in existence
- Profit status

If you want more information about us, call xxx, or write to xxx. You may also contact us by fax at xx or visit our website at xxx.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our *{HMOs insert "plan network", and FFS insert "our PPO network"}* will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed *{insert "higher patient cost sharing" or "shorter day or visit limitations"}* on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Patient safety *{text to follow}*
-

Changes to this Plan

-

Section 3. How you get care

Identification cards

We will send you an identification (ID) card. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or obtain a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at xxx-xxx-xxxx.

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, or our point-of-service program, you will pay less.

- **Covered providers**

We consider the following to be covered providers when they perform services within the scope of their license or certification: *{Insert your list}*

Medically underserved areas. Note: In medically underserved areas, we cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines which states are "medically underserved." For 2001, the states are: Alabama, Idaho, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, North Dakota, South Carolina, South Dakota, Utah, and Wyoming.

- **Covered facilities**

Covered facilities include: *{Plan specific list moved here from 2000 brochure's Definitions}*

- Hospital
-

What you must do to get covered care

It depends on the kind of care you want to receive. You can go to any physician you want, but we must approve some care in advance.

Note:

Specialty care: If you have a chronic or disabling condition and lose access to your specialist because we:

- terminate our contract with your specialist for other than cause; or
- drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan,

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us if you think you are eligible.

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

Note:

Hospital care. 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 xxx.

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

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

These provisions apply only to the hospital benefit of the hospitalized person; we cover your other non-hospital care.

How to Get Approval for…

• Your hospital stay

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of a 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, you physician or hospital will take care of precertification. Because you are still responsible for ensuring that we are asked to precertify your care, 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. In addition, if the stay is not medically necessary, we will not pay any benefits.

How to precertify an admission: *{Plan specific – this is sample only}*

- You, your representative, your doctor, or your hospital must call us at *{insert phone #}* at least *{insert days, hours, etc}* prior to admission.
- If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function. You, your representative, the 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 your baby.

If your hospital stay Needs to be extended:

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

What happens when you do not follow the precertification rules

- 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.
- If no one contacted 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. *{Plan specific – check with contract specialist}*
- 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. *{Plan specific – check with contract specialist}*

Exceptions: You do not need precertification in these cases: *{Plan specific list}*

- You are admitted to a hospital outside the United States.
- You have another group health insurance policy that is the primary payer for the hospital stay.
- Your Medicare Part A is the primary payer for the hospital stay. Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we will become the primary payer and you do need precertification.

• Other services

Some services require a referral, precertification, or prior authorization. *{Plan specific list; describe all that you list}*

Section 4. Your costs for covered services

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

•Copayments

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

Example: When you see your PPO physician you pay a copayment of $10 *{plan specific}* per visit.

•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. Copayments do not count toward any deductible. *{Plan specific}*

- The calendar year deductible is $xxx per person under High Option and $xxx per person under Standard Option. Under a family enrollment, the deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $xxx under High Option and $xxx under Standard Option. *{Plan specific}*

- We also have separate deductibles for: *{if you have other deductibles, bullet list and explain them here. A hospital deductible is not a deductible -- it is a copayment}*

Note: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan.

And, if you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option. If you change plans during the year, you must begin the new deductible under your new plan.

•Coinsurance

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

Example: You pay 20% of our allowance for office visits. *{List Plan-specific}*

Note: If your provider routinely waives (does not require you to pay) your copayments, 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 30% coinsurance, the actual charge is $70. We will pay $49 (70% of the actual charge of $70). *{Plan specific amounts}*

•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 10.

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: 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, you pay just -- 10% of our $100 allowance ($10). Because of the agreement, your PPO physician will not bill you for the $50 difference between our allowance and his bill. *{Tailor percentages & dollar amounts to fit your benefits.}*

- **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 you pay 25% of our $100 allowance ($25). Plus, because there is no agreement between the non-PPO physician and us, he can bill you for the $50 difference between our allowance and his bill.

The following table illustrates the examples of how much you have to pay out-of-pocket 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	90% of our allowance: 90	75% of our allowance: 75
You owe: Coinsurance	10% of our allowance: 10	25% of our allowance: 25
+Difference up to charge?	No: 0	Yes: 50
TOTAL YOU PAY	$10	$75

Your out-of-pocket maximum

{Plan specific catastrophic protection benefit – see contract staff to plain language last year's text w/addition of carryover.}

When government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to

you or a family member. They may not seek more than their governing law requires.

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.

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

Under the FEHB law, we must limit our payments for those benefits you would be entitled to if you had Medicare. And, your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. The following chart has more information about the limits.

If you…

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

Then, for your inpatient hospital care,

- The law requires us to base our payment on an amount -- the "equivalent Medicare amount" -- set by Medicare's rules for what they would pay, not on the actual charge;
- You are responsible for your coinsurance and any applicable deductibles or copayments you owe under this Plan;
- You are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits; and
- The law prohibits a hospital from collecting more than the Medicare equivalent amount.

And, for your physician care, the law requires us to base our payment and your coinsurance on…

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

If your physician…	Then you are responsible for…
Participates with Medicare or accepts Medicare assignment for the claim and is a member of our PPO network,	your deductibles, coinsurance, and copayments;
Participates with Medicare and is not in our PPO network,	your deductibles, coinsurance, copayments, and any balance up to the Medicare approved amount;
Does not participate with Medicare,	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount

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

If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us.

When you have Original Medicare

We limit our payment to an amount that supplements the benefits that Medicare would pay, regardless of whether Medicare pays. Note: We pay our regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

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

- If your physician accepts Medicare assignment, then you pay nothing for covered charges. *{Plan specific. If you don't waive, then say: "If your physician accepts Medicare assignment, then you pay our deductible*

- If your physician does not accept Medicare assignment, then you pay the difference between the charge and our payment combined with Medicare's payment.

Note: The physician may not bill you for more than 115% of the amount Medicare bases its payment on, called the "limiting charge." The Medicare Summary Notice (MSN) form will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask them to reduce their charges. If they do not, report them to your Medicare carrier who sent you the MSN form. Call us if you need further assistance.

{NOTE FOR PLAN: Please check letters that go to enrollees so that they fit processes described here, e.g., letters should say "because you're getting this letter, you need to send us the MSN…" Don't assume enrollee knows what to do.}

When you have a Medicare Private Contract

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

Please see Section 9, Coordinating benefits with other coverage, for more information about how we coordinate benefits with Medicare.