BlueCross. BlueShield.
Federal Employee Program

Important! Change in 2009 Standard Option Benefit for Surgery

Dear Service Benefit Plan Member,

The purpose of this letter is to advise you about changes that have been made to the 2009 Standard Option benefit for surgery (including maternity care) provided by Non-participating providers. As you may know, there has been some concern about the original change in this benefit for 2009 under which you would pay up to a maximum of $7,500 for surgery performed by a Non-participating physician that is not related to an accidental injury or medical emergency. Previously, for 2008, you paid 25% of the Plan allowance (subject to your calendar year deductible), plus any difference between our allowance and the amount billed by the Non-participating physician.

In some cases, the difference between our allowance and the amount billed by these physicians resulted in members experiencing many thousands of dollars of unexpected out-of-pocket expenses. Changing the benefit structure to impose a $7,500 limit was an effort to control the unexpected expenses. However, this benefit structure did not provide for the payment of benefits for surgeries costing less than the $7,500 limit, and was not consistent with the way we provide coverage for other types of care you may receive from out-of-network providers.

We are pleased to announce a new benefit structure for 2009 that will restore the cost-sharing you expect from us, and a service that will preserve your right to use Non-participating providers while providing you with information to help you avoid unexpectedly large bills from Non-participating providers.

What is the new benefit?
Members will pay 30% of our allowance for the surgery (subject to their calendar year deductible) plus the difference between our allowance and the amount the surgeon bills. To help you avoid unexpectedly large bills from Non-participating providers, we are adding a special service for situations where the surgeon's bill will be **$5,000 or more**. You should use this service to obtain our allowance for your surgery ahead of time. Beginning in 2009, you can call the number on the back of your ID card to obtain the information necessary to allow you to estimate your out-of-pocket costs for the surgery and make an informed choice about the provider you select for your surgical care. We strongly encourage you to take advantage of this new service.

How will I know if the billed charge will be $5,000 or more?
Ask your Non-participating surgeon what the bill will be. We suggest you do this before making a final decision about the services.

Medicare Part B is my primary payer. How do these changes affect me?
If you have Medicare Part B as your primary payer, your benefits under the Service Benefit Plan will continue to be provided in the same manner as 2008. When Medicare Part B is your primary payer, Federal regulation limits the amounts physicians can bill you, and we waive some of your costs under the Service Benefit Plan. As a result, your cost-sharing responsibility is limited. Refer to your 2009 Service Benefit Plan Brochure for more information.

How do I get more information on this change?
For more details on the revised benefit, please refer to the attached list of changes to the *printed version* of 2009 Blue Cross and Blue Shield Service Benefit Plan Brochure (RI 71-005). You can also review our *online brochure* (available at www.fepblue.org, and through the OPM website at www.opm.gov/insure) which has been revised to reflect the changes. If you would like printed copies of the revised brochure pages and are unable to print them directly, you may request copies by calling the customer service number on the back of your ID card.

Belated Enrollment Opportunity
To ensure that you have adequate time to evaluate your enrollment options this Open Season, OPM is allowing Federal agencies to accept belated Open Season enrollment changes through January 2009. Your employment (or retirement) office will be able to assist you with any questions you may have about making a belated enrollment change.

Does the new benefit apply to surgery by a Non-participating physician that is related to an accidental injury or medical emergency?
No. Benefits for surgery related to an accidental injury or medical emergency are not affected by these changes. Refer to your 2009 Service Benefit Plan Brochure for more information.

What are the Standard Option benefits for care provided by Preferred and Participating physicians?
Your benefits for surgery and maternity care performed by Preferred or Participating providers are not affected by the changes to the Non-participating provider benefit. Providers who participate in our network have agreements to **accept our allowances as payment in full** for their covered services. With the exception of a change in coinsurance from 10% to 15% for Preferred provider care and from 25% to 30% for Participating provider care, your benefit coverage for these types of services remains unchanged from 2008. Refer to your 2009 Blue Cross and Blue Shield Service Benefit Plan Brochure for more information.

We are committed to ensuring our members have the freedom and flexibility to choose the providers they want to see. Standard Option members can receive care from any covered licensed provider – in or outside our provider network – and still receive benefits. An estimated 95% of eligible providers participate in our extensive nationwide Blue Cross and Blue Shield Provider Network. While Standard Option members can always choose the services of Non-participating providers, you can limit your costs for quality care by using in-network providers.

If you need assistance locating a Preferred or Participating provider, please call your local Blue Cross and Blue Shield Plan or visit our website, www.fepblue.org.

Wishing You Good Health,

Blue Cross and Blue Shield Service Benefit Plan

Attachment

LIST OF REVISIONS
To the Print Version of the
2009 BLUE CROSS AND BLUE SHIELD
SERVICE BENEFIT PLAN BROCHURE (RI 71-005)
FOR STANDARD OPTION SURGERY BENEFITS

Page 9, 11th bullet under "Changes to our Standard Option only" heading

Delete: You now pay 100% of the billed amount up to a maximum of $7,500 for surgery performed by a Non-participating physician. Previously, you paid 25% of the Plan allowance, plus any difference between our allowance and the billed amount. [See Section 5(b).]

Replace with: You may now receive specific benefit information in advance about non-emergency surgeries to be performed by Non-participating physicians when the charge for the surgery will be $5,000 or more. (See page 17.)

Page 17, bottom of page

Add: **Surgery by Non-participating providers under Standard Option**

You may receive specific benefit information in advance about non-emergency surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. When you contact your local Blue Cross and Blue Shield Plan before your surgery, the Local Plan will review your planned surgery to determine your coverage, the medical necessity of the procedure(s), and the Plan allowance for the services. You can call your Local Plan at the customer service number on the back of your ID card.

Note: Standard Option members are not required to obtain prior approval for surgeries performed by Non-participating providers (unless the surgery is listed on page 16 or is one of the transplant procedures listed above) – even if the charge will be $5,000 or more. If you do not call your Local Plan in advance of the surgery, we will review your claim to provide benefits for the services in accordance with the terms of your coverage.

Page 21, 4th bullet from bottom of page

Delete: Under Standard Option, your $7,500 copayment (or the total amount you paid if less than $7,500) for surgery performed by a Non-participating physician. See Section 5(b);

Page 35, Standard Option "You Pay" column, 4th paragraph

Delete: Non-participating: 100% of the billed amount up to a maximum of $7,500 for the delivery itself and any other maternity-related surgical procedures per surgeon per surgical day (No deductible). Note: You pay 30% of the Plan allowance, plus any difference between our allowance and the billed amount (deductible applies), for all other professional services, e.g., prenatal care and surgical assistance (see below for our coverage of anesthesia).

Replace with: Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount

Add: ***Note:*** You may receive specific benefit information in advance for the delivery itself and any other maternity related surgical procedures to be provided by a Non-participating physician when the charge for that care will be **$5,000 or more**. Call your Local Plan at the customer service number on the back of your ID card to obtain information about your coverage and the Plan allowance for the services.

Page 51, between last 2 bullets

Add: Standard Option members may receive specific benefit information in advance about surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 17 for more information.

Pages 52, 54-58, and 60-62, Standard Option "You Pay" column, 3rd paragraph

Delete: Non-participating: 100% of the billed amount up to a maximum of $7,500 for the surgery itself per surgeon per surgical day (No deductible). Note: You pay 30% of the Plan allowance, plus any difference between our allowance and the billed amount (deductible applies), for all other professional surgical services, e.g., pre- and post-operative care by the surgeon.

Replace with: Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount

Pages 52, 54, and 55, after 3rd paragraph

Add: ***Note:*** You may receive specific benefit information in advance about surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 17 for more information.

Page 56, after 3rd paragraph

Add: ***Note:*** You may receive specific benefit information in advance about kidney and cornea transplants to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 17 for more information.