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Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

JUL 27 1993

FEDERAL COMMUNICATIONS COMMISSION
OFFICE OF THE SECRETARY

In the Matter of)	
1993 Annual Access)	CC Docket No. 93-193
Tariff Filings)	
National Exchange Carrier)	Transmittal No. 556
Association)	
Universal Service Fund and)	CC Docket No. 93-123

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SUMMARY

In this Direct Case, BellSouth addresses each of the designated issues relevant to its filing and shows that the accounting order should be terminated and the investigation favorably concluded forthwith.

With respect to the issue of exogenous treatment of the TBO portion of post-retirement benefits, BellSouth shows that the amounts included as exogenous costs meet the requirements which were imposed for determining exogenous treatment. First, the accounting change was not within the control of LECs in the same sense that separations rule changes (which are afforded exogenous treatment) are not within the control of LECs. Second, BellSouth submitted studies showing that even a conservative estimate of amounts not included in the price cap index supports the amounts filed by BellSouth.

With respect to the issue of sharing and low-end adjustments, BellSouth shows that it followed the existing Commission rules to determine sharing adjustments for the 1993 filing. The calculations were required to be based upon BellSouth's rate of return for the 1992 base year. Nothing in the Commission's rules would permit BellSouth to calculate that rate of return differently from the way it did.

With respect to the issue of the exogenous treatment of the General Support Facility rule change, BellSouth shows

that it properly reflected the change. BellSouth calculated the costs based upon actual 1992 costs and changed its price cap indices accordingly. Rate changes were made within the bounds of those indices. The changes made by BellSouth were fully consistent with the Commission's rules and guidelines.

With respect to the issue of the appropriate category for the LIDB per query charge, BellSouth shows that placement in the local transport category of the traffic sensitive basket is consistent with the regulatory simplification and relative pricing flexibility which price cap regulation was intended to afford.

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In the Matter of)	
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1993 Annual Access Tariff Filings)	CC Docket No. 93-193
)	
National Exchange Carrier Association)	Transmittal No. 556
)	
Universal Service Fund and Lifeline Assistance Rates)	CC Docket No. 93-123
)	
GSF Order Compliance Filings)	
)	

DIRECT CASE

BellSouth Telecommunications, Inc. ("BellSouth") hereby submits its direct case in the above-captioned tariff investigation proceeding, instituted by the Commission in its Designation Order.¹

In the Designation Order, the Commission suspended BellSouth's 1993 Annual Access Tariff Filing, as well as the filings of other local exchange carriers. It instituted an accounting order and designated certain issues for investigation. Below, BellSouth addresses each of the designated issues relevant to its tariff filing.² As can be seen, the Commission should terminate the accounting order

¹ 1993 Annual Access Tariff Filings, CC Docket No. 93-193, Memorandum Opinion and Order Suspending Rates and Designating Issues for Investigation (DA 93-762), released June 23, 1993.

² Of the seven issues designated, BellSouth addresses the first, second, sixth and seventh. The remaining issues were not specifically addressed to BellSouth or to its filing.

imposed upon BellSouth and should conclude its investigation forthwith, without requiring that BellSouth make any further revisions to its filing.

A. **ISSUE 1. HAVE THE LECS BORNE THEIR BURDEN OF DEMONSTRATING THAT IMPLEMENTING SFAS-106 RESULTS IN AN EXOGENOUS COST CHANGE FOR THE TBO AMOUNTS UNDER THE COMMISSION'S PRICE CAP RULES?**

As a preliminary matter, BellSouth reiterates here its position that exogenous treatment for the incremental costs due to the change in accounting methodology required by SFAS-106, i.e., the change from a pay-as-you-go basis in accounting to an accrual basis in accounting, is appropriate and consistent with the Commission's Price Cap rules. BellSouth fully briefed this issue in its pleadings in the Docket 92-101 proceedings,³ summarized its position in the Supporting Information in its Transmittal No. 105,⁴ and explained its position in its appeal of the OPRB order.⁵ Nevertheless, for the sole purpose of BellSouth's Annual Price Cap Tariff Filing, and to assure the greatest consistency with the OPRB Order and the criteria established therein, BellSouth sought exogenous treatment for only the

³ SAS, S.G., Treatment of Local Exchange Carrier Tariffs Implementing Statement of Financial Accounting Standards, "Employers Accounting for Postretirement Benefits Other than Pensions", 71 RR 2d (P&F) 1160 (1993) ("OPRB Order").

⁴ Supporting Information, Volume 2, at A-7 - A-16.

⁵ Southwestern Bell et al. v. FCC, 93-1168 (D.C. Circuit).

retiree portion of the TBO.⁶ BellSouth has demonstrated that the TBO amounts included in its 1993 annual access tariff filing are appropriately considered to be an exogenous cost change under the Commission's OPRB Order.⁷

The Commission has indicated that there is a two-pronged test which a change must meet in order to qualify for exogenous treatment: 1) the change must be outside of

information.⁹ However, in requesting such information, BellSouth submits that the Commission is missing the point of the control test.

As BellSouth has discussed on numerous occasions in various proceedings related to the SFAS-106 change, the issue is whether LECs had control over either the accounting change mandated by the Financial Accounting Standards Board or over the fact that the Commission has required LECs to reflect this methodology. The answer is that they did not, and that, therefore, the control prong of the test is met. Whether or not LECs may be able to control some or all of the costs which are subject to the accounting change should not be relevant to a determination of exogenous cost status.

For instance, under the Commission's rules, separations rule changes are afforded exogenous treatment.¹⁰ This is despite the fact that LECs have control over the investment which is subject to the separations rule change. Thus, to deny exogenous treatment for the accounting change at issue here, under the rationale that the underlying costs are within the control of LECs, is irrational and flies in the face of the Commission's price cap rules and policies. Instead, the SFAS-106 rule change falls squarely within the first-prong of the exogenous test.

⁹ The Commission also requested LECs to provide, as a part of their Direct Cases, certain workforce information. That information is provided herewith as Appendix B.

¹⁰ 47 C.F.R. Section 61.45(d)(1).

As to the second prong of the test, whether the change is already reflected in the PCI formula, two studies have been placed on the record, the Godwins and NERA studies. Both studies, using very conservative assumptions and methodologies, conclude that only a very small portion of the SFAS-106 change will be reflected in the GNP-PI, that a unique and disproportionate effect is placed on the LECs, and that exogenous treatment is warranted. The additional sensitivity analysis performed by Godwins provides a further demonstration of the conservative nature of the Godwins study and provides the full range of values derived in all 648 variations of the Godwins model.

BellSouth believes that Godwins has employed very conservative assumptions to produce a reasonable estimate of the impact SFAS-106 will have on the GNP-PI. Therefore, BellSouth applied the Godwins factor of 84.8% to its SFAS-106 TBO exogenous cost amount to remove any potential for double-counting in the 1993 annual access tariff filing.

B. ISSUE 2. HOW SHOULD PRICE CAP LECs REFLECT AMOUNTS FROM PRIOR YEAR SHARING OR LOW-END ADJUSTMENTS IN COMPUTING THEIR RATES OF RETURN FOR THE CURRENT YEAR'S SHARING AND LOW-END ADJUSTMENTS TO PRICE CAP INDICES?

With respect to their 1993 annual access tariff filings, price cap LECs were required to follow the Commission's existing rules. Under such rules, there is no provision for taking into account in this year's annual filing any sharing or low-end adjustment amounts from prior years. Rather, the sharing and low-end adjustments

reflected in this year's annual filing must be based upon the rate of return for 1992, unadjusted by any sharing or low-end adjustments made in the 1992 filing for 1991 earnings.

The existing rules establish the means by which a price cap LEC is required to determine sharing and low-end adjustments for the purpose of establishing its indices for the current year's (1993) filing. Section 61.45(d) requires that the LEC's reported rate of return during the base year (1992) be utilized.¹¹ If the LEC reports earnings above a threshold rate of return, e.g., 12.25%, then it is obligated to share. Similarly, a low-end adjustment is permitted for LECs whose rate of return during the base year is below 10.25%.¹²

There is only one rate of return under the rules from which to determine whether earnings during the base year were above 12.25% or below 10.25%. That is the rate of return specified under Part 65 of the Commission's rules. Such rules do not provide for any adjustment whatsoever of the rate of return to account for any sharing or low-end

sharing and adjustment mechanisms are based on total interstate rate of return and that is the only earnings data used in the price caps plan."¹³

In addition, price cap LECs are required to report that rate of return on FCC Form 492A.¹⁴ The Commission recognized the need to modify Form 492 for price cap carriers and directed the Common Carrier Bureau to modify the form accordingly.¹⁵ In making such modifications, the Bureau did not provide for adjustments of base year earnings to account for sharing or low-end adjustments for the prior year. Indeed, the Bureau made the necessary and appropriate changes in accordance with the LEC price cap plan.¹⁶

To determine any sharing adjustments needed to be made in its 1993 annual filing, BellSouth calculated its rate of return for the 1992 base year in accordance with the Commission's rules and Form 492A. BellSouth calculated its sharing amount based upon that rate of return, as specified by the form, and included Form 492A in its filing.¹⁷ The

¹³ Id., para. 380.

¹⁴ 47 C.F.R. Sections 55.602(d) and 1.705

rate of return shown on the form establishes the basis for the sharing calculations because it is the only rate of return that exists under the rules. Further support for the procedures followed by BellSouth can be found in that there was no intervention against these procedures. Conversely, intervention was filed against LECs using alternate procedures.

The Commission should lift the accounting order imposed on BellSouth's filing as a result of this issue and should conclude this investigation accordingly. No petitioner challenged the methodology utilized by BellSouth and, indeed, any such challenge would be baseless, given that BellSouth followed the existing rules. The fact that the Commission has now instituted a rulemaking proceeding for the purpose of determining whether or not its rules should be changed¹⁸ cannot be used to support a finding adverse to BellSouth's 1993 filing. If the rules are ultimately changed as a result of such proceeding, such rules can only be accorded prospective effect, i.e., can only impact rates scheduled to become effective on July 1, 1994, at the earliest.¹⁹

¹⁸ Price Cap Regulation of Local Exchange Carriers, Rate of Return Sharing and Lower Formula Adjustment, CC Docket No. 93-179 (FCC 93-325), Notice of Proposed Rulemaking, released July 6, 1993.

¹⁹ See, *Bowen v. Georgetown University Hospital*, 488 U.S. 204 (1988).

C. ISSUE 6. HAVE THE LECS PROPERLY REALLOCATED GSF COSTS IN ACCORDANCE WITH THE GSF ORDER?

The answer, for BellSouth, is in the affirmative.

BellSouth fully complied with the Commission's requirements for recognition of the rule change as an exogenous cost, and neither an accounting order nor an investigation is justified on account of this matter.

Subsequent to the time on which the 1993 annual filings were made, the Commission issued its GSF Order.²⁰ In this order, the Commission revised Section 69.307(b) of its rules to correct a misallocation of GSF investment which it found had occurred under the prior rule. The Commission permitted price cap LECs to treat the reallocation of costs resulting from the rule modification as an exogenous change, with the appropriate adjustment to their price cap indexes to reflect the reallocation. The exogenous change was to reflect a reallocation based upon actual 1992 base period cost data.

The Commission specifically did not require "that each rate element itself be adjusted by a fixed percentage amount," or that DS1 or DS3 service rates be adjusted by a

rule change.²² No petitions were filed against these revisions.

As described in the Description and Justification accompanying such filing,²³ BellSouth obtained the actual 1992 base period costs and reallocated them based upon the new rule. The difference between the "GSF View" and the "Base View" was then utilized to calculate the exogenous cost change and the price cap indices were revised accordingly. The rate revisions made were all below cap and within band. As it is clear that BellSouth followed the Commission's rules with respect to the GSF rule change and exogenous treatment thereof, the Commission should conclude this aspect of its investigation of BellSouth's annual filing forthwith and should terminate the accounting order immediately.

D. ISSUE 7. TO WHAT CATEGORY OR CATEGORIES SHOULD THE LIDB PER QUERY CHARGES BE ASSIGNED?

With the 1993 Annual Access Filing, BellSouth included its Line Information Database ("LIDB") service under Price Caps for the first time. BellSouth placed the LIDB per query charges in the local transport category of the traffic sensitive basket. No contrary requirement has been established either by the Commission's rules or by the

²² See, BellSouth Transmittal No. 121, filed June 17, 1993.

²³ The data and calculations submitted with BellSouth's GSF transmittal are incorporated herein by reference.

waiver granted to LECs permitting them to establish the necessary rate elements for the service.²⁴

To the extent that the Commission is considering requiring LECs to spread the LIDB per query charge over more than one category or to create a new category, it should not do so. There is no reason for the additional regulation which would be incumbent with such an approach. Indeed, such an approach would be counter to the balanced policy choices made when the Commission's price cap rules and policies were developed for LECs. Under the Commission's initial approach, a limited number of categories were created within the traffic sensitive basket in order to assure the maintenance of some semblance of pricing flexibility for LECs. With each occasion on which the Commission modifies the initial requirements through creation of additional price caps categories, in order to impose individualized regulation of individual services, what little flexibility afforded to the LECs under the initial rules is further diminished. In addition, such disaggregation only serves to increase the regulatory and reporting workload on both the Commission and the LECs. It would thus contravene the regulatory simplification which was intended to result from the introduction of price cap regulation.

²⁴ In the Matter of Local Exchange Carrier Line Information Database, 7 FCC Rcd 525 (1991).

Thus, the Commission should not act here to further erode its price cap rules and policies, and should permit the categorization of BellSouth's LIDS per query charge as transport. Any further disaggregation should not be required until the full ramifications can be considered as a

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

APPENDIX A

BELLSOUTH DIRECT CASE

July 27, 1993

In the Designation Order, the Commission required LECs to provide

pertinent sections of their employee handbooks, contracts with unions, and other items that include statements to the employees concerning the company's ability to modify its post-employment benefits package.

BellSouth offers medical, dental and group life insurance post-retirement benefits. See Exhibits 1-3 for the respective Summary Plan Descriptions for the above benefits.

The financial statement disclosures in BellSouth's 1992 Annual Report relative to OPRBs are attached as Exhibit 4.

Article 19, Pensions and Benefits, of the Agreement between the Communications Workers of America and BellSouth Telecommunications, which was effective August 9, 1992, is provided as Exhibit 5.

EXHIBIT 1 OF APPENDIX A

**THE BELLSOUTH
MEDICAL ASSISTANCE PLAN**

SUMMARY PLAN DESCRIPTION

REVISED MAY 1, 1992

FOR BELLSOUTH PARTICIPATING COMPANIES

Claims Filing and General Correspondence Address

Blue Cross and Blue Shield of Alabama
BellSouth Dedicated Service Center
P.O. Box 830279
Birmingham, Alabama 35283-0279

Review Request Address

BellSouth Review Facilitator
Blue Cross and Blue Shield of Alabama
P.O. Box 13126
Birmingham, Alabama 35202-3126

ERISA Appeals Address

BellSouth ERISA Appeals Coordinator
Blue Cross and Blue Shield of Alabama
P.O. Box 13126
Birmingham, Alabama 35202-3126

FOR INFORMATION RELATING TO:

Coverage and Claim Payments

Active Employees: 1 800 292-8802

Retired Employees: 1 800 272-5218

PPO Providers: 1 800 252-5238

Non-PPO Providers: 1 800 252-5239

Forms, Duplicate Claim Reports, and ID Cards

1 800 633-8915

Eligibility

Call your Benefit Office. (See pages 60-61 for telephone numbers.)

Quality Care Program

United HealthCare, Inc.
200 Atlanta Technology Center
Suite 100
1575 Northside Drive
Atlanta, Georgia 30318
1 800 541-2234

Mail Order Prescription Drug Program

National Rx Services, Inc.
P.O. Box 30493
Tampa, Florida 33630-3493
1 800 447-7856

PARTICIPATING COMPANIES

The Medical Assistance Plan is available to employees of the following Companies (referred to in this booklet as the "Company" or "Participating Company") who are eligible for coverage under this Plan:

BellSouth Advertising & Publishing Corporation
BellSouth Business Systems
BellSouth Communications, Inc.
BellSouth Communications Systems
BellSouth Corporation
BellSouth D.C., Inc.
BellSouth Enterprises, Inc.
BellSouth Financial Services Corporation
BellSouth Information Systems, Inc.
BellSouth International, Inc.
BellSouth Cellular Corporation
BellSouth Resources, Inc.
BellSouth Telecommunications, Inc.*
Intelligent Media Services, Inc.
Intelligent Messaging Services, Inc.
Sunlink Corporation

*Formerly BellSouth Human Resources Administration, Inc., BellSouth Services Incorporated, Southern Bell Telephone and Telegraph Company, and South Central Bell Telephone Company.

The list of Participating Companies may change. Please contact your Benefits Office if you have questions regarding your employer's participation.

INTRODUCTION

The Medical Assistance Plan, as revised effective January 1, 1992, is designed to help protect you against financial hardship if you or a covered family member require medical attention. It does so by helping pay for medically-necessary care or treatment.

There are special features within the Medical Assistance Plan which require you and your covered dependents to make certain choices about how and where to seek medical care. These features include the Quality Care Program (QCP) and the BellSouth Preferred Provider Organization (PPO) network of hospitals, physicians, and pharmacies. By using these special features, you can receive maximum Plan benefits. Read this booklet carefully and keep it for future reference. **As you read this booklet, keep in mind that you and your physician must make all decisions regarding appropriate medical treatment for you or your covered dependents.**

This booklet provides the Summary Plan Description (SPD) of the Medical Assistance Plan (referred to in this booklet as "MAP" or the "Plan"). It is intended to explain only the major provisions of the Plan as of January 1, 1992. If there is a conflict between this booklet and the contracts and documents which control the Plan, the contracts and documents will govern in all cases.

Eligibility for, or participation in, the Plan does not constitute a contract of employment and should not be considered as such.

BellSouth currently intends to continue MAP as described in this booklet but reserves the right, at its discretion, to amend, reduce, or terminate the Plan and coverage at any time for active, retired, or former employees and all dependents, subject to applicable collective bargaining agreements.

BellSouth will update this booklet periodically to describe changes in the Plan, but there may be a delay between the effective date of a change and the date you receive the information. You should contact Blue Cross and Blue Shield of Alabama if you have any questions regarding coverage before you incur expenses for any non-emergency treatment.

BENEFITS AT A GLANCE

This is only a summary of MAP benefits in effect as of January 1, 1992. Refer to the specific sections of

CHART DEFINITIONS

1. **Payment Allowance (PA)** limits are established for determining non-PPO payments in each PPO area which are based on the negotiated fees charged to BellSouth by PPO providers within that area.
2. **Reasonable and Customary (R&C)** limits are established by BC/BS and are based on the amounts usually charged to most patients for physician fees and certain services and supplies within the same locality.
3. **Covered Charges** are charges associated with a medically necessary service, supply, or procedure provided to a participant for a non-occupational illness or injury that are eligible for consideration based on the limits established under the medical plan and that are not excluded by any other provisions of the Plan. In addition, the following rules apply:

IN A PPO AREA, COVERED CHARGES FROM A:

- **PPO hospital/physician** are the expenses billed at the contract rates for covered services negotiated between BellSouth and that hospital/physician.
- **Non-PPO hospital/physician** are the expenses for covered services that are billed to non-Medicare-eligible participants up to that PPO area's PA.
- **PPO or non-PPO hospital/physician** are expenses for covered services that are billed to Medicare-eligible participants up to the amount allowed by Federal guidelines (see page 75).

IN A NON-PPO AREA, COVERED CHARGES are the expenses for covered services billed from any hospital.

4. **Facility Fees** are all charges billed by facilities such as hospitals or ambulatory surgical facilities, such as room and board, lab, x-ray, etc. Services billed by physicians will not be considered facility charges.

Emergency, Inpatient, Outpatient Services

EMERGENCY (e.g., patient being hospitalized, bone fractures, abrasions, lacerations, poisoning, or rape)

- Covered charges incurred within 72 hours of injury or illness
- Deductible not required
- Ambulatory surgical facility/hospital outpatient department emergency room fee at 100% of covered charges
- PPO physician/surgeon at 90% of covered charges
- Non-PPO physician/surgeon at 90% of R&C

NON-EMERGENCY

- Facility charges**
- Emergency room (facility) fee not covered
 - Deductible required
 - PPO hospital at 100% of covered charges after a \$25 copayment
 - If you live in a PPO area, non-PPO hospital at 90% PA after a \$50 copayment
 - If you do not live in a PPO area, non-PPO hospital services at 90% of covered charges after a \$25 copayment
- Physician/surgeon:**
- PPO physician at 90% of covered charges, no deductible
 - If you live in a PPO area, non-PPO physician at 80% of PA, deductible required
 - If you do not live in a PPO area, non-PPO physician at 90% of R&C, deductible required

Adoption Coverage

Following an adoption, MAP covers up to \$1,000 of eligible medical expenses incurred per child between time of placement in home and the court assigning a case number for adoption.

Adopted child must be enrolled in MAP before receiving this benefit.

- Pre-existing condition provision does not apply
- PPO provisions apply

Adoptive Benefits

OCP certification required, otherwise no coverage

- Deductible required
- 100% of covered charges for:
 - Birthing centers/nurse midwives
 - Hospice care
 - Extended care/skilled nursing facilities
 - Home health care
 - Partial hospitalization for substance rehab program
 - Special arrangements or treatments when medically appropriate

90% of covered charges for private-duty nursing

Ambulatory Surgical Facility / Hospital Outpatient Department (Facility Fee)

- Deductible required
- PPO hospital at 100% of covered charges
- If you live in a PPO area, non-PPO hospital at 90% of PA
- If you do not live in a PPO area, non-PPO hospital at 90% of covered charges

Physician Services

- PPO physician at 90% of covered charges, no deductible
- If you live in a PPO area, non-PPO physician at 80% of PA, deductible required
- If you do not live in a PPO area, non-PPO physician at 90% of R&C, deductible required

Therapeutic Services

- Deductible required
- 90% of R&C up to \$100 for first lifetime covered visit
- 90% of R&C up to \$50 for subsequent visits
- Limited to 2 visits per calendar week, up to 20 visits per year.

Prescription

Applies to covered charges each calendar year. Does not count toward \$1000 OOP limit.

Individual: \$165

Family: \$400 (all covered charges applied toward individual deductibles) or two individual deductibles, whichever occurs first

Inpatient Detoxification / Drug Abuse

No benefit unless certified by OCP, including Medicare eligible participants.

- Deductible required
- PPO hospital at 100% of covered charges
- If you live in a PPO area, non-PPO hospital at 90% of PA
- If you do not live in a PPO area, non-PPO hospital at 100% of covered charges
- Must use a PPO facility to obtain maximum benefits if receiving treatment within a PPO area, regardless of where you live.

Limits

- 2 detox confinements per 5 years
- Up to 30 days each detox
- Admissions must be separated by 180 days to be considered separate admissions
- Physician fees must be included in inpatient facility program charge, otherwise not covered.

Inpatient Hospital / Medical Services (Facility Fee)

- Deductible required
- PPO hospital at 100% of covered charges
- If you live in a PPO area, non-PPO hospital at 90% of PA
- If you do not live in a PPO area, non-PPO hospital at 100% of covered charges

Inpatient

- Deductible required
- PPO hospital at 100% of covered charges
- If you live in a PPO area, non-PPO hospital at 90% of PA
- If you do not live in a PPO area, non-PPO hospital at 90% of covered charges
- If admitted for diagnostic tests only, hospital room & board not covered.

Outpatient

- Deductible required
- PPO hospital at 100% of covered charges
- If you live in a PPO area, non-PPO hospital at 90% of PA
- If you do not live in a PPO area, non-PPO hospital at 90% of covered charges

MAP Coverage for Prescription Therapy

MAP covers cost of the agent and its administration, but not hospital charges.

AGENT

- 100% of R&C, no deductible

ADMINISTRATION

- Deductible not required
- PPO physician at 100% of covered charges
- If you live in a PPO area, non-PPO physician at 80% of PA
- If you do not live in a PPO area, non-PPO physician at 100% of R&C

Partial Hospitalization / Drug Abuse

No benefit unless certified by OCP, including Medicare eligible participants.

- Deductible required
- PPO hospital at 100% of covered charges
- If you live in a PPO area, non-PPO hospital at 90% of PA
- If you do not live in a PPO area, non-PPO hospital at 100% of covered charges
- Must use a PPO facility to obtain maximum benefits if receiving treatment within a PPO area, regardless of where you live.

Limits

- One rehab for up to 30 days per lifetime
- May substitute a partial hospitalization substance abuse program in place of this confinement
- Must be separated by 180 days from a partial hosp. program to be considered a separate admission.
- Physician fees must be included in inpatient facility program charge.

Mammogram Screening (Facility Fee)

DIAGNOSED CONDITION

- Deductible required
- PPO hospital at 100% of covered charges
- If you live in a PPO area, non-PPO hospital at 90% of PA
- If you do not live in a PPO area, non-PPO hospital at 90% of covered charges

ROUTINE

- Prior to age 40, routine exams not covered
 - Limited to one baseline for ages 40-49
 - Beginning at age 50, annual screening covered
 - No deductible required
 - PPO hospital at 100% of covered charges
 - If you live in a PPO area, non-PPO hospital at 90% PA
 - If you do not live in a PPO area, non-PPO hospital at 100% of covered charges
- For physician benefits, see pages 35-36.

14 Mandatory Second Surgical Opinion (PPO, HMO, PPO)

- Deductible not required
- 100% of covered charges for QCP-listed physician
- 100% of R&C when physician is QCP-approved, but not listed

No coverage when physician is not QCP-approved or opinion is not authorized by QCP

Requirement may be waived by QCP

15 Maternity Care (OB Fee For Pre & Post Natal Care)

- Deductible not required
- PPO physician at 100% of covered charges
- If you live in a PPO area, non-PPO physician at 80% of PA
- If you do not live in a PPO area, non-PPO physician at 100% of R&C

16 Mental/Nervous Care

All mental/nervous care expenses (inpatient/outpatient), including substance abuse, are limited to a lifetime maximum of \$150,000.

INPATIENT CARE

- Must be certified by QCP otherwise no benefit, applies also to Medicare eligible participants.
- Admissions must be separated by 60 days to be considered a new admission.
- Deductible required

HOSPITAL CHARGES OTHER THAN SUBSTANCE ABUSE

Days in the Hospital	PPO Hospital or No PPO in Area	Non-PPO Hospital Within Any PPO Area
<30	100% of CC	90% of PA
30-59	95% of CC	85% of PA
60-89	90% of CC	80% of PA
90 or >	85% of CC	75% of PA

- Amount participant pays does not apply to OOP. Once OOP reached, these benefits do not increase to 100%.
- Participants who live outside PPO area but receive treatment within PPO area must use a PPO facility to obtain maximum benefits.

Physician Fees

- 90% of R&C (one visit per day), deductible required

OUTPATIENT CARE

Physician Fees

- Deductible required
- 90% of R&C up to \$50 maximum
- Limited to two visits per calendar week, not to exceed 52 visits per year
- Services must be performed by an approved provider. See page 30.

After OOP limit is reached, payment limits still apply.

17 Out Of Home Care

Individual: \$1,000

Family: Two individual family members completely meeting their OOP limits

The following do not count toward OOP limit:

- Deductible
- QCP penalty
- Covered charges not paid due to COB
- Copayments for the Mail Order Prescription Drug Program, PPO pharmacies & physicians, and Emergency Room
- Expenses not covered at all (e.g., expenses due to inpatient care for M/N conditions when not certified by QCP or as a result of a lower benefit schedule)
- Expenses above R&C or PA limits
- Expenses exceeding the scheduled amount for inpatient and outpatient care of M/N conditions or chiropractic care

18 Outpatient Care (Inpatient Facility)

- Deductible not required
- PPO hospital at 100% of covered charges
- If you live in a PPO area, non-PPO hospital at 100% of PA
- If you do not live in a PPO area, non-PPO hospital at 100% of covered charges

19 Pap Smear and Physician Fee

Lab test only

- Deductible not required
- PPO hospital at 100% of covered charges
- If you live in a PPO area, non-PPO hospital at 100% of PA
- If you do not live in a PPO area, non-PPO hospital at 100% of covered charges

PHYSICIAN

- Deductible not required
- PPO physician at 100% of covered charges
- If you live in a PPO area, non-PPO physician at 80% of PA
- If you do not live in a PPO area, non-PPO physician at 100% of R&C

20 Partial Hospitalization Program Benefit

No benefit unless certified by QCP, applies also to Medicare eligible participants.

- Deductible required
- PPO hospital at 100% of covered charges
- If you live in a PPO area, non-PPO hospital at 90% of PA
- If you do not live in a PPO area, non-PPO hospital at 100% of allowable expense
- You must use a PPO facility to receive maximum benefits if receiving treatment in a PPO area, regardless of where you live.

Limits

- One program up to 30 days per lifetime.
- You may substitute an inpatient confinement in place of this program up to the cost of a partial hospitalization program.
- Must be separated by 180 days from an inpatient rehab to be considered a separate admission.
- Physician fees must be included in inpatient facility program charges.

21 Inpatient Physician Fee

- PPO physician at 90% of covered charges, no deductible (\$5 copayment required for Office Visit)
- If you live in a PPO area, non-PPO physician at 80% of PA, deductible required
- If you do not live in a PPO area, non-PPO physician at 90% of R&C, deductible required

INPATIENT PHYSICIAN VISIT

- Limited to one visit per day
- Consultations limited to one per specialty per admission

For multiple surgical procedures, see page 25.

22 Pharmacy Program

- Generic drugs covered
- Brandname covered if generic unavailable or generic substitute not allowed by physician
- Over-the-counter drugs & medical supplies are not covered, even if prescribed by a physician

GENERAL BENEFITS

- Deductible required

Generics

90% of R&C

Brandnames

- If generic not available or generic not allowed by physician, 90% of R&C
- If generic available and allowed by physician, but not chosen, 90% of the average generic cost

MAIL ORDER PRESCRIPTION DRUG PROGRAM

- May purchase up to a 90-day supply
- \$7 copayment
- When generic dispensed, \$3 coupon returned to be used with next purchase
- When a generic is available and allowed but not chosen, participant pays the \$7 copayment plus the difference in cost between the generic and the brandname drug

PPO PHARMACY PROGRAM

- May purchase up to a 30-day supply
- \$10 copayment (If price of drug less than \$10, no copayment, but employee pays cost of drug.)
- When a generic is available and allowed but not chosen, participant pays the \$10 copayment plus the difference between the generic and the brandname drug

23 Inpatient

\$250 for each failure to comply with QCP requirements (no calendar-year limit)

More than one penalty may be applied for a single hospital confinement.

24 Well Child Care (Physician Fee)

ANNUAL LIMIT:

\$250/child; \$400/family

- Routine exams and immunizations to age 6
- Annual screenings for ages 6 through 12
- Deductible not required
- \$5 copayment
- PPO physician at 90% of covered charges
- If you live in a PPO area, non-PPO physician at 80% of PA
- If you do not live in a PPO area, non-PPO physician at 90% of R&C

Prenatal vitamins are covered under this provision.

25 Well Baby Care (Physician Fee)

- Limited to one visit during mother's confinement
- Deductible not required
- PPO physician at 90% of covered charges
- If you live in a PPO area, non-PPO physician at 80% of PA
- If you do not live in a PPO area, non-PPO physician at 90% of R&C