Enclosure 2A - Fee-for-Service brochure examples

This is the key for the "Print size" and "Print style". Follow the visual in making text: **bold,** ***bold-italicized,*** and *italicized*, and for shading degrees.

ì Times New Roman, 32-point
í Times New Roman, 14-point
î Times New Roman, 16-point
ï Times New Roman, 13-point
ð Times New Roman, 10 point
ñ {{Use Graphic for logo AND it's text}}
ò Times New Roman, 11-point
ó Times New Roman, 12-point
ô Tahoma, 14-point (or equivalent)

FES TYPESETTING EXAMPLES

Attach Your Logo

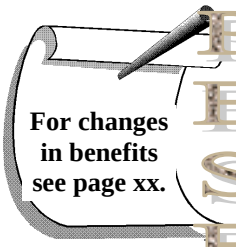
❶Plan name

❷http://www.planAddress.org

❶2001

FEHB TYPESETTING EXAMPLES

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

❻ 

❹**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

❻

Authorized for distribution by the:

OPM
UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

❻

❻ FEHB
Federal Employees
Health Benefits Program

❺RI 71-xxx

❷Table of Contents

FEHB TYPESETTING EXAMPLES

FFS TYPESETTING EXAMPLES

❷Section 2. How we change for 2001

❺Program-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.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling *{insert plan phone number and contact}*, **or** checking our website *{insert plan website}*. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:

  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.

- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.
- North Dakota is deleted from the list of states designated as medically underserved in 2001. See page xx for information on medically underserved areas.

Changes to this Plan

- Your share of the non-Postal premium will [decrease][increase] by xx% for Self Only or xx% for Self and Family.
-

Section 3. How you get care

❽Identification cards

❺We 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 fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (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.

❺• 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 are "medically underserved." For 2001, the states are: Alabama, Idaho, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, 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.

Transitional care:

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 or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can

FES TYPESETTING EXAMPLES

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

❺Under 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.

❽If you…

- ❺are 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.)

❽Then, for your inpatient hospital care,

- ❺The law requires us to base our payment on an amount -- the "equivalent Medicare amount" -- set by Medicare's rules for what Medicare would pay, not on the actual charge;
- You are responsible for your applicable deductibles, coinsurance, 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.

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

FEES TYPESETTING EXAMPLES

❷Section 5. Benefits -- OVERVIEW

❽*(See page xx for how our benefits changed this year and page xx for a benefits summary.)*

❺**NOTE**: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at *{phone number}* or at our website at www. *{insert web address}*.

TEST TYPESETTING EXAMPLES

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

❼IMPORTANT

Here are some important things you should keep in mind about these benefits:

- ❺Please 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.
- ❺The calendar year deductible is: $275 per person ($550 per family). 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.
- ❺Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

❼IMPORTANT

40% shading

❽Benefit Description	❽You pay ❺After 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	*10% shading*
❺Professional services of physicians • In physician's office	PPO: $15 copayment (no deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Office medical consultations • Second surgical opinion • At home	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount *{Throughout this brochure, you may reduce this column, but not less than to 2". Keep column width consistent -- e.g., don't have a 2" You pay column in one section and a 3" You pay column in another section.}*
Not covered: Routine physical checkups and related tests	*All charges*

FEES TYPESETTING EXAMPLES

❷Section 6. General exclusions -- things we don't cover

❺The exclusions in this section apply to all benefits. **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, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest {*plan specific—can vary somewhat; discuss with contracts specialist }*;
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

*{{Insert other "**General** Exclusions" from your 2000 brochure—your contract specialist will help you edit for plain language and necessity – BE SURE TO PUT "; or" after the next to last entry and then a period after the last entry}}*

FFS TYPE SETTING EXAMPLES

❷Section 7. Filing a claim for covered services

❽How to claim benefits

❺To obtain claim forms or other claims filing advice or answers about our benefits, contact us at _____, or at our website at www.xxx.

In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at xxx.

When you must file a claim -- such as for overseas claims or when another group health plan is primary -- submit it on the HCFA-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:

- You must send a copy of the explanation of benefits (EOB) from any primary payer (such as the Medicare Summary Notice (MSN)) with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- Claims for rental or purchase of durable medical equipment; private duty nursing; and physical, occupational, and speech therapy require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies that are not ordered through the Mail Service Prescription Drug Program must include receipts that include the prescription number, name of drug or supply, prescribing physician's name, date, and charge.

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❷Section 8. The disputed claims process

{NOTE: For step numbers below, sample below is 16pt Tahoma. But as long as the numbers stand out and look balanced, it won't matter what type face you use.}

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

❺Step	Description
1	❺Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: *{{Plan address}};* and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	❺We 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 ~~medical~~ 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. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division xx, P.O. Box 436, Washington, D.C. 20044-0436.