The Federal Employees Health Benefits (FEHB) Program: FEHB PLANS 2010 – Nationwide Fee-for-Service, Open to All Therapy Services


(Click on any state of US map, then choose link to “Nationwide Fee-for-Service Open to All.” PDF icons in the table below are live links that will take patients to the plan brochures online.)

Information in this document was compiled by Angela Foehl, JD, MPH, Director of the National Policy Agenda for The American Art Therapy Association. September 15, 2010

NOTES: Plans are listed alphabetically in these tables but are ordered by Plan Code number on OPM’s website. Information below was excerpted from FEHB 2010 Plan Brochures (available online) that have more details. The table below is a summary; as such, it does not include all pertinent information. Please confirm coverage, reimbursement and other information with Plan Brochure to ensure complete understanding. (* Use of the term “we” means the insurance carrier-this excerpted information is copied from carriers’ Plan Brochures.)

CAVEATS:
- Coverage terms are typically separated into two categories: 1) rehabilitative therapy (OT, PT); and 2) mental health / substance abuse therapy.
- Coverage may apply only to specifically credentialed and/or licensed therapists, depending upon the insurance carrier.
- Coverage terms may vary, depending upon the category of the therapist’s licensure or certification, such as occupational therapist or psychologist, even if the therapeutic service provided is the same or similar, i.e., art therapy.

NOTE: Medically underserved areas (per OPM determination) may have special coverage terms, such as coverage for any licensed medical practitioner for any covered service performed within the scope of that license in the “medically underserved” states. For 2010, those states are: Alabama, Arizona, Idaho, Illinois, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota and Wyoming.

- **Deductible:** Some plans require that the plan member pays out-of-pocket until the annual deductible dollar amount is met before coverage applies.
- See plan brochures for coverage details, conditions, limits, and exclusions
For details on what is not covered by each plan, see plan brochures under “Section 6. General exclusions.” “The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat patients’ illness, disease, injury, or condition.”
### TABLES: FEHB Plans 2010: Nationwide Fee-for-Service, Open to All

<table>
<thead>
<tr>
<th>Plan Code</th>
<th>Plan Brochure</th>
<th>OT, PT THERAPY SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>APWU</td>
<td>[2.78 MB]</td>
<td>APWU - THERAPY SERVICES, general</td>
</tr>
<tr>
<td>FFS w/PPO (2)</td>
<td>[60-VISIT/YR THERAPY POOL]</td>
<td>1. High Option FFS 2. CDHP + PPO 2010 Change/Clarification</td>
</tr>
<tr>
<td>1) High Option (FFS w/PPO)</td>
<td>2) Consumer Driven Option (CDHP) (FFS w/PPO)</td>
<td>We consider the following to be covered providers when they perform services within the scope of their license or certification:</td>
</tr>
<tr>
<td>A fee-for-service plan (high option) and a consumer driven health plan with preferred provider organizations</td>
<td>TDD 1-800-622-2511</td>
<td>1. <strong>Doctor</strong> – A licensed doctor of medicine (M.D.), a licensed doctor of osteopathy (D.O.) . . . or, for certain specified services covered by this Plan, a . . . <strong>licensed clinical psychologist</strong> practicing within the scope of the license.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. <strong>Alternate Provider</strong> – Alternate providers are covered when performing certain specified services covered by this Plan and when such treatment is within the scope of the provider’s license. Alternate providers are limited to <strong>licensed physical, occupational and speech therapists; licensed physician’s assistants; Registered Nurses (R.N.)</strong>. . .</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. <strong>Other covered providers include a qualified clinical psychologist, clinical social worker</strong>, . . . <strong>nurse practitioner /clinical specialist, and nursing school administered clinic.</strong> For purposes of this FEHB brochure, the term “doctor” includes all of these providers when the services are performed within the scope of their license or certification.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Medically underserved areas.</strong> Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in the states OPM determines are “medically underserved.” For 2010, the states are: AL, AZ, ID, IL, KY, LA, MS, MO, MT, NM, ND, SC, SD and WY.</td>
</tr>
</tbody>
</table>

### MENTAL HEALTH / SUBSTANCE ABUSE SERVICES

**Section 5 (e). Mental health and substance abuse benefits, p46**

The Mental health and substance abuse benefits have a separate calendar year deductible. In-network deductible is $275 per person, $550 per family. The out of network deductible is $500 per person, $1,000 per family.

**Note:** Preauthorization of mental health and substance abuse therapies is required, including hospital stays and outpatient care. All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies . . .

**Note:** In-network benefits are payable only when we determine the care is clinically appropriate to treat patients’ condition and only when patient receive the care as part of a treatment plan that we approve.

- Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, licensed social workers, or licensed intensive outpatient treatment centers
- Inpatient services provided by a hospital or other facility
- Services in approved partial hospitalization setting

**Not covered:** Services we have not approved

*Note: OPM will base its review of disputes about treatment plans on the treatment plan’s clinical appropriateness. OPM will generally not order us to...*
• **Medical Necessity:** Claims for . . . therapy require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.

**THERAPY POOL:** Physical therapy and occupational therapy provided by a licensed registered therapist up to a combined 60 visits per calendar year.

**Note:** Preauthorization of rehabilitative therapies is required.
(See Other services under How to get approval for... in Section 3.)

• **Prior approval/pre-notification** is required for home health care such as . . . rehabilitative therapy (physical, occupational or speech therapy) p14

Note: We only cover physical and occupational 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:
1. Orders the care
2. Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and
3. Indicates the length of time the services are needed

**Not covered:**
• **Maintenance therapies**
• **Exercise programs**
• **Physical and occupational therapies without preauthorization**

**Section 6. General exclusions**
• Biofeedback; Non-medical self care or self help training, such as recreational, educational, or milieu therapy;
• Charges that we determine to be in excess of the Plan allowance.

**Out-of-network benefits:** See p47

pay or provide one clinically appropriate treatment plan in favor of another.

**High Option**
The following cannot be included in the accumulation of out-of-pocket expenses:
• Expenses in excess of visit maximums for OT, PT and speech therapy (see pages 29 and 30)

THERAPY POOL: 60 visits per year, max. Services of OT therapy, PT therapy and/or speech therapy are combined.

Note: “We also have the right to deny any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.”

MEMBER PAYS-High Option
After the calendar year deductible...
PPO: 10% of the Plan allowance
Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

MEMBER PAYS-CDHP
In-network: 15% of the Plan allowance
Out-of-network: 40% of the Plan allowance and any difference between our allowance and the billed amount

OTHER: Personal Care Account-CDHP:
• All eligible health care expenses (except in-network preventive care) are paid first from patients’ Personal Care Account (PCA).

How we pay providers
PPO Providers: Allowable benefits are based upon charges and discounts which we or our PPO administrators have negotiated with participating providers. PPO provider charges are always within our Plan allowance.
Non-PPO providers: We determine our allowance for covered charges by using health care charge data prepared by EMC for the High Option and Ingenix for the Consumer Driven Health Plan, including our own
data, when necessary. We apply this charge data under the High Option at the 70th percentile and under the Consumer Driven Option at the 80th percentile.

---

<table>
<thead>
<tr>
<th>Plan Code</th>
<th>Plan Code</th>
<th>Plan Brochure</th>
<th>BC/BS- OT, PT THERAPY SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>10, 11</td>
<td>1.8 MB</td>
<td>Go</td>
<td>Standard &amp; Basic Options (FFS w/ PPO)</td>
</tr>
</tbody>
</table>

**Plan Website**

**Section 6. General exclusions**

We do not cover the following:

- Experimental or investigational procedures, treatments, drugs, or devices
- Self-care or self-help training;
- Recreational or educational therapy, and any related diagnostic testing, except as provided by a hospital during a covered inpatient stay

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

- **Physicians** – Doctors of medicine (M.D.); Doctors of osteopathy (D.O.); . . . covered services provided in medically underserved areas as described on page 12; and the performance of covered physical therapy evaluations and physical therapy treatment modalities identified on page 41.
- **Other Covered Health Care Professionals** – Professionals who provide additional covered services and meet the state’s applicable licensing or certification requirements and the requirements of the Local Plan. Examples of other covered health care professionals include: . . .
  - **Clinical Psychologist** – A psychologist who (1) is licensed or certified in the state where the services are performed; (2) has a doctoral degree in psychology (or an allied degree if, in the individual state, the academic licensing/certification requirement for clinical psychologist is met by an allied

**PRIOR APPROVAL:** required before receiving any outpatient Professional or outpatient facility care (mental health and substance abuse services) [except visits for pharmacotherapy (medication management) or psychological testing].

**Precertification for Hospital stays:** required

**Covered – (In-Network) Preferred Providers:**

Professional services, including individual or group therapy, provided by licensed professional mental health and substance abuse practitioners when acting within the scope of their license

- Office and home visits
- In a hospital outpatient department (except for emergency rooms)
- Psychotherapy for smoking cessation
- Pharmacotherapy (medication management)
- Psychological testing Inpatient professional visits
- Professional charges for facility-based intensive outpatient treatment
- Professional charges for outpatient diagnostic tests
- Professional charges for intensive outpatient treatment in a provider’s office or other professional
degree) or is approved by the Local Plan; and (3) has met the clinical psychological experience requirements of the individual State Licensing Board.

**Clinical Social Worker**—A social worker who (1) has a master’s or doctoral degree in social work; (2) has at least two years of clinical social work practice; and (3) if the state requires it, is licensed, certified, or registered as a social worker where the services are performed.

**Mental Health or Substance Abuse professional**—A professional who is licensed by the state where the care is provided to provide mental health and/or substance abuse services within the scope of that license.

**Physical, Speech, and Occupational Therapist**—A professional who is licensed where the services are performed or meets the requirements of the Local Plan to provide physical, speech, or occupational therapy services.

**Other professional providers** specifically shown in the benefit descriptions in Section 5. P27 Section 5(a). Medical services and supplies provided by physicians and other health care professionals

<table>
<thead>
<tr>
<th>Covered:</th>
<th>Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and treatment services</td>
<td>• Inpatient services provided and billed by a hospital or other covered facility</td>
</tr>
<tr>
<td>Professional services of physicians and other health care professionals:</td>
<td>• Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services</td>
</tr>
<tr>
<td>• Outpatient consultations</td>
<td>• Diagnostic tests</td>
</tr>
<tr>
<td>• Office visits</td>
<td></td>
</tr>
<tr>
<td>• Home visits</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient professional services:</strong></td>
<td></td>
</tr>
<tr>
<td>• During a hospital stay</td>
<td></td>
</tr>
<tr>
<td>• Services for nonsurgical procedures when ordered, provided, and billed by a physician during a covered inpatient hospital admission</td>
<td></td>
</tr>
<tr>
<td><strong>OT, Cognitive Rehab Therapy, PT</strong></td>
<td></td>
</tr>
<tr>
<td>• PT therapy, OT therapy, and speech therapy when performed by a licensed therapist or physician</td>
<td></td>
</tr>
<tr>
<td>• Cognitive rehabilitation therapy when performed by a licensed therapist or physician</td>
<td></td>
</tr>
</tbody>
</table>

**Not covered: Preferred (In-Network)**

- Services we have not approved
- Educational or training services
- Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present
- Services performed or billed by residential therapeutic camps (e.g., wilderness camps, Outward Bound, etc.)
- Light boxes

**Not covered: Non-preferred (Out-of-Network) benefits**

- Marital, family, educational, or other counseling or training services
- Services performed by a non-covered provider
- Testing and treatment for learning disabilities and mental retardation
- Services performed or billed by schools, residential treatment centers, halfway houses, or members of their staffs
- Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present
- Services performed or billed by residential therapeutic camps (e.g., wilderness camps, Outward Bound, etc.)
- Light boxes
**Note:** When billed by a skilled nursing facility, nursing home, or extended care facility, we pay benefits as shown here for professional care, according to the contracting status of the facility.

**Not covered:**
- Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay
- Maintenance or palliative rehabilitative therapy
- Exercise programs

<table>
<thead>
<tr>
<th>MEMBER PAYS - Standard Option</th>
<th>Preferred primary care provider or other health care professional: $20 copayment per visit (No deductible)</th>
<th>Preferred: specialist: $30 copayment per visit (No deductible)</th>
<th>Participating: 35% of the Plan allowance</th>
<th>Non-Participating: 35% of the Plan allowance, plus any difference between our allowance and the billed amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>THERAPY POOL - Standard Option:</strong> Benefits are limited to 75 visits per person, per calendar year for PT, OT, or speech therapy, or a combination of all three.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Visits that patient pays for while meeting patients’ calendar year deductible count toward the limit cited above.
**Note:** When billed by a facility . . . we provide benefits . . . according to the contracting status of the facility.

<table>
<thead>
<tr>
<th>MEMBER PAYS - Basic Option</th>
<th>Preferred primary care provider or other health care professional: $25 copayment per visit</th>
<th>Preferred specialist: $35 copayment per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>THERAPY POOL:</strong> Patient pays 30% of the Plan allowance for drugs and supplies administered or obtained in connection with patients’ care.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Benefits are limited to 50 visits per person, per calendar year for PT, OT, or speech therapy, or a combination of all three.

**Participating/Non-Participating:** Patient pays all charges

*Note:* See Section 5(c) for our payment levels for rehabilitative therapies billed for by the outpatient department of a hospital.

**Alternative treatments**

*Not covered:* Services patients receive from non-covered providers such as:
- naturopaths
- hypnotherapists
- Biofeedback
- Self-care or self-help training

*Note:* We may also cover services of certain alternative treatment providers in medically underserved areas. See page 12

**How we pay professional and facility providers**

Each Local Plan contracts with hospitals and other health care facilities, physicians, and other health care professionals in its service area, and is responsible for processing and paying claims for services within that area. Many, but not all, of these contracted providers are in our PPO (Preferred) network.

- **PPO providers.** PPO (Preferred) providers have agreed to accept a specific negotiated amount as payment in full for covered services provided to patients. We refer to PPO facility and professional providers as "Preferred." They will generally bill the Local Plan directly, who will then pay them directly. Patients do not file a claim. Patients’ out-of-pocket costs are generally less when patients receive covered services from Preferred providers, and are limited to patients’ coinsurance or copayments (and, under Standard Option only, the applicable deductible).
- **Participating providers.** Some Local Plans also contract
with other providers that are not in our Preferred network. If they are professionals, we refer to them as "Participating" providers. If they are facilities, we refer to them as "Member" facilities. They have agreed to accept a different negotiated amount than our Preferred providers as payment in full. They will also generally file patients’ claims for them. They have agreed not to bill patients for more than patients’ applicable deductible, and coinsurance or copayments, for covered services. We pay them directly, but at our Non-preferred benefit levels. Patients’ out-of-pocket costs will be greater than if patients use Preferred providers. **Note:** Not all areas have Participating providers and/or Member facilities.

**• Non-participating providers.** Providers who are not Preferred or Participating providers do not have contracts with us, and may or may not accept our allowance. **We refer to them as "Non-participating providers" generally,** although if they are facilities **we refer to them as "Non-member facilities.**” When patients use Non-participating providers, patients may have to file claims with us. We will then pay our benefits to patients, and patients must pay the provider. Patients must pay any difference between the amount Non-participating providers charge and our allowance (except in certain circumstances – see page 128). In addition, patients must pay any applicable coinsurance amounts, copayment amounts, amounts applied to patients’ calendar year deductible, and amounts for non-covered services.

Under Basic Option, patients must use Preferred providers to receive benefits. See page 14 for the exceptions to this requirement.

**Note:** In Local Plan areas, Preferred providers and Participating providers who contract with us will accept 100% of the Plan allowance as payment in full for covered services. As a result, patients are only responsible for applicable coinsurance or copayments (and, under **Standard Option** only, the applicable deductible), for covered services, and any charges for non-covered services.
GEHA Benefit Plans
NATIONWIDE: 31
FFS w/ PPO(2)
High & Standard Options

[31 & 34: THERAPY POOL: 30 VISITS/YR]
A fee-for-service (high & standard option) HEALTH PLAN WITH A
PREFERRED PROVIDER ORGANIZATION

GEHA High Deductible Health Plan
NATIONWIDE: 34

TDD (800) 821-4833

Plan | Plan Code | Plan Brochure | OT, PT THERAPY SERVICES | MENTAL HEALTH / SUBSTANCE ABUSE SERVICES
--- | --- | --- | --- | ---
| | | | GEHA-THERAPY SERVICES | 2010 Change/Clarification
#31 High & Standard Options FFS + PPO
#34 High Deductible (same coverage terms as #31 but patient pays more of costs)

2010 Change/Clarification
• Outpatient visits for psychotherapy visits are no longer limited to 30 visits per calendar year. Inpatient hospital days and inpatient physician hospital visits are no longer limited to 100 per calendar year.
• Inpatient treatment for alcoholism and drug abuse is no longer limited to 30 lifetime days.
• Outpatient Intensive Day Treatment is no longer limited to 60 days per calendar year.

All benefits are subject to medical necessity review. Admissions to out-of-network Residential Treatment Centers are now covered subject to medical necessity review.
• Precertification is now required for out-of-network Intensive Day Treatment. (see page 13)
• Licensed Professional Counselors and Licensed Marriage and Family Therapists are now covered providers when services are performed within the scope of their license. (see pages 11 and 57)

DEFINITION: Mental health/substance abuse
Conditions and diseases listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) 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 of or dependence upon substances such as alcohol, narcotics or hallucinogens.

• #31 & #34 THERAPY POOL: 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

• We have added additional information on requirements and procedures for precertifying PT, OT and speech therapy. (see pages 34-35)
• All PT & OT therapy visits require preauthorization.
• Authorization for therapy is based on medical necessity.

Coverage 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

SNF CARE: Medically necessary physical or occupational therapy on an outpatient basis from a qualified professional therapist at a skilled nursing facility is covered up to plan limits.

Not covered:
• Exercise programs
• Long-term rehabilitative therapy
Biofeedback, educational, recreational or milieu therapy, either in or out of a hospital;

**Not covered:**
- Computer devices to assist with communications
- Computer programs of any type, including but not limited to those to assist with speech therapy

In order to make individual-specific authorization decisions, OrthoNet will review the treating provider’s evaluation; including diagnosis, duration of member’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.

**MEMBER PAYS-HIGH**
**PPO:** 10% of the Plan allowance  
**Non-PPO:** 25% of the Plan allowance and any difference between our allowance and the billed amount

**MEMBER PAYS-Standard**
**PPO:** 15% of the Plan allowance  
**Non-PPO:** 35% of the Plan allowance and any difference between our allowance and the billed amount

**How we pay providers**
Fee-for-service plans reimburse a provider for covered services. The FFS plan reimburses patients for health care expenses, usually on a percentage basis. These percentages, as well as deductibles, methods for applying deductibles to families and the percentage of coinsurance patients must pay vary by plan.

**Covered:**
- Individual or group therapy by psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists
- Medication management
- Psychological tests (requires precertification)
- Inpatient professional fees
- Diagnostic tests

**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 member’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

**Biofeedback, educational, recreational or milieu therapy, either in or out of a hospital**

**Extended care benefits/Skilled nursing care facility benefits:** No benefit
<table>
<thead>
<tr>
<th>Plan</th>
<th>Plan Code</th>
<th>Plan Brochure</th>
<th>OT, PT THERAPY SERVICES</th>
<th>MENTAL HEALTH / SUBSTANCE ABUSE SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAIL HANDLERS BENEFIT PLANS</td>
<td>41 45 48</td>
<td>[1.97 MB] (All)</td>
<td>MHBP-THERAPY SERVICES 1. Standard Option (FFS-45) 2. Value Plan (FFS-41) 3. Consumer Option (HD w/PPO-48)</td>
<td>Covered: All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Note: Managed In-Network benefits are payable only when we determine the care is clinically appropriate to treat patients’ condition and only when patients receive the care as part of a treatment plan that we approve.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Outpatient professional services, including individual or group therapy by providers approved by us. This may include services provided by a Licensed Professional Counselor or Licensed Marital Family Therapist.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Medication management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Outpatient diagnostic tests including psychological testing and laboratory procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Inpatient professional services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>We require preauthorization of mental health/substance abuse services under the managed In-Network benefit. See Section 5(e).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Not covered: • Educational, recreational or milieu therapy, whether in or out of the hospital.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Hospital admissions for medical rehabilitation unless the admission is to an approved acute inpatient rehabilitation facility and the patient can actively participate in a minimum of 3 hours of acute inpatient rehabilitation to include any combination of the following therapies: physical, occupational, speech, respiratory therapy per day</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Outpatient professional services, including individual or group therapy by providers approved by us. This may include services provided by a Licensed Professional Counselor or Licensed Marital Family Therapist.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Medication management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Outpatient diagnostic tests including psychological testing and laboratory procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Inpatient professional services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>We require preauthorization of mental health/substance abuse services under the managed In-Network benefit. See Section 5(e).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Not covered: • Educational, recreational or milieu therapy, whether in or out of the hospital.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Hospital admissions for medical rehabilitation unless the admission is to an approved acute inpatient rehabilitation facility and the patient can actively participate in a minimum of 3 hours of acute inpatient rehabilitation to include any combination of the following therapies: physical, occupational, speech, respiratory therapy per day</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Outpatient professional services, including individual or group therapy by providers approved by us. This may include services provided by a Licensed Professional Counselor or Licensed Marital Family Therapist.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Medication management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Outpatient diagnostic tests including psychological testing and laboratory procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Inpatient professional services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>We require preauthorization of mental health/substance abuse services under the managed In-Network benefit. See Section 5(e).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Not covered: • Educational, recreational or milieu therapy, whether in or out of the hospital.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Hospital admissions for medical rehabilitation unless the admission is to an approved acute inpatient rehabilitation facility and the patient can actively participate in a minimum of 3 hours of acute inpatient rehabilitation to include any combination of the following therapies: physical, occupational, speech, respiratory therapy per day</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Outpatient professional services, including individual or group therapy by providers approved by us. This may include services provided by a Licensed Professional Counselor or Licensed Marital Family Therapist.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Medication management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Outpatient diagnostic tests including psychological testing and laboratory procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Inpatient professional services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>We require preauthorization of mental health/substance abuse services under the managed In-Network benefit. See Section 5(e).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Not covered: • Educational, recreational or milieu therapy, whether in or out of the hospital.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Hospital admissions for medical rehabilitation unless the admission is to an approved acute inpatient rehabilitation facility and the patient can actively participate in a minimum of 3 hours of acute inpatient rehabilitation to include any combination of the following therapies: physical, occupational, speech, respiratory therapy per day</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Outpatient professional services, including individual or group therapy by providers approved by us. This may include services provided by a Licensed Professional Counselor or Licensed Marital Family Therapist.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Medication management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Outpatient diagnostic tests including psychological testing and laboratory Procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Inpatient professional services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>We require preauthorization of mental health/substance abuse services under the managed In-Network benefit. See Section 5(e).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Not covered: • Educational, recreational or milieu therapy, whether in or out of the hospital.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Hospital admissions for medical rehabilitation unless the admission is to an approved acute inpatient rehabilitation facility and the patient can actively participate in a minimum of 3 hours of acute inpatient rehabilitation to include any combination of the following therapies: physical, occupational, speech, respiratory therapy per day</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Outpatient professional services, including individual or group therapy by providers approved by us. This may include services provided by a Licensed Professional Counselor or Licensed Marital Family Therapist.</td>
</tr>
</tbody>
</table>
SNF.

**Not covered:**
- Naturopathic and homeopathic services...
- Self care or home management training or programs
- All charges after the Plan has paid the $2,500 combined rehabilitative, chiropractic and alternative treatment therapies annual maximum

Note: Services of certain alternative treatment providers may be covered in medically underserved areas — see Covered providers, Section 3.

**MEMBER PAYS - Standard**

**PPO:** 10% of the Plan’s allowance and all charges after the Plan has paid the $2,500 combined rehabilitative, chiropractic and alternative treatment therapies maximum

**Non-PPO:** 30% of the Plan’s allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the $2,500 combined rehabilitative, chiropractic and alternative treatment therapies maximum

**MEMBER PAYS - Value**

**PPO:** 20% of the Plan’s allowance and all charges after the Plan has paid the $2,500 combined rehabilitative, chiropractic and alternative treatment therapies maximum

**Non-PPO:** 40% of the Plan’s allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the $2,500 combined rehabilitative, chiropractic and alternative treatment therapies maximum

**MEMBER PAYS - Consumer**

**PPO:** $15 copayment per visit and all charges after the Plan has paid the $2,500 combined rehabilitative, chiropractic and alternative treatment therapies maximum

**Non-PPO:** 40% of the Plan’s allowance and any difference between our allowance and the billed amount; all charges after the Plan has paid the $2,500 combined rehabilitative, chiropractic and alternative treatment therapies maximum

- Custodial care; see Section 10 Definitions
- Non-covered facilities, such as nursing homes, subacute care facilities, extended care facilities, schools, domiciliaries and rest homes
- Personal comfort items, such as telephone, television, barber services, guest meals and beds
- Private inpatient nursing care
- Institutions that do not meet the definition of covered hospitals
- All charges after the Plan has paid $30,000 for services provided by a Christian Science nursing facility
How we pay providers
PPO provider or facility: our Plan allowance is the negotiated rate for the service. Patients are not responsible for charges above the negotiated amount. Non-PPO facilities and providers do not have special agreements with the Plan. Our payment is based on the Plan allowance for covered services. Patients may be responsible for amounts over the allowance.

If PPO providers are available and a patient does not use them, the Plan will base its allowance on a fee schedule that represents an average of the PPO fee schedules for a particular service in a particular geographic area (see definition of Plan allowance, Section 10, for further details).

Plan Code
NALC

FFS w/ PPO
A fee-for-service plan with a Preferred provider organization

<table>
<thead>
<tr>
<th>Plan Code</th>
<th>Plan Brochure</th>
<th>OT, PT THERAPY SERVICES</th>
<th>NALC-THERAPY SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>32</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section 6. General exclusions
We do not cover the following:
- Experimental or investigational procedures, treatments, drugs, or devices
- Therapy, other than speech therapy, for developmental delays and learning disabilities

THERAPY POOL: PT, OT, SLP
- A combined total of 75 visits per calendar year for treatment provided by a licensed registered therapist or physician for the following:
  - PT therapy
  - OT therapy
  - Speech therapy

MENTAL HEALTH / SUBSTANCE ABUSE SERVICES

Covered: Individual or group therapy by psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists
- Medication management

Inpatient hospital and patient residential treatment centers - Standard Option Covered:
- 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.

Not covered:
**Therapy is covered when the attending physician:**
- Orders the care;
- Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and
- Indicates the length of time the services are needed.

**Note:** For therapies performed on the same day as outpatient surgery, see Section 5(c). Outpatient hospital or ambulatory surgical center.

**Not covered:**
- Exercise programs
- Maintenance therapy that maintains a functional status or prevents decline in function

**MEMBER PAYS**

**PPO:** $15 copayment per visit (no deductible) and all charges after 75 visit limit

**Non-PPO:** 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount and all charges after 75 visit limit

**How we pay providers**
For a PPO provider or facility, our Plan allowance is the negotiated rate for the service. Patients are not responsible for charges above the negotiated amount. Non-PPO facilities and providers do not have special agreements with us. Our payment is based on our allowance for covered services. Patients may be responsible for amounts over the allowance. We also obtain discounts from some non-PPO providers.

**Precertification-required**
To be eligible to receive full benefits for mental health and substance abuse, patients must follow the authorization process:
- Patients must call InforMed at (800) 242-1025 to receive authorization for inpatient care and outpatient intensive day treatment.

**Section 6. General exclusions**
We do not cover the following:
- Services, drugs, or supplies patients receive while patients 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

Services or supplies furnished or billed by a noncovered facility, except that medically necessary prescription drugs and physical, occupational and speech therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to Plan limits;
- Biofeedback, educational, recreational or milieu
<table>
<thead>
<tr>
<th>Plan Code</th>
<th>Plan Brochure</th>
<th>OT, PT THERAPY SERVICES</th>
<th>MENTAL HEALTH / SUBSTANCE ABUSE SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAMBA- THERAPY SERVICES High &amp; Standard Options (FFS w/ PPO)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010 Changes -High &amp; Standard Options THERAPY POOL: PT/OT Services of a qualified physical therapist, occupational therapist, doctor of osteopathy (D.O.), or physician for the following:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physical therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Occupational therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Option: Benefits are limited to 75 visits per person, per calendar year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Option 50 visits per person, per calendar year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Visits that patient pays for while meeting patients’ calendar year deductible count toward the per-person/per-calendar year visit limitation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not covered:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Long-term rehabilitative therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Exercise programs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MEMBER PAYS-High PPO: 10% of the Plan allowance and all charges in excess of the 50 visit limitation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-PPO: 30% of the Plan allowance and any difference</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior Authorization is required for:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient treatment and day or after care treatment (partial hospitalization).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Covered outpatient services for the treatment of mental conditions and substance abuse. Patients’ provider must submit a treatment plan to CIGNA/Care ALLies prior to patients’ 9th outpatient visit. In determining when patients’ treatment plan must be submitted, we count all outpatient psychotherapy visits, even if patients use different providers.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered (In-Network): All diagnostic and treatment services contained in a treatment plan that we approve may include services, drugs, and supplies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: In-Network benefits are payable only when we determine the care is clinically appropriate to treat patients’ condition and part of a treatment plan that we approve.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient professional services by providers such as psychiatrists, psychologists, or clinical social workers including:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
between our allowance and the billed amount and all charges in excess of the 50 visit limitation  
**MEMBER PAYS - Standard**  
PPO: 15% of the Plan allowance and all charges in excess of the 30 visit limitation  
Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the 30 visit limitation  

**MEMBER PAYS - High**  
PPO: 10% of the Plan allowance and all charges in excess of the 50 visit limitation  
Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the 50 visit limitation  

**How we pay providers**  
When patients use a PPO provider or facility, our Plan allowance is the negotiated rate for the service. Patients are not responsible for charges above the negotiated amount.  
Non-PPO facilities and providers do not have special agreements with the Plan. When patients use a non-PPO provider to perform the service or provide the supply, covered expenses will be considered at the 75th percentile factor of claims data and fee information gathered for specific geographic areas and payable at the Plan’s out-of-network (non-PPO) benefits. Patients are responsible for amounts over the Plan’s allowance.  
We also obtain discounts from some non-PPO providers.  

- individual or group therapy  
- collateral visits with members of the patient’s immediate family  

**Not covered (In-Network):**  
- Marital counseling  
- Treatment for learning disabilities  
- Telephone consultations and/or therapy  
- On-line consultations  
- Travel time to the patient's home to conduct therapy

**Covered: Out-of-Network benefits High & Standard Option**  
We will cover the office visit fee for therapy sessions rendered by providers such as psychiatrists, psychologists, or clinical social workers.  
Therapy sessions include:  
- Office visits, group therapy, and collateral visits with members of the patient’s immediate family  

Other outpatient care includes:  
Day or after care (partial hospitalization) in a hospital  

Note: Almost all benefits for the treatment of mental health and substance abuse require precertification, see page 52. During the precertification process, we may establish an approved treatment plan.  

**Not covered out-of-network:**  
- The same exclusions contained in this brochure that apply to other benefits apply to mental health and substance abuse benefits. OPM's review of disputes about out-of-network treatment plans will be based on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.  
- Marital counseling  
- Treatment for learning disabilities  
- Telephone consultations and/or therapy
EXPLANATION OF PLAN TYPES
Different types of plans help patients get and pay for care differently.
Fee-For-Service (FFS) plans generally use two approaches.

1. **Fee-for-Service FFS Plans (non-PPO)** - A traditional type of insurance in which the health plan will either pay the medical provider directly or reimburse patient after patient have filed an insurance claim for each covered medical expense. When patient need medical attention, patient visit the doctor or hospital of patient's choice. This approach may be more expensive for patient and require extra paperwork.

2. **Fee-for-Service FFS Plans with a Preferred Provider Organization (PPO)** - An FFS option that allows patient to see medical providers who reduce their charges to the plan; patient pays less money out-of-pocket when patient use a PPO provider. When patient visits a PPO patient usually won't have to file claims or paperwork. However, going to a PPO hospital does not guarantee PPO benefits for all services received within that hospital. For instance, lab work and radiology services from independent practitioners within the hospital may not be covered by the PPO agreement. Most networks are quite wide, but they may not have all the doctors or hospitals patient want. This approach usually will save patient money.

3. Generally enrolling in a FFS plan does not guarantee that a PPO will be available in patients’ area. PPOs have a stronger presence in some regions than others, and in areas where there are regional PPOs, the non-PPO benefit is the standard benefit. In “PPO-only” options, patient must use PPO providers to get benefits.

**Health Maintenance Organization (HMO)** - A health plan that provides care through a network of physicians and hospitals in particular geographic or service areas. HMOs coordinate the health care service patients receive and free patients from completing paperwork or being billed for covered services. Patients’ eligibility to enroll in an HMO is determined by where patient live or, for some plans, where patient work. Some HMOs are affiliated with or have arrangements with HMOs in other service areas for non-emergency care if patient travel or are away from home for extended periods. Plans that offer reciprocity discuss it in their brochure. HMOs limit patients’ out-of-pocket costs to the relatively low amounts shown in the benefit brochures.

The HMO provides a comprehensive set of services - as long as patient use the doctors and hospitals affiliated with the HMO. HMOs charge a copayment for primary physician and specialist visits and generally no deductible or coinsurance for in-hospital care. Most HMOs ask patient to choose a doctor or medical group to be patients’ primary care physician (PCP). Patients’ PCP provides patients’ general medical care. In many HMOs, patient must get authorization or a “referral” from patients’ PCP to see other providers. The referral is a recommendation by patients’ physician for patient to be evaluated and/or treated by a different physician or medical professional. The referral ensures that patient see the right provider for the care most appropriate to patients’ condition.

Care received from a provider not in the plan's network is not covered unless it is emergency care or the plan has a reciprocity arrangement.
**HMO Plans Offering a Point of Service (POS) Product:** In an HMO, the POS product lets patient use providers who are not part of the HMO network. However, patient pays more for using these non-network providers. Patient usually pays higher deductibles and coinsurances than patient pays with a plan provider. Patient will also need to file a claim for reimbursement, like in a FFS plan. The HMO plan wants patient to use its network of providers, but recognizes that sometimes enrollees want to choose their own provider. Some plans are Point of Service (POS) plans and have features similar to both FFS plans and HMOs.

**Consumer-Driven Health Plans (CDHP):** Describes a wide range of approaches to give patient more incentive to control the cost of either patient's health benefits or health care. Patients have greater freedom in spending health care dollars up to a designated amount, and patients receive full coverage for in-network preventive care. In return, patient assumes significantly higher cost sharing expenses after patient have used up the designated amount. The catastrophic limit is usually higher than those common in other plans.

**Health Reimbursement Arrangement (HRA):** Health Reimbursement Arrangements are a common feature of Consumer-Driven Health Plans. They may be referred to by the health plan under a different name, such as Personal Care Account. They are also available to enrollees in High Deductible Health Plans who are ineligible for an HSA. HRAs are similar to HSAs except an enrollee cannot make deposits into and HRA, a health plan may impose a ceiling on the value of an HRA, interest is not earned on an HRA, and the amount in an HRA is not transferable if the enrollee leaves the health plan.

**Health Savings Account (HSA):** A Health Savings Account allows individuals to pay for current health expenses and save for future qualified medical expenses on a pretax basis. Funds deposited into an HSA are not taxed, the balance in the HSA grows tax-free, and that amount is available on a tax-free basis to pay medical costs. To open an HSA, patient must be covered under a High Deductible Health Plan and cannot be eligible for Medicare or covered by another plan that is not a High Deductible Health Plan or a general purpose HCFSA or be dependent on another person's tax return. HSAs are subject to a number of rules and limitations established by the Department of Treasury. Visit [www.ustreas.gov/offices/public-affairs/hsa/](http://www.ustreas.gov/offices/public-affairs/hsa/) for more information.

**High Deductible Health Plan (HDHP):** A High Deductible Health Plan is a health insurance plan in which the enrollee plays a deductible of at least $1,150 (Self Only coverage) or $2,300 (family coverage). The annual out-of-pocket amount (including deductibles and copayments) the enrollee pays cannot exceed $5,800 (Self Only coverage) or $11,600 (family coverage). HDHPs can have first dollar coverage (no deductible) for preventive care and higher out-of-pocket copayments and coinsurance for services received from non-network providers. HDHPs offered by the FEHB Program establish and partially fund HSAs for all eligible enrollees and provide a comparable HRA for enrollees who are eligible for an HSA. The HSA premium funding or HRA credit amounts vary by plan.

**Comparing the Types of Plans by Patients’ Use of Providers:**

**Patients are in an FFS plan and do not use the PPO** (or one is not available):
- Patient will generally pay more when patient get care
- Fewer preventive health care services may be covered
- Patient will have to file claims for services patients’ self

**Patients are in an FFS plan and use the PPO:**
- Patient will generally pay less when patient get care
- More preventive health care services may be covered
- Patient may have less paperwork

**Patients are in an FFS plan’s “PPO-only” option:**
- Patient must use network providers to get benefits
Patient will generally pay copayments and have no deductibles
Patient will have little, if any, paperwork

**Patient belongs to an HMO:**
Patient will have limitations on the doctors and other providers patient can use
Patient will usually pay less when patient get care
Patient will have little, if any, paperwork
More preventive health care services may be covered

**Patient belongs to a POS plan and uses only the providers in that network:**
Patient will pay less when patient get care
Patient will get full network benefits and coverage
Patient will have very little paperwork

**Patient belongs to a POS and does not use network providers or referral procedures:**
Patient will pay more when patient get care
Some services may not be covered out of network at all
Patient generally have to file claims for services patients’ self

Be sure to look at the primary care physicians, specialists, and hospitals with whom patients’ health plan contracts (the provider network). Does it promote prevention and early detection and intervention? Does it have the specialists to treat patients’ chronic condition? Does it contract with a hospital close to patients’ home?

**Patient belongs to an HDHP and uses only the providers in that network:**
Patient will usually pay less when patient get care
Preventive care is often covered in full, usually with no or only a small deductible or copayment