Organization of American States
17th St. & Constitution Avenue N.W.
Washington, D.C. 20006
United States of America
P. 202.458.3000
www.oas.org

SELF-INSURED HEALTH PLAN – CAREFIRST BLUECROSS BLUESHIELD (BCBS)
SUMMARY OF HEALTH CARE BENEFITS

1-JAN-2013

COVERED SERVICES	HEADQUARTERS AND USA SUBSCRIBERS - PREFERRED PROVIDER ORGANIZATION		SUBSCRIBERS LIVING OUTSIDE USA*
	SELECT PREFERRED PROVIDERS (SPP) IN-NETWORK	NON-PREFERRED PROVIDERS/ OUT-OF-NETWORK	
MAXIMUM LIFETIME BENEFIT	$3,000,000 / per person		
DEDUCTIBLES / CO-PAYMENTS	Inpatient Hospital Co-payment $100 per admission - worldwide Calendar Year Medical Deductible USA Subscribers $250 per person - $750 max. per family **Applies only to out-of-network services**		$100 per admission – worldwide No deductible when services are rendered outside USA
MAXIMUM OUT-OF-POCKET EXPENSE PER CALENDAR YEAR	$1,000 - Single $2,000 - Family	$1,500 - Single $3,000 - Family	Salary Related / Single / Family $ 0 - 10K / $250 / $500 $10 - 20K / $500 / $1,000 $20 - 30K / $750 / $1,500 $30 + K / $1,000 / $2,000
HOSPITAL CHARGES ✠ Inpatient/Outpatient	100% coverage after inpatient co-payment	80% coinsurance after co-payment and deductible 100% after out-of-pocket maximum	90% coinsurance after inpat.co-payment 100% after out-of-pocket maximum
✠ Nervous or Mental Condition, Alcohol/Drug / Substance Abuse	100% coverage after inpatient co-payment Limited to 45 days per confinement	80% coinsurance after co-payment and deductible Limited to 45 days per confinement	90% coinsurance after inpat.copayment- limited to 45 days per confinement
OFFICE VISTS, LABS AND TESTING ✠ Office visits / consultations	$20 co-payment/visit - 100% coverage thereafter	80% coinsurance UCR after deductible 100% after out-of-pocket maximum	90% coinsurance 100% after out-of-pocket maximum
✠ Laboratory, X-Rays/Scans/Diagnostic Testing	$20 co-payment / exam – 100% thereafter	80% coinsurance UCR after deductible 100% after out-of-pocket maximum	90% coinsurance 100% after out-of-pocket maximum
✠ Nervous or Mental Condition, Alcohol / Drug/ Substance Abuse First five visits per calendar year Following visits	80% coinsurance UCR 50% coinsurance UCR	80% coinsurance UCR after deductible 50% coinsurance UCR	80% coinsurance UCR 50% coinsurance UCR
EMERGENCY CARE (life threatening injuries or illness) ✠ Hospital emergency room ✠ Physician services	100% coverage after $75 co-payment Waived if admitted	100% coverage after $75 co-payment Waived if admitted	90% coinsurance 100% after out-of-pocket maximum
ANNUAL PHYSICALS / WELL BABY CARE	Covered in full after $20 co-payment per visit	$600 maximum/80% coinsurance UCR after deductible	$600 maximum / 90% coinsurance
PRESCRIPTION DRUGS** ✠ Co-pays at Participating Pharmacies (USA) (34 day supply) ✠ Co-pays by Mail Order Program (USA) (90 day supply)	$50 Calendar Year Deductible (Does not apply to Retirees with Medicare Primary Coverage) $0 Pref. Preventive /$5 Generic/ $35 Pref. Brand / $45 Non-Pref. Brand / 75% coinsurance (member pays 25% up to a max. of $250) $0 Pref. Preventive/ $10 Generic / $50 Pref. Brand / $60 Non-Pref. Brand / 75% coinsurance (member pays 25% up to a max. of $400)		90% coinsurance outside USA 80% coinsurance after $250 deductible in USA
EYE CARE BENEFITS ✠ Exam every 12 months ✠ Eyeglasses, frames, contact lenses	$20 co-payment Covered out-of-network	80% coinsurance UCR after deductible $150 maximum every 12 months	90% coinsurance $150 maximum every 12 months
UTILIZATION MANAGEMENT PROVISION	This program has a built-in utilization management feature. This means all hospital admissions, including those for mental health care and obstetrical conditions require certification. When you seek care within the Preferred Provider Network, the provider arranges all hospital admission certifications for you. When you seek care outside of the network, you must arrange for your own certifications.		**NOT APPLICABLE**

*Subscribers outside USA - All medical care rendered in USA will be reimbursed through the Preferred Provider Organization In-network or Out-of-network. Deductibles and Co-payments will apply.

** Effective March 01, 2013

SUMMARY OF DENTAL BENEFITS
(For subscribers in USA and outside USA) 1-JAN-2013

COVERED SERVICES	CALENDAR YEAR DEDUCTIBLE	REIMBURSEMENT
Calendar Year Maximum Per Person - $2,500 **Preventive and Diagnostic Services** ✠ Prophylaxis - twice a year ✠ Routine oral exams - twice a year ✠ X-rays - bitewings twice a year - full mouth once every three years ✠ Fluoride treatments - twice a year - under age 19 ✠ Space maintainers - simple - under age 19 ✠ Palliative emergency treatment	No deductible	100% UCR
Basic and Major Surgical Services ✠ Fillings or restorations - Simple extractions ✠ Periodontal scaling and root planning – Gingival Curettage ✠ Surgical periodontal services - treatment of tissue & bones supporting teeth ✠ Endodontic services - pulpotomy - root canal ✠ Oral surgical services - extractions, impactions, cysts, tumors, biopsies ✠ General anesthesia	$50 / per person $150 / maximum per family	80% UCR after deductible
Major Restorative Services ✠ Prosthodontic services - dentures, bridges crowns, inlays, onlays, implants ✠ Repair of prosthetic appliances - bridges, dentures		50% UCR after deductible
Orthodontic Services (Dependents under age 19) **LIFETIME MAXIMUM PER PERSON $1,500** ✠ Installation of orthodontic appliances and treatment – Max. 36 months.	No deductible	50% UCR

Deductible: Amount paid by insured/family each calendar year before insurance company pays benefits
Coinsurance: Percentage of charges paid by insurance company
Co-payment: Amount paid by insured
Out-of-pocket Maximum: Maximum amount paid by insured/family in a calendar year, including deductible. Once this amount is disbursed by insured, insurance company pays 100% of allowable charges for the rest of the calendar year
UCR: Payment is based on the Usual, Customary and Reasonable allowance determined annually by CareFirst BlueCross BlueShield

This summary is a list of the principal benefits intended only as a quick reference. For additional information on requirements, limitations and exclusions, please refer to the benefit booklet or contact the Department of Human Resources