



Alliance Health Benefit Plan

2001

<http://www.ahbp.com>

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

Sponsored and administered by: The National Alliance of Postal and Federal Employees.

Who may enroll in this Plan: All eligible civilian employees and annuitants who become members or associate members of the National Alliance of Postal and Federal Employees (NAPFE).

To become a member or associate member: At installations and subdivisions where there is a NAPFE local, you may join as a regular or associate member. If there is no local, or you are an annuitant, you will automatically become an associate member of the NAPFE.

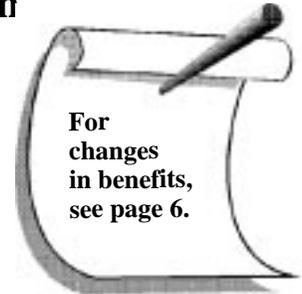
Annuitants (retirees) may enroll in this plan.

Membership dues: \$5.00 per month. Members will have the option of paying dues on an annual or semi-annual basis. Dues paid on an annual basis on or before March first of the plan year will receive a 10% discount. NAPFE will bill new associate members for annual dues when it receives notice of enrollment. NAPFE will also bill continuing associate members for the annual membership.

Enrollment codes for this Plan:

1R1 Self Only

1R2 Self and Family



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UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
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Introduction

The Alliance Health Benefit Plan
1628 11th Street NW
Washington, DC 20001

This brochure describes the benefits of Alliance Health Benefit Plan under our contract CS 1164 with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 6. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making Governments's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member, "we" means the Alliance Health Benefit Plan.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this fee-for-service plan

This Plan is a fee-for-service (FFS) plan. You can choose your own physicians, hospitals, and other health care providers.

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

We also have Preferred Provider Organizations (PPO):

Our fee-for-service plan offers services through a PPO. When you use our PPO providers, you will receive covered services at reduced cost. Contact us for the names of PPO providers and to verify their continued participation. You can also go to our web page, which you can reach through the FEHB web site, www.opm.gov/insure. Do not call OPM or your agency for our provider directory.

PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every speciality in all areas. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply.

How we pay providers

This Plan has entered into an agreement with **First Health®** to use **The First Health® Network**, a Preferred Provider Organization (PPO). This is a group of doctors, hospitals and other providers who have contracted with **First Health®** to provide medical services at reduced cost. This PPO operates in 50 states, plus Puerto Rico and the District of Columbia. Each time you need medical care you have the choice to use a health care provider who participates in the network or one who doesn't.

When you use a PPO hospital, your benefits increase from 70% after the \$250 inpatient deductible to 90% after the \$150 inpatient deductible. When you use a PPO doctor, your surgery benefits increase to 90% after a \$100 deductible and your office visit benefits increase to paid in full after a \$15 copayment. Non-PPO benefits for both are 70% after a \$300 deductible. Precertification is required as explained on pages 9 and 10 for all inpatient hospitalizations. It is your responsibility to complete this prior notification; however, your PPO doctor may initiate precertification and will file your claims for you. Note: PPO benefits are not payable when Alliance Health Benefit Plan is not the primary payer.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Network providers must meet specific criteria including location, medical speciality, professional skill and proper credentials
- Years in existence
- Profit status

If you want more information about us, call 1/800-321-0347, or write to Alliance Health Benefit Plan, 1628 11th Street NW, Washington, DC 20001. You may also contact us by fax at 202-939-6389 or visit our website at <http://www.ahbp.com>.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our PPO network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed higher patient cost sharing and shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling 1/800-225-4423, or checking out our website, www.ahbp.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:
 - Speak up if you have questions or concerns.
 - Keep a list of all the medicines you take.
 - Make sure you get the results of any test or procedure.
 - Talk with your doctor and health care team about your options if you need hospital care.
 - Make sure you understand what will happen if you need surgery.
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.
- North Dakota is deleted from the list of states designated as medically underserved in 2001. See page 7 for information on medically underserved areas.

Changes to this Plan

- Your share of the non-postal premium will decrease 2% for Self Only or 5% for Self and Family.
- PPO physician's office visit is increased from \$10 per visit to \$15 per visit.
- Preventive services for dental benefits are limited to 2 visits per year.
- For non-PPO Mental Conditions Inpatient Care benefits, members pay 30% coinsurance.
- For non-PPO Substance Abuse Inpatient Care benefits, members pay 30% coinsurance.

Clarifications

- Covered providers also include Christian Science Nurses and Christian Science Practitioners who are listed in the Christian Science Journal.
- Covered facilities also include Christian Science Nursing Facilities that are approved by the Commission for the Accreditation of Christian Science Nursing Organizations/Facilities, Inc..
- Home health services also include services provided by a Christian Science Nurse who is listed in the Christian Science Journal.
- Nursing services also include a Christian Science Nurse who is listed in the Christian Science Journal.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1/800-225-4423.

Where you get covered care

You can get care from any “covered provider” or “covered facility.” How much we pay — and you pay— depends on the type of covered provider or facility you use. If you use our preferred providers, you will pay less.

- **Covered providers**

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

(1) a licensed doctor of medicine (M.D.), or a licensed doctor of osteopathy (D.O.), and a licensed podiatrist practicing within the scope of their license.

(2) other covered providers include: a Chiropractor, Dentist, Optometrist, Clinical Psychologist, Clinical Social Worker, Nurse Midwife, Nurse Practitioner/Clinical Specialist, Nurse Anesthetist or Nursing School Administered Clinic. Charges for Christian Science Nurses and Christian Science Practitioners who are listed in the Christian Science Journal will be covered under this Plan the same as other medical providers.

Medically underserved areas. Note: In medically underserved areas, we cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are “medically underserved.” For 2001, the states are: Alabama, Idaho, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, South Carolina, South Dakota, Utah, and Wyoming.

- **Covered facilities**

Covered facilities include:

- **Birth Center:** A free standing facility licensed or certified by the State in which it functions, or Plan approved, which offers comprehensive maternity care in a home-like atmosphere.
- **Hospice:** A facility which provides short periods of stay for a terminally ill person in a home-like setting for either direct care or respite. This facility may either be free-standing or affiliated with a hospital. It must operate as an integral part of the hospice care program.

- **Hospital:** An institution licensed by the State or conforming to the standards of, and accredited by, the Joint Commission on Accreditation of Health Care Organizations (JCAHO) providing inpatient diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of licensed doctors of medicine (M.D.), or licensed doctors of osteopathy (D.O.). The hospital must provide continuous 24-hour-a-day professional registered nursing (R.N.) services and may not be an Extended Care Facility (other than an approved ECF); nursing home; a place for rest; an institution for exceptional children, the aged, drug addicts, or alcoholics; or a custodial or domiciliary institution having the primary purpose of furnishing food, shelter, training, or non-medical personal services. This definition includes college infirmaries and Veterans Administration Hospitals. This includes also Christian Science Nursing facilities that are approved by the Commission for the Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

What you must do to get covered care

It depends on the kind of care you want to receive. You can go to any physician you want, but we must approve some care in advance.

Transitional care:

Speciality care: If you have a chronic or disabling condition and lose access to your specialist because we:

- terminate our contract with your specialist for other than cause; or
- drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan.

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

Hospital care. We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1/800-321-0347.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to benefits of the hospitalized person.

How to Get Approval for...

• Your hospital stay

Precertification is the process by which — prior to your inpatient hospital admission — we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition. Unless we are misled by the information given to us, we won't change our decision on medical necessity.

In most cases, your physician or hospital will take care of precertification. Because you are still responsible for ensuring that we are asked to precertify your care, you should always ask your physician or hospital whether they have contacted us.

Warning:

We will reduce our benefits for the inpatient hospital stay by \$500 if no one contacts us for precertification. If the stay is not medically necessary, we will not pay any benefits.

How to precertify an admission:

- You, your representative, your doctor, or your hospital must call us at 1/800-225-4423 at least 48 hours before admission.
- If you have an emergency due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Provide the following information:
 - Enrollee's name and Plan identification number;
 - Patient's name, birth date, and phone number;
 - Reason for hospitalization, proposed treatment, or surgery;
 - Name and phone number of admitting doctor;
 - Name of hospital or facility; and
 - Number of planned days of confinement.
- We will then tell the doctor and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your doctor, and the hospital.

Maternity care

You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.

If your hospital stay needs to be extended:

If your hospital stay — including for maternity care — needs to be extended, your doctor or the hospital must ask us to approve the additional days.

What happens when you do not follow the precertification rules

- When we precertified the admission but you remained in the hospital beyond the number of days we approved and did not get the additional days precertified, then:
 - for the part of the admission that was medically necessary, we will pay inpatient benefits, but
 - for the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.
- If no one contacted us, we will decide whether the hospital stay was medically necessary.
 - If we determine that the stay was medically necessary, we will pay the inpatient charges, less the \$500 penalty.
 - If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.
- If we denied the precertification request, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

Exceptions:

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States or Puerto Rico.
- You have another group health insurance policy that is the primary payer for the hospital stay.
- Your Medicare part A is the primary payer for the hospital stay. Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we will become the primary payer and you do need precertification.

• Other services

Some services require a referral, precertification, or prior authorization.

- Right-sided heart catheterization.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for your covered care:

- **Copayments**

A copayment is a fixed amount of money you pay to the provider when you receive services.

Example: When you see your PPO physician you pay a copayment of \$15 per visit.

- **Deductible**

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- The calendar year deductible is \$100 per person for PPO benefits and \$300 per person for Non-PPO benefits. Under a family enrollment, the deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$300 for PPO benefits and \$900 for Non-PPO benefits.
- We also have separate deductibles for:
 - There is a combined annual \$200 deductible per person for mail order and/or retail prescription drugs.
 - There is a Non-PPO \$500 deductible per person, per confinement for inpatient care for mental conditions.

Note: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

- **Coinsurance**

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: You pay 10% of our allowance for office visits.

- 10% for PPO inpatient hospital room/board, and other hospital charges;
- 30% for non-PPO inpatient hospital room/board, and other hospital charges;

- 10% for PPO inpatient and outpatient surgical benefits, maternity benefits, and other medical benefits;
- 30% for non-PPO inpatient and outpatient surgical benefits, maternity benefits, and other medical benefits;
- 10% for PPO inpatient treatment of mental conditions;
- 30% for non-PPO inpatient treatment of mental conditions;
- 10% for PPO doctors' visits for (inpatient) mental conditions;
- 50% for non-PPO doctors' visits (inpatient and outpatient) for mental conditions;
- 10% for PPO inpatient treatment of substance abuse;
- 30% for non-PPO inpatient treatment of substance abuse;
- 50% for non-PPO outpatient treatment of substance abuse;
- 20% for skilled nursing facility

Note: If your provider routinely waives (does not require you to pay) your copayments, deductibles, or coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

For example, if your physician ordinarily charges \$100 for a service but routinely waives your 30% coinsurance, the actual charge is \$70. We will pay \$49 (70% of the actual charge of \$70).

- **Differences between our allowance and the bill**

Our "Plan allowance" is the amount we use to calculate our payment for covered services. Fee-for-service plans arrive at their allowances in different ways, so their allowances vary. For more information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10.

Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the provider you use.

- **PPO providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible and coinsurance. Here is an example: You see a PPO physician who charges \$150, but our allowance is \$100. If you have met your deductible, you are only responsible for your coinsurance. That is, you just pay — 10% of our \$100 allowance (\$10). Because of the agreement, your PPO physician will not bill you for the \$50 difference between our allowance and his bill.
- **Non-PPO providers**, on the other hand, have no agreement to limit what they will bill you. When you use a non-PPO provider, you will pay your deductible and coinsurance — **plus** any difference between our allowance and charges on the bill. Here is an example: You see a non-PPO physician who charges \$150 and our allowance is again \$100. Because you've met your deductible, you are responsible for your coinsurance, so you pay 30% of the \$100 allowance (\$30). Plus, because there is no agreement between the non-PPO physician and us, he can bill you for the \$50 difference between our allowance and his bill.

The following table illustrates the examples of how much you have to pay out-of-pocket for services from a PPO physician vs. a non-PPO physician. The table uses our example of a service for which the physician charges \$150 and our allowance is \$100. The table shows the amount you pay if you have met your calendar year deductible.

EXAMPLE	PPO physician	Non-PPO physician
Physician's charge	\$150	\$150
Our allowance	We set it at: 100	We set it at: 100
We pay	90% of our allowance: 90	70% of our allowance: 70
You owe: Coinsurance	10% of our allowance: 10	30% of our allowance: 30
+Difference up to charge?	No: 0	Yes: 50
TOTAL YOU PAY	\$10	\$80

Your out-of-pocket maximum for deductibles, coinsurance, and copayments

For those services with coinsurance, the Plan pays 100% of the plan allowance for the remainder of the calendar year after the calendar year deductible is met when out-of-pocket expenses for coinsurance in that calendar year exceed \$2,000 under the PPO benefit. The Plan pays 100% of the plan allowance, if out-of-pocket expenses for the coinsurance in that calendar year exceed \$3,000 under the non-PPO benefit. Any expenses incurred through PPO or non-PPO benefits are applied toward both catastrophic limits.

Out-of-pocket expenses for the purposes of this benefit are:

- The \$100 calendar year deductible for PPO benefits;
- The \$300 calendar year deductible for non-PPO benefits;
- The \$150 PPO per admission inpatient hospital copayment;
- The \$250 non-PPO per admission inpatient hospital copayment;
- The 10% you pay for PPO hospital, surgical, maternity and other medical benefits;
- The 30% you pay for non-PPO hospital, surgical, maternity and other medical benefits.

The following cannot be counted toward out-of-pocket expenses:

- Expenses in excess of the plan allowance or maximum benefit limitations;
- Expenses for dental care;
- Any amounts you pay because benefits have been reduced for non-compliance with the Plan's cost containment requirements (see pages 9-10);
- PPO office visit copayments;
- Expenses for prescription drugs purchased through retail or mail order program; and
- Expenses for skilled nursing facility confinements.

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you got in January before the effective date of your coverage in this Plan. If you have already met the covered out-of-pocket maximum expense level in full, your old plan's catastrophic protection benefit will continue to apply until the effective date. If you have not met this expense in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective on January 1.

When government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

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

Under the FEHB law, we must limit our payments for those benefits you would be entitled to if you had Medicare. And, your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. The following chart has more information about the limits.

If you...

- are age 65 or over, and
 - do not have Medicare Part A, Part B, or both; and
 - have this Plan as an annuitant or as a former spouse, or as a family member of an annuitant or former spouse; and
 - are not employed in a position that gives FEHB coverage. (Your employing office can tell you if this applies.)
-

Then, for your inpatient hospital care,

- The law requires us to base our payment on an amount — the “equivalent Medicare amount” — set by Medicare’s rules for what Medicare would pay, not on the actual charge;
 - You are responsible for your applicable deductibles, coinsurance or copayments you owe under this Plan;
 - You are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits; and
 - The law prohibits a hospital from collecting more than the Medicare equivalent amount.
-

And, for your physician care, the law requires us to base our payment and your coinsurance on...

- an amount — set by Medicare and called the “Medicare approved amount,” or
 - the actual charge if it is lower than the Medicare approved amount.
-

If your Physician...	Then you are responsible for...
Participates with Medicare or accepts Medicare assignment for the claim and is a member of our PPO network,	your deductibles, coinsurance, and copayments;
Participates with Medicare and is not in our PPO network,	your deductibles, coinsurance, copayments and any balance up to the Medicare approved amount;
Does not participate with Medicare,	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are only permitted to collect up to the Medicare approved amount.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us.

When you have the Original Medicare Plan

We limit our payment to an amount that supplements the benefits that Medicare would pay under Part A (Hospital insurance) and Part B (Medical insurance), regardless of whether Medicare pays. Note: We pay our regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

If you are covered by Medicare Part B and it is primary, your out of pocket costs for services both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

- If your physician accepts Medicare assignment, then you pay nothing for covered charges.
- If your physician does not accept Medicare assignment, then you pay the difference between our payment combined with Medicare's payment and the charge.

Note: The physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payments on, called the “limiting charge.” The Medicare Summary Notice (MSN) that Medicare will send you will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask them to reduce their charges. If they do not, report them to your Medicare carrier who sent you the MSN form. Call us if you need further assistance.

When you have a Medicare Private Contract

A physician may ask you to sign a private contract agreeing that you can be billed directly for service ordinarily covered by Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Medicare’s payment.

Please see Section 9, Coordinating benefits with other coverage, for more information about how we coordinate benefits with Medicare.

Section 5. Benefits — OVERVIEW

(See page 6 for how our benefits changed this year and pages 78-79 for a benefits summary.)

Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1/800-225-4423 or at our website at www.ahbp.com.

(a) Medical services and supplies are provided by physicians and other health care professionals	20-30
• Diagnostic and treatment services	
• Lab, X-ray, and other diagnostic tests	
• Preventive care, adult	
• Preventive care, children	
• Maternity care	
• Family planning	
• Infertility services	
• Allergy care	
• Treatment therapies	
• Rehabilitative therapies	
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Section 5 (a). Medical services and supplies provided by physicians and other health care professionals

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductibles are: PPO \$100 per person (\$300 per family); Non-PPO \$300 per person (\$900 per family). Calendar year deductibles apply to almost all benefits in this Section. We added “(No deductible)” to show when a calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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Benefit Description	You pay After the calendar year deductible...
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say “No deductible” when it does not apply.	
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office 	PPO: \$15 copayment Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of newborn child covered under a family enrollment • Second surgical opinion • At home 	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Lab, X-ray and other diagnostic tests	You pay
<p>Tests, such as</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap smears • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiograms and EEG 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges.</p>
Preventive care, adults	
<p>Routine screenings, limited to:</p> <ul style="list-style-type: none"> • Colorectal Cancer Screening, including <ul style="list-style-type: none"> • Fecal occult blood test annually for members age 40 and older • Sigmoidoscopy, screening — one every five years starting at age 50 	<p>PPO: Nothing after office visit copayment</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Prostate Specific Antigen (PSA test) — one annually for men age 40 and older</p>	<p>PPO: Nothing after office visit copayment</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Routine pap test — one annually for women age 18 and older</p>	<p>PPO: Nothing after office visit copayment</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Routine mammogram — covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	<p>PPO: Nothing after office visit copayment</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>

Preventive care, adults - Continued on next page.

Preventive care, adults - <i>Continued</i>	You pay
Routine physical — one annually every two years Note: The maximum PPO benefit is \$150	PPO: \$15 copayment (No deductible) Non-PPO: All charges
Routine Immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster — once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over 	PPO: Nothing after office visit copayment Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
<i>Not Covered:</i> <ul style="list-style-type: none"> • Preventive medical care and services, including: <ul style="list-style-type: none"> • Periodic checkups • associated X-ray and lab test • immunizations such as polio, flu, mumps and smallpox, except as shown under preventive care, adults and preventive care, children 	<i>All charges</i>
Preventive care, children	
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics for children under age 22 	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
<ul style="list-style-type: none"> • For well-child care charges for routine examinations, immunizations and care (to age 6) limited to 12 well care visits. • Sickle Cell Screening — for newborns for sickle cell anemia 	PPO: \$15 copayment (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
<ul style="list-style-type: none"> • Examinations, limited to: <ul style="list-style-type: none"> • Examinations for amblyopia and strabismus — limited to one screening (ages 2 through 6) • Examinations done on the day of the immunizations (through age 22) 	PPO: \$15 copayment (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Maternity care	You pay
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 10 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay, if medically necessary, but you must precertify. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b) 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex</i></p>	<p><i>All charges</i></p>

Family planning	You pay
<ul style="list-style-type: none"> • Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs) <p>Note: We cover contraceptive drugs in Section 5(f).</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered: Reversal of voluntary surgical sterilization, genetic counseling.</i></p>	<p><i>All charges</i></p>
Infertility services	
<p>Diagnosis and treatment of infertility, except as excluded.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> • <i>artificial insemination</i> • <i>in vitro fertilization</i> • <i>embryo transfer and GIFT</i> • <i>intravaginal insemination (IVI)</i> • <i>intrauterine insemination (IUI)</i> • <i>intrauterine insemination (IUI)</i> • <i>Services and supplies related to ART procedures.</i> 	<p><i>All charges</i></p>
Allergy care	
<p>Testing and treatment, including materials (such as allergy serum)</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Allergy injection</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered: provocative food testing and sublingual allergy desensitization</i></p>	<p><i>All charges</i></p>

Treatment therapies	You pay
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 34.</p> <ul style="list-style-type: none"> • Dialysis — Hemodialysis and peritoneal dialysis • Intravenous (IV) Infusion Therapy — Home IV and antibiotic therapy • Respiratory and inhalation therapies 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
Rehabilitative therapies	
<p>Physical therapy, occupational therapy, and speech therapy provided by a:</p> <ul style="list-style-type: none"> • qualified physical therapist; • speech therapist; and • occupational therapist <p>Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury and when a physician:</p> <ol style="list-style-type: none"> 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 service is needed. 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Exercise programs</i> • <i>Speech therapy, physical therapy, and occupational therapy related to services, treatment, educational testing or training related to learning disabilities or developmental delays.</i> • <i>Chelation therapy, except for acute arsenic, gold, lead, or mercury poisoning.</i> • <i>Massage therapy</i> 	<p><i>All charges</i></p>

Hearing services (testing, treatment, and supplies)	You pay
Testing only when necessitated by accidental injury	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>hearing testing, except for accidental injury</i> • <i>hearing aids, testing and examinations for them</i> 	<i>All charges</i>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) Note: See Preventive care, children for eye exams for children	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses and examinations for them</i> • <i>Eye exercise and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges</i>

Foot care	You pay
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>See orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>PPO: \$15 copayment and/or 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<p><i>All charges</i></p>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy. <p>Note: Internal prosthetic devices are paid as hospital benefits; See Section 5 (c) for payment information. Insertion of the device is paid as surgery, see Section 5 (b).</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not Covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> 	<p><i>All charges</i></p>

Durable medical equipment (DME)	You pay
<p>Durable medical equipment (DME) is equipment and supplies that:</p> <ol style="list-style-type: none"> 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. <p>We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Hospital beds; • Wheelchairs, to include medically necessary motorized wheelchairs; • Iron lung; • Certain types of traction equipment; • Oxygen and rental of equipment for its administration; • Crutches; and • Walkers. <p>Note: Call us at 1/800-225-4423 as soon as your physician prescribes this equipment. We arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>exercise equipment</i> • <i>whirlpool baths</i> • <i>sun-lamps</i> • <i>heating pads</i> • <i>air conditioners</i> • <i>humidifiers, dehumidifiers, and purifiers</i> 	<p><i>All charges</i></p>

Home health services	You pay
<p>Nursing services:</p> <ul style="list-style-type: none"> • 240 units annually up to \$15 per unit when rendered by a: <ul style="list-style-type: none"> • Registered Nurse (R.N.), a licensed practical nurse (L.P.N.) , or a Christian Science Nurse who is listed in the Christian Science Journal <p>Note: One private duty nursing unit consist of up to one hour of private duty nursing care.</p>	<p>PPO: all charges after \$15 per unit with the maximum of 240 units</p> <p>Non-PPO: all charges after \$15 per unit with the maximum of 240 units</p>
<p>Home health care services:</p> <ul style="list-style-type: none"> • 60 home health visits per calendar year up to a maximum plan payment of \$40 per visit when: <ul style="list-style-type: none"> • A home health care visit consists of; <ul style="list-style-type: none"> • Less than an 8-hour shift of nursing care; or • One therapy session; or • One social worker visit; or • Less than an 8-hour shift by a home health aide. • Covered home health care services are: <ul style="list-style-type: none"> • Nursing care provided on a part-time basis (less than an 8-hour shift) by: <ol style="list-style-type: none"> a) a registered nurse (RN); or b) a licensed practical nurse (LPN); or c) a Christian science nurse • Physical, occupational or speech therapy provided by a licensed therapist; • Services of a licensed social worker (but not more than 2 visits); • Home health aide services provided on a part-time basis (less than an 8-hour shift) that; <ol style="list-style-type: none"> a) are performed by a home health aide under the supervision of a registered nurse (RN); and b) consist mainly of medical care and therapy provided solely for the care of the patient. <p>Note: The home health care services must be furnished:</p> <ul style="list-style-type: none"> • by a home health care agency (or by visiting nurses where services of a home health care agency are not available); • in accordance with a home health care plan, see definition on page 67; and • in the patient’s home 	<p>PPO: (No deductible) all charges after we pay \$40 per day</p> <p>Non-PPO: (No deductible) all charges after we pay \$40 per day</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient’s family</i> • <i>Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.</i> 	<p><i>All charges</i></p>

Alternative treatments	You pay
<p>Acupuncture — by a doctor of medicine or osteopathy for:</p> <ul style="list-style-type: none"> • anesthesia when used as an anesthetic agent for covered surgery 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Chiropractor — The Plan pays a maximum of \$225 per person annually for outpatient services provided:</p> <ul style="list-style-type: none"> • by a licensed chiropractor <p>Note: No other services of a chiropractor are covered under any other provision of this Plan.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
Educational classes and programs	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Cardiac rehabilitation program — Outpatient visits must consist of outpatient cardiac rehabilitative exercise, education, and counseling when: <ul style="list-style-type: none"> • patient has been diagnosed as having angina pectoris (chest pain); or • patient has been hospitalized for a diagnosed myocardial infarction (heart attack); or • coronary surgery. <p>Note: Services must be provided by an approved hospital-based or hospital-coordinated cardiac rehabilitation program.</p>	<p>PPO: 30% of the Plan allowance</p> <p>Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • Smoking Cessation — Up to \$100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. 	<p>PPO: all charges after benefits stop at \$100</p> <p>Non-PPO: all charges after benefits stop at \$100</p>

Section 5 (b). Surgical and anesthesia services provided by physicians and other health care professionals

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductibles are: PPO \$100 per person (\$300 per family); Non-PPO: \$300 per person (\$900 per family). Calendar year deductibles apply to almost all benefits in this section. We added “No deductible” to show when a calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.)
- **YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification.**

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Benefit Description	You pay After the calendar year deductible...
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say “No deductible” when it does not apply.	
Surgical procedures	
<ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by a surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Electroconvulsive therapy 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>

Surgical procedures — Continued on next page.

Surgical procedures — Continued	You pay
<ul style="list-style-type: none"> • Removal of tumors and cysts • Correction of congenital anomalies (See Reconstructive surgery) • Surgical treatment of morbid obesity — a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) — Orthopedic braces and prosthetic devices for device coverage information • Voluntary sterilization, Norplant (a surgically implanted contraceptive), and intrauterine devices (IUDs) • Treatment of burns • Assistant surgeons — we cover up to 20% of our allowance for the surgeon’s charge 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p>When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are</p> <ul style="list-style-type: none"> • For the primary procedure <ul style="list-style-type: none"> • PPO: 90% of the Plan allowance • Non-PPO: 70% of the reasonable and customary charge • For the secondary procedure(s): <ul style="list-style-type: none"> • PPO: 90% of one-half of the Plan allowance • Non-PPO: 70% of one-half of the reasonable and customary charge <p>Note: Multiple and bilateral surgical procedures performed through the same incision are “incidental” to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.</p>	<p>PPO: 10% of the Plan allowance for the primary procedure; 10% of one-half of the Plan allowance for the secondary procedure(s) and 10% of one-quarter of the Plan allowance for procedure(s) thereafter.</p> <p>Non-PPO: 30% of the Plan allowance for the primary procedure and 30% of one-half of the Plan allowance for the secondary procedure(s) and 30% of one-quarter of the Plan allowance for procedure(s) thereafter and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standbys are medically necessary</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<p><i>All charges</i></p>

Reconstructive surgery	You pay
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> • the condition produced a major effect on the member’s appearance and • the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> • surgery to produce a symmetrical appearance on the other breast; • treatment of any physical complication, such as lymphedemas; • breast prostheses; and surgical bras and replacements (see Prosthetic devices for coverage) 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Note: We pay for internal breast prostheses as hospital benefits.</p> <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery — any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury.</i> • <i>Surgeries related to sexual transformations or sexual dysfunction.</i> 	<p><i>All charges</i></p>

Oral and maxillofacial surgery	You pay
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaw or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva and alveolar bone)</i> 	<p><i>All charges</i></p>
Organ/tissue transplants	
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single — only for the following end-stage pulmonary diseases: primary fibrosis, primary pulmonary hypertension, or emphysema; Double — only for patients with cystic fibrosis • Pancreas (when condition is not treatable by use of insulin therapy) • Allogeneic bone marrow transplants — only for patients with Acute leukemia, Advanced Hodgkins lymphoma, Advanced non-Hodgkin’s lymphoma, Advanced neuroblastoma (limited to children over age one), Aplastic anemia, Chronic myelogenous leukemia, Infantile malignant osteopetrosis, Severe combined immunodeficiency, Thalassemia major, and Wiskott-Aldrich syndrome • Autologous bone marrow transplants — (autologous stem cell and autologous peripheral stem cell support) for Acute lymphocytic or non-lymphocytic leukemia, Advance Hodgkin’s lymphoma, Advanced non-Hodgkin’s lymphoma, Advanced neuroblastoma, Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors, Breast cancer, Multiple myeloma, and Epithelial ovarian cancer. 	<p>The First Health[®] National Transplant Program: 10% of the Plan allowance</p> <p>PPO: 20% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and the difference between our allowance and the billed amount.</p>

Organ/tissue transplants - Continued on next page.

Organ/tissue transplants — <i>Continued</i>	You pay
<p>First Health[®] National Transplant Program</p> <ul style="list-style-type: none"> • Covered Transplant Services: <ul style="list-style-type: none"> • Pre-transplant evaluation; • Organ procurement; • Transplant procedures and associated hospitalization; • Transplant-related follow-up care provided by the designated transplant hospital for up to 1 year; • Pharmacy costs provided by the First Health[®] National Transplant Program for immunosuppressant and other transplant-related medications while hospitalized; • Donor expenses, if not covered under any other plan; • Transplant-related services provided by the First Health[®] National Transplant Program facility that are associated with the transplant events listed above, including laboratory and other diagnostic services; • Physician services related to the transplant events listed above • Travel and lodging benefit: <ul style="list-style-type: none"> • If the recipient lives more than 100 miles from a designated transplant facility, the Plan will provide an allowance for pre-approved travel and lodging expenses up to \$10,000 per transplant. The allowance will not be subject to the calendar year deductible or coinsurance. The allowance will provide coverage of reasonable travel and temporary lodging expenses for the recipient and one companion (two companions if the recipient is a minor). Covered travel and lodging expenses will be established by the Plan's case manager during the precertification process. Travel and lodging to a designated facility for the pre-transplant evaluation is covered under this benefit even if the transplant is not eventually certified as medically necessary. 	<p>The First Health[®] National Transplant Program: 10% of the Plan allowance</p> <p>PPO: 20% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and the difference between our allowance and the billed amount.</p>

Organ/tissue transplants — Continued on next page.

Organ/tissue transplants — <i>Continued</i>	You pay
<p>PPO benefit—not designated as National Transplant Program:</p> <ul style="list-style-type: none"> If you do not use a First Health® National Transplant Program facility, but you do use a PPO facility, 80% benefits will be applied to your expenses. Total benefit payments, including donor expenses, the transplant procedure itself, and transplant-related follow-up care for one year at the transplant facility will be limited to a maximum payment of \$150,000 for a liver transplant and \$100,000 for any other transplant. The travel and lodging allowance will not be available. Charges incurred for prescription drugs and follow-up care outside of the transplant facility/hospital will not be counted toward this maximum. <p>Note: Cornea and pancreas transplants are not available through the First Health® National Transplant Program; therefore, the Travel/Lodging benefit is not available.</p> <p>Precertification:</p> <ul style="list-style-type: none"> In order to receive benefits for the transplants listed above, you are required to call First Health® OnCall at 1/800-225-4423 as soon as the need for a transplant is discussed with your physician. When you call, it will be necessary to provide the program with all information needed to complete the review. In order to receive the highest level of benefits, all transplant-related services must be received at one of the designated hospitals within the First Health® National Transplant Program. All covered transplant benefits, including pre-transplant evaluation expenses (even if the transplant does not occur) will be provided by the Plan. If you do not follow the procedures required by the First Health® National Transplant Program, the Plan’s co-payment will be reduced to the PPO or non-PPO benefit level for all related covered physician/hospital expenses, after any applicable deductible. Also, no coverage will be provided for transportation or lodging and meal expenses if a transplant procedure is not performed at a First Health® National Transplant Program facility. The penalty assessed when you do not follow the procedures required by the First Health® National Transplant Program does not apply toward your out-of-pocket maximum. 	<p>The First Health® National Transplant Program: 10% of the Plan allowance</p> <p>PPO: 20% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and the difference between our allowance and the billed amount.</p>

Organ/tissue transplants — Continued on next page.

Organ/tissue transplants — <i>Continued</i>	You pay
<p>Limitations:</p> <ul style="list-style-type: none"> For the purposes of the maximum total payment, charges from doctors and hospitals while the patient is confined in a transplant facility will be counted toward the maximum. Charges incurred for prescription drugs and follow-up care outside of the transplant facility/hospital will not be counted toward this maximum. <p>Note: If the Plan cannot refer a member in need of a transplant to a First Health® National Transplant Program facility, the \$100,000/\$150,000 maximum will not apply.</p> <p>Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute (NCI) or National Institute of Health (NIH) approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	(See above)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Services, supplies, drugs and aftercare for, or related to, artificial or non-human organ implants or transplants;</i> <i>Services that are considered experimental/investigational or not medically necessary;</i> <i>Expenses for services which are specifically excluded under the Medical Expenses Not Covered section of this Plan; and</i> <i>Transplants not listed as covered</i> 	<i>All charges</i>
Anesthesia	
<p>Professional services provided in —</p> <ul style="list-style-type: none"> Hospital (inpatient) 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Professional services provided in —</p> <ul style="list-style-type: none"> Hospital outpatient department Skilled nursing facility Ambulatory surgical center Office 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for the anesthesia charges</p>

Section 5 (c). Services provided by a hospital or other facility, and ambulance services

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

- Please remember that all your benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Unlike Sections (a) and (b), in this section the calendar year deductibles apply to only a few benefits. In that case we added “(calendar year deductibles apply)”
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, emergency room physicians, anesthesiologists, and pathologists, may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e. hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e. physicians, etc.) are in Section 5 (a) or (b).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM \$500 PENALTY.** Please refer to the precertification information in Section 3 to be sure which services require precertification.

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Benefit Description	You pay
NOTE: The calendar year deductible applies ONLY when we say below: “calendar year deductible applies”.	
Inpatient Hospital	
<p>Room and board, such as</p> <ul style="list-style-type: none"> • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. <p>NOTE: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital’s average charge for semiprivate accommodations. If the hospital only has private rooms, we base our payment on the average semiprivate rate of the most comparable hospital in the area.</p> <p>NOTE: When the non-PPO hospital bills a flat rate, we prorate the charge to determine how to pay them, as follows: 30% room and board and 70% other charges.</p>	<p>PPO: \$150 per admission and 10% of the covered charges</p> <p>Non-PPO: \$250 per admission and 30% of the covered charges</p> <p>Note: If you use a PPO provider and a PPO facility, we may still pay non-PPO benefits if you receive treatment from a radiologist, pathologist or anesthesiologist who is not a PPO provider</p>

Inpatient hospital — Continued on next page.

Inpatient hospital — <i>Continued</i>	You pay
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) <p>NOTE: We base payment on whether the facility or a health care professional bills for the services or supplies. For example, when the hospital bills for its nurse anesthetists' services, we pay Hospital benefits and when the anesthesiologist bills, we pay surgery benefits.</p>	(see above)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Any part of a hospital admission that is not medically necessary (see definition), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting</i> • <i>Custodial care; see definition.</i> • <i>Non-covered facilities, such as nursing homes, extended care facilities, schools, rest homes, places for the aged, convalescent homes, residential treatment facilities, and any place that is not a hospital</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> 	<i>All charges</i>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service 	<p>PPO; 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>

Outpatient hospital or ambulatory surgical center — Continued on next page.

Outpatient hospital or ambulatory surgical center — Continued	You pay
NOTE: — We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	(see above)
<i>Not covered: all services not listed</i>	<i>All charges</i>
Extended care benefits/Skilled nursing care facility benefits	
<p>Skilled nursing facility (SNF): We cover semiprivate room, board, services, supplies in a SNF for up to 60 days confinement when:</p> <ol style="list-style-type: none"> 1) you are admitted within 14 days from a precertified hospital stay of at least 3 consecutive days; and 2) you are admitted for the same condition as the hospital stay; and 3) your skilled nursing care is supervised by a physician and provided by an R.N., L.P.N., or L.V.N.; and 4) SNF care is medically appropriate. 	<p>PPO: 20% of the Plan allowance</p> <p>Non-PPO: 20% of the Plan allowance</p>
Hospice care	
<p>Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan approved independent hospice administration.</p> <ul style="list-style-type: none"> • We pay \$4,500 per lifetime for inpatient and outpatient services. 	<p>PPO: Nothing until Plan allowance stops at \$4,500</p> <p>Non-PPO: Nothing until Plan allowance stops at \$4,500</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Bereavement counseling</i> • <i>Funeral arrangements</i> • <i>Pastoral counseling</i> • <i>Financial or legal counseling</i> • <i>Homemaker or caretaker services</i> 	<i>All charges</i>
Ambulance	
<ul style="list-style-type: none"> • Local professional ambulance service when medically appropriate 	<p>PPO: 10% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p>

Section 5 (d). Emergency services/accidents

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- The calendar year deductibles are: PPO \$100 per person (\$300 per family); Non-PPO \$300 per person (\$900 per family). Calendar year deductibles apply to almost all benefits in this Section. We added “(No deductible)” to show when a calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious, examples include deep cuts and broken bones. Others are emergencies because they are potentially life threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies — what they all have in common is the need for quick action.

What is an accidental injury?

An accidental injury is a bodily injury sustained solely through violent, external, and accidental means, such as broken bones, animal bites, poisonings and dental care required as a result of accidental injury to sound natural teeth.

Benefit Description	You pay After the calendar year deductible...
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say “No deductible” when it does not apply.	
Accidental injury	
If you receive care for your accidental injury within 72 hours, we cover: <ul style="list-style-type: none"> • Non-surgical physician services and supplies • Related outpatient hospital services Note: We pay Hospital benefits if you are admitted.	PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount
If you receive care for your accidental injury after 72 hours, we cover: <ul style="list-style-type: none"> • Non-surgical physician services and supplies • Surgical care Note: We pay Hospital benefits if you are admitted.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Medical emergency	You pay
Outpatient medical or surgical services and supplies in an emergency room.	PPO: \$25 copayment Non-PPO: \$25 copayment and the difference between our allowance and the billed amount
Care in a physician's office	PPO: \$15 and/or 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount.
Ambulance	
<p>Professional ambulance service</p> <p>Note: If hospital treatment requiring special equipment is necessary but not locally available, the Plan covers transportation within the United States and Canada by professional ambulance, railroad, or scheduled commercial airlines to the nearest hospital equipped to furnish the treatment.</p> <p>Note: See 5 (c) for non-emergency service.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Transportation necessary to obtain the services of a doctor or any other practitioner</i> 	<p><i>All charges</i></p>

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

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

You may now choose to get Out-of-Network (same as before) or **In-Network** (new in 2001). When you receive In-Network care, you must get our approval for services and follow a treatment plan we approve. If you do, cost-sharing and limitations for In-Network mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- The calendar year deductibles or, for facility care, the inpatient deductibles apply to almost all benefits in this section. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your cost for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits descriptions below.
- In-Network mental health and substance abuse benefits are below, then Out-of-Network benefits begin on page 45.

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Benefit Description	You pay After the calendar year deductible...
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply.	
In-Network benefits	
<p>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.</p> <p>Note: In-Network benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>

In-Network benefits — Continued on next page.

In-Network benefits — Continued	You pay
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	\$15 per visit
<ul style="list-style-type: none"> • Diagnostic tests 	10% of the Plan allowance
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	\$150 per admission copayment and 10% of the Plan allowance
<p><i>Not covered: Services we have not approved.</i></p> <p><i>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 pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All charges.</i>

Preauthorization

To be eligible to receive these enhanced mental health and substance abuse benefits you must follow your treatment plan and all of our network authorization processes:

- **Pre-certification:** The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive full Plan benefits. Emergency admissions must be reported within two business days following the day of the admission even if you have been discharged. Otherwise, the benefits payable will be reduced by \$500. See page 9 for details.
- You may obtain a provider directory by calling 1/800-321-0347.
- **Outpatient approval procedures:** Covered outpatient services for treatment of mental conditions or substance abuse require pre-certification. Pre-certification is required when treatment continues beyond 2 visits per person, per calendar year.

Special transition benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following conditions:

In-Network benefits — Continued

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause, or
- If changes to this plan's benefit structure for 2001 cause your out-of-pocket costs for your out-of-network provider to be greater than they were in contract year 2000.

If these conditions apply to you, we will allow you reasonable time to transfer your care to a network mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.

Network limitation

If you do not obtain and follow an approved treatment plan, we will provide only out-of-network benefits.

Out-of-Network benefits	You pay
Inpatient and outpatient professional services to treat mental conditions.	30% of our allowance and any difference between our allowance and the billed amount for up to 45 visits; all charges after 45 visits
Inpatient and outpatient professional services to treat substance abuse conditions.	50% of our allowance and any difference between our allowance and the billed amount and all charges after the \$4000 maximum
Inpatient care to treat mental conditions includes ward or semiprivate accommodations and other hospital charges	After a \$500 deductible per admission to a non-PPO hospital, 30% of charges for up to 45 days per calendar year; all charges after 45 days
Inpatient care to treat substance abuse includes room and board and ancillary charges for confinement in a treatment facility for rehabilitative treatment of alcoholism or substance abuse	30% of Plan allowance and any difference between our allowance and the billed amount and all charges after maximum benefit of \$4000
<p><i>Not covered out-of-network:</i></p> <ul style="list-style-type: none"> • <i>Services by pastoral and marital counselors</i> • <i>Treatment for learning disabilities and mental retardation</i> • <i>Services rendered or billed by schools, residential treatment centers or halfway houses or members of their staffs</i> 	<i>All charges</i>

Out-of-network benefits — Continued on next page.

Out-of-Network benefits — Continued

Lifetime maximum

Out-of-Network inpatient care for the treatment of alcoholism and drug abuse is limited to a 60-day maximum per lifetime.

Precertification

The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive these Out-of-Network benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits will be reduced by \$500. See Section 3 for details.

See these sections of the brochure for more valuable information about these benefits:

- Section 3, *How you get care*, for information about catastrophic protection for these benefits.
 - Section 7, *Filing a claim for covered services*, for information about submitting out-of-network claims.
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Section 5 (f). Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on page 49.
- All benefits are subject to definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The combined annual prescription drug deductible is \$200 per person for prescriptions filled through the retail and/or mail order service program.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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- **Who can write your prescription.** A licensed physician or licensed dentist must write the prescription.
 - **Where you can obtain them.** You may fill the prescription at a pharmacy participating in the network, a non-network pharmacy, or by mail. We pay a higher level of benefits when you use a network pharmacy.
 - **Network Pharmacy Benefit.** After satisfying your combined annual \$200 per person prescription drug deductible, you pay a \$10 copay for the initial prescription for up to a 30 day supply of medication (as prescribed by your doctor) and \$10 each for the first and second refills. After that, for the third and any subsequent refills, your cost increases to 50% of Alliance's negotiated price for medications.
 - **Mail Service Pharmacy Program.** After satisfying your combined annual \$200 per person prescription drug deductible, you pay 20% of the covered charges per generic medication or per brand name medication. To order by mail, send your prescriptions to Merck Medco Rx Services, Post Office Box 650322, Dallas, TX 75265-0322
 - **Non-Network Pharmacy Benefit.** After satisfying your combined annual \$200 per person prescription drug deductible, you pay a \$10 copay per prescription or refill, for the initial 30 day supply and two refills. The third and subsequent refills will require you to pay 50% of the cost of the prescription drug. You will also be responsible for any charges in excess of the participating pharmacy charges. You must pay the full amount of the prescription drug and file a claim with First Health Rx as indicated below.

Prescription drug benefits — Continued on next page.

- **We use a formulary.** We administer an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. You may call for the list.
- **These are the dispensing limitations.** For participating and non-participating pharmacies, the dispensing limit is a 30 day supply. For mail order the dispensing limit is a 90 day supply with the initial mail order prescription being limited to a 45 day supply.
- **Refilling your prescription.** To be sure you never run short of your prescription medication, you should re-order on or after the refill date indicated on the refill slip or when you have fewer than 14 days of medication left. Refills sent in prior to scheduled or authorized refill will not be filled.
- **When you have to file a claim.** If a participating pharmacy is not available where you reside or if you do not use your prescription drug identification card, you must pay in full for your medication, obtain a prescription drug receipt and submit a claim to: Alliance Health Benefit Plan, Prescription Drug Program, First Health Rx, Post Office Box 22410, Tucson, AZ 85734. Reimbursement will be based on Plan cost had you used a participating pharmacy. The Alliance's cost represents a negotiated fee. The actual cost to Alliance may be less than the retail price, so your reimbursement may be less.

Prescription drug benefits begin on next page.

Benefit Description	You pay After the annual prescription drug deductible...
Covered medications and supplies	
<p>Each new enrollee will receive a description of our prescription drug program, a combined prescription drug/Plan identification card, a mail order form/patient profile and a preaddressed reply envelope.</p> <p>You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail:</p> <ul style="list-style-type: none"> • Drugs and medicines (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a physician’s prescription for their purchase, except as excluded below • Insulin • Diabetic diagnostic supplies used to test blood and urine for glucose levels • Needles and syringes for the administration of covered medications • Contraceptive drugs and devices <p>Here are some things to keep in mind about our prescription drug program:</p> <ul style="list-style-type: none"> • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a federally-approved generic drug is available, and your physician has not specified “dispense as written” for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic. <p>We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 1/800-225-4423</p>	<ul style="list-style-type: none"> • Network Retail: \$10 generic or brand name for initial prescription and first and second refills. For third and subsequent refills 50% of Plan cost. • Non-Network Retail: \$10 generic or brand name for initial prescription and first and second refills. For third and subsequent refills 50% of Plan cost and any difference between our cost and the cost of the drug. • Network Mail Order: 20% of cost for generic or brand name

Prescription drug benefits — Continued on next page.

Covered medications and supplies — <i>Continued</i>	You pay
<p><i>Not covered</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Medication that does not require a prescription under Federal law even if your doctor prescribes it or a prescription is required under your State law</i> • <i>Drugs to aid in smoking cessation except those limited to the \$100 lifetime maximum as part of the smoking cessation benefit, see page 30</i> • <i>Drugs related to treatment of sexual dysfunction, sexual inadequacy or sexual transformation</i> • <i>Drugs that are investigational or experimental</i> • <i>Drugs prescribed for weight loss</i> 	<p><i>All charges</i></p>

Section 5 (g). Special features

Special features	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24 hour nurse line	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-800-225-4423 and talk with a nurse who will discuss treatment options and answer your health questions.</p>
Services for deaf and hearing impaired	<p>TDD services are available at 1/800-259-8179.</p>
High risk pregnancies	<p>For assistance you should call First Health[®] at 1-800-225-4423 during the first trimester of your pregnancy. At this time, a Case Manager will ask you questions about your general health and medical history. This information will be discussed with your physician or practitioner to help determine the risk factor of your pregnancy.</p>
Centers of excellence for transplant/heart surgery/etc.	<p>For assistance with the First Health[®] National Transplant Program call us at 1/800-225-4423 for more information.</p>
Travel benefit for organ transplants	<p>First Health[®] National Transplant Program: Travel and lodging must be approved in advance. They include the cost incurred for one companion to travel with the patient to receive services in connection with any approved PPO transplant procedure. Travel and lodging expenses are covered up to a \$10,000 maximum.</p>

Section 5 (h). Dental benefits

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductibles are: PPO \$100 per person (\$300 per family); Non-PPO \$300 per person (\$900 per family). Calendar year deductibles apply to the accidental dental injury benefit only. We added “(No deductible)” to show when a calendar year deductible does not apply.
- Non-PPO dental benefit is subject to a \$25 per person and \$50 per family calendar year deductible.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Note: We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure.

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Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Services must be received within 12 months from the date of the accident.	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
Dental benefits	You pay
<p>Preventive services:</p> <ul style="list-style-type: none"> • Cleanings • Exams • Flouride treatments • Sealants • Diagnostic X-rays <p>Note: Cleanings, exams, flouride treatments and sealants are limited to two visits per person annually.</p>	<p>PPO: Nothing “(No deductible)”</p> <p>Non-PPO: 10% of the Plan allowance and any difference between our allowance and the billed amount</p>

Dental benefits — Continued on next page.

Dental benefits — Continued	You pay
<p>Basic restorative care:</p> <ul style="list-style-type: none"> • Fillings <p>Note: The annual benefit maximum per person (Combined In-Network and Out-of-Network) is \$500.</p>	<p>PPO: 20% of the Plan allowance “(No deductible)”</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Dental extractions including the removal of impacted teeth</i> • <i>All dental services and appliances not listed above</i> • <i>Periodontal prophylaxis</i> • <i>Emergency exams</i> • <i>Charges in excess of the combined annual benefit maximum</i> 	<p><i>All charges</i></p>

Section 5 (i). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

Enrollment in the Alliance Insurance Programs listed below is not a requirement for participation in the Alliance Health Benefit Plan. These benefits are offered to Plan members on a voluntary basis through carriers other than the Health Plan. The Alliance Health Benefit Plan is not responsible for any services or representations made by these carriers outside these Alliance Insurance Programs.

PLAN FEATURES

NO CLAIM FORMS!

CIGNA Dental Health Plan

No deductibles
No maximums
100% Coverage — Diagnostic and Preventive Care (Exams, X-rays, Cleanings)
50% Coverage — Basic Restorative Care (Fillings, Periodontics, Endodontics, Simple Extractions)
50% Coverage — Major Restorations (Onlays, Dentures, Crowns, Bridgework)
Call 1/800-367-1037

AFLAC (American Family Life Assurance Company of Columbus)

Accident/Sickness/Disability, Hospital Intensive Care; Cancer Insurance Policy
These policies provide benefits paid directly to you, unless assigned, that can help you with non-medical expenses.
Call 1/800-992-3522 and TDD 1/800-622-2345 or
espanol 1/800-742-3522

For policies available to residents of CT, MA, NJ and NY, call 1/800-366-3436 for more information.

Wal-Mart Pharmacy Mail Services

From the nation's leading discount retailer, discount prescription services for any family member whether or not a dependent.
No annual fees or deductibles.
Call 1/800-321-0347 for more information.

Call 1/800-321-0347 for General Information

BENEFITS ON THIS PAGE ARE NOT PART OF THE FEHB CONTRACT

Section 6. General exclusions — things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sex transformations, sexual dysfunction, or sexual inadequacy;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services and supplies when furnished without charge while in active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories, or possessions or (2) during combat
- Services and supplies when furnished by immediate relatives or household members, such as spouse, parent, child, brother, sister by blood, marriage or adoption;
- Services and supplies when furnished or billed by a non-covered facility, except that medically necessary prescription drugs are covered;
- Services and supplies not specifically listed as covered;
- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copay or coinsurance, the Plan will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges the enrollee or Plan has no legal obligation to pay, such as: excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 16), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 18), or State premium taxes however applied;
- Biofeedback;
- Dental services and appliances (except as specified on pages 52 and 53);
- Exercise equipment, whirlpool baths, sunlamps, heating pads, air conditioners, humidifiers, dehumidifiers, and purifiers;
- Services and supplies to the extent the charge exceeds reasonable and customary charges;
- Services by practitioners who do not meet the definition of "covered provider"; or
- Charges for a stand-by doctor.

Section 7. Filing a claim for covered services

How to claim benefits

To obtain claim forms or other claims filing advice or answers about our benefits, contact us at 1/800-225-4423, or at our website at www.ahbp.com.

In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500 Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 1/800-225-4423.

When you must file a claim — such as for overseas claims or when another group health plan is primary — submit it on HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Name of patient and relationship to enrollee;
- Plan identification number of the enrollee;
- Name and address of person or firm providing the service or supply;
- Dates that services or supplies were furnished;
- Diagnosis;
- Type of each service or supply; and
- The charge for each service or supply.

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

In addition:

- You must send a copy of the explanation of benefits (EOB) form and any primary payer (such as Medicare Summary Notice (MSN) with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse or Christian Science nurse who is listed in the Christian Science Journal.
- Claims for rental or purchase of durable medical equipment; private duty nursing; and physical, occupational, and speech therapy require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.

- Claims for prescription drugs and supplies that are not ordered through the Mail Service Prescription Drug Program must include receipts that include the prescription number, name of drug or supply, prescribing physician's name, date, and charge.

Records

Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you receive the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

Overseas claims

For covered services you receive in hospitals outside the United States and Puerto Rico and performed by physicians outside the United States, send a completed Overseas Claim Form and the itemized bills to: Alliance Health Benefit Plan, First Health, Post Office Box 22410, Tucson, AZ 85734. Obtain Overseas Claims Forms from this address and send any written inquiries concerning the processing of overseas claims to this address.

Overseas services claims should include an English translation and charges should be converted to U.S. dollars using the exchange rate applicable at the time the expenses was incurred.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

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

Step	Description
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| 1 | Ask us in writing to reconsider our initial decision. You must: <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: Alliance Health Benefit Plan, 1628 11th Street NW, Washington , D.C. 20001; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. |
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| 2 | We have 30 days from the date we receive your request to: <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care coverage provider to give you the care); orWrite to you and maintain our denial — go to step 4; orAsk you or your provider for more information. If we ask your provider, we will send you a copy of our request — go to step 3. |
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| 3 | You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. |
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If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

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| 4 | If you do not agree with our decision, you may ask OPM to review it. |
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You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us — if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, P.O. Box 436, Washington, D.C. 20044-0436.

The Disputed Claims process (*Continued*)

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must provide a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

6 If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuits, benefits, and payments of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of the benefits in dispute.

NOTE: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1/800-321-0347 and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division II at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage You must tell us if you are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

• What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities, under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A.
- Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare+Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare+Choice plan you have.

• The Original Medicare Plan

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care.

Claims process — You probably will never have to file a claim form when you have both our Plan and Medicare.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 1/800-225-4423 or at our website at www.ahbp.com.

We waive some costs when you have Medicare — When Medicare is the primary payer, we will waive some out-of-pocket costs as follows:

- Inpatient Hospital Benefits: If you are enrolled in Medicare Part A, the Plan will waive the deductible and coinsurance.
- Surgical Benefits: If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance.
- Mental Conditions/Substance Abuse Benefits: If you are enrolled in Medicare Part A, the Plan will waive the deductible and coinsurance for inpatient care. If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance for outpatient care.
- Other Medical Benefits: If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance for medical benefits.

The following chart illustrates whether Original Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When either you — or your covered spouse — are age 65 or over and ...	Then the primary payer is...	
	Original Medicare	This Plan
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when...		
a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB		✓
Ask your employing office which of these applies to you.		
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you — or a covered family member — have Medicare based on end stage renal disease (ESRD) and...		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and...		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or	✓	
b) Are an active employee		✓

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medical benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area, but we will not waive any of our copayments, coinsurance, or deductibles.

Suspended FEHB coverage and a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare managed care plan's service area.

- **Private Contract**

A physician may ask you to sign a private contract agreeing that you can be billed directly for service ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment.

- **Enrollment in Medicare Part B**

Note: We cannot require you to enroll in Medicare. If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program.

TRICARE

TRICARE is a health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you file under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your benefits.

Medicaid

When you have this Plan and Medicaid, we pay first.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expense we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. Subrogation applies when you are sick or injured as a result of the act or omission of another person or party. Subrogation means the Plan's right to recover any benefit payments made to you or your dependent by a third party's insurer, because of an injury or illness caused by the third party. Third party means another person or organization.

If you or your dependent receive Plan benefits and have a right to recover damages from a third party, the Plan is subrogated to this right. All recoveries from a third party (whether by lawsuit, settlement, or otherwise) must be used to reimburse the plan for benefits paid. Any remainder will be yours or your dependent's. The Plan's share of the recovery will not be reduced because you or your dependent has not received full damages claimed, unless the Plan agrees in writing to a reduction.

You must promptly advise the Plan whenever a claim is made against a third party with respect to any loss for which the Plan benefits have been paid or will be paid. You or your dependent must execute any assignments, liens, or other documents and provide information as the Plan request. Plan benefits may be withheld until documents or information is received.

If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms used in this brochure

Accidental injury	An injury caused by an external force such as a blow or a fall and which requires immediate medical attention. Also included are animal bites, poisonings and dental care required as a result of accidental injury to sound natural teeth. An injury to teeth while eating is not considered to be an accidental injury.
Admission	The period from entry (admission) into a hospital or other covered facility until discharge. In counting days of inpatient care, the date of entry and the date of discharge are counted as the same day.
Assignment	An authorization by an enrollee or spouse for the Plan to issue payment of benefits directly to the provider. The Plan reserves the right to pay a member directly for all covered services.
Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Christian Science Nurses and Practitioners	Christian Science Nurses and Practitioners are those who are listed in the Christian Science Journal.
Christian Science Nursing facility	A Christian Science Nursing facility is a nursing facilities that is approved by the Commission for the Accreditation of Christian Science Nursing Organizations/Facilities, Inc.
Congenital anomaly	A condition existing at or from birth which is a significant deviation from the common form or norm. For purposes of this Plan, congenital anomalies include protruding ear deformities, cleft lips, cleft palates, birthmarks, webbed fingers or toes and other conditions that the Plan may determine to be congenital anomalies. In no event will the term “congenital anomaly” include conditions relating to teeth or intra-oral structures supporting the teeth.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 11.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 11.
Cosmetic surgery	Any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.

Covered services

Services we provide benefits for, as described in this brochure.

Custodial care

Treatment or services that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. Such as:

- help in walking, getting in and out of bed, bathing, eating by spoon, tube or gastrostomy, exercising, dressing;
- homemaking;
- moving the patient;
- acting as a companion or sitter;
- supervising medication that can usually be self administered; or
- treatment of any services that any person may be able to perform with minimal instruction, such as recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

The Plan determines which services are custodial care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 11.

Durable medical equipment

Equipment and supplies that:

- 1) are prescribed by your attending doctor;
- 2) are medically necessary;
- 3) are primarily and customarily used for a medical purpose;
- 4) are generally useful only to a person with an illness or injury;
- 5) are designed for prolonged use; and
- 6) serve a specific therapeutic purpose in the treatment of an illness or injury.

Effective date

The date the benefits described in this brochure are effective:

Benefits described in this brochure are effective January 1 for continuing enrollments. For new enrollees in this Plan the effective date of enrollment is determined by the employing office or retirement system of the enrollee.

Experimental or investigational services

A drug, device or biological product is experimental or investigational:

- 1) If the drug, device or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished. Approval means all forms of acceptance by the FDA.
- 2) An FDA-approved drug, device or biological product (for use other than its intended purposes and labeled indications), or medical treatment or procedure is experimental or investigational if 1) reliable evidence shows that it is subject to ongoing phase I, II, or III clinical trials or under study to determine maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus

of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

3) Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; written protocol or protocols used by treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

FDA-approved drugs, devices, or biological products used for their intended purposes and labeled indications and those that have received FDA approval subject to postmarketing approval clinical trials, and devices classified by the FDA as category B, Non-experimental/ Investigational Devices are not considered experimental or investigational.

Determination of experimental/investigational status may require review of appropriate government publications such as those of the National Institute of Health, National Cancer Institute, Agency for Health Care Policy and Research, Food and Drug Administration, and National Library of Medicine.

Independent evaluation and opinion by Board Certified Physicians may be obtained for their expertise in subspecialty areas.

Group health coverage

Health care coverage that a member is eligible for because of employment by, membership in, or connection with, a particular organization or group that provides payment for hospital, medical or health care services or supplies, or that pays a specific amount for each day or period of hospitalization if the specified amount exceeds \$200 per day, including extension of any of these benefits through COBRA.

Home health care

A plan of continued care and treatment of an injured or sick person who is under the care of a doctor, and whose doctor certifies that without the home health care, confinement in a hospital or skilled nursing facility would be required.

Home health care agency

A public agency or private organization that is licensed as a Home Health Care Agency by the state and is certified as such under Medicare.

Hospice care program

Professional inpatient and outpatient care rendered by a licensed or certified hospice to terminally ill patients for personal care and relief of pain using technical and related medical procedures.

Initial emergency treatment

Initial emergency treatment is care rendered by a hospital or doctor for an accidental injury. Initial emergency treatment does not include benefits for ambulance transportation or treatment an enrollee receives as a result of an inpatient admission. Once an enrollee is admitted to the hospital, inpatient benefits will be applied.

Medical emergency

The sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Medical emergencies include heart attacks, poisonings, loss of consciousness or respiration, convulsions, and such other acute conditions.

Medical necessity

Services, drugs, supplies or equipment provided by a hospital or covered provider of the health care services that the Plan determines are:

- appropriate to diagnose or treat the patient's condition, illness or injury;
- consistent with standards of good medical practice in the United States;
- not primarily for the personal comfort or convenience of the patient, the family, or the provider;
- not part of or associated with the scholastic education or vocational training of the patient; and
- in the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug or equipment does not, in itself, make it a medical necessity.

Mental conditions/ substance abuse

Conditions and diseases listed in the most recent edition of the International Classification of Disease (ICD) 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.

Plan allowance

Our Plan allowance is the amount we use to determine our payments and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. We determine our allowance as follows:

Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the provider you use.

- **PPO providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible, copayment and/or coinsurance. Here is an example: You see a PPO physician who charges \$150, but our allowance is \$100. If you have met your deductible, you are only responsible for your coinsurance. That is, you just pay 10% of our \$100 allowance (\$10). Because of the agreement, your PPO physician will not bill you for the \$50 difference between our allowance and his bill.

- **Non-PPO providers**, on the other hand, have no agreement to limit what they will bill you. When you use a non-PPO provider, you will pay your deductible and coinsurance — **plus** any difference between our allowance and charges on the bill. Here is an example: You see a non-PPO physician who charges \$150 and our allowance is again \$100. Because you've met your deductible, you are responsible for your coinsurance, so you pay 30% of the \$100 allowance (\$30). Plus, because there is no agreement between the non-PPO physician and us, he can bill you for the \$50 difference between our allowance and his bill.
- The Plan allowance for any non-PPO service or supply is the charge determined by the Plan on a semiannual basis to be in the 90th percentile of the prevailing charges made for a service or supply by providers in the geographic area where it is furnished. The prevailing charges data is obtained from prevailing health care charge guides such as that prepared by the Health Insurance Association of America (HIAA) and the Plan's administrator, First Health. In determining the plan allowance for a service or supply that is unusual, or not often provided in the area, or provided by only a small number of providers in the area, the Plan may take into account factors such as: the complexity; the degree of skills needed; the type of speciality of the provider; the range of services or supplies provided by a facility; and the prevailing charge of other areas. When a PPO provider is used, the fee that has been negotiated between the Plan and the PPO provider is considered the plan allowance.

For more information see *Differences between our allowance and the bill* in Section 4.

Sound natural teeth

A tooth that is whole or properly restored and is without impairment, periodontal or other condition and is not in need of treatment provided for any reason other than an accidental injury.

Us/We

Us and we refer to the Alliance Health Benefit Plan.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form, benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under the former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

- **TCC**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay your premium, you cannot convert;
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1/800-321-0347 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE — 202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Department of Defense/FEHB Demonstration Project

What is it?

The Department of Defense/FEHB Demonstration Project allows for some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years and began with the 1999 open season for year 2000. Open season enrollments will be effective January 1, 2001. DoD and OPM have set up some special procedures to implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible

DoD determines who is eligible to enroll in the FEHB Program. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare;
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare;
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried; or
- You are a survivor dependent of a deceased active or retired uniformed service member; and
- You live in one of the geographic demonstration areas.

If you are eligible to enroll in a plan under the Federal Employees Health Benefits Program, you are not eligible to enroll in the DoD/FEHB Demonstration Project.

The demonstration areas

- Dover AFB, DE
- Fort Knox, KY
- Dallas, TX
- New Orleans, LA
- Adair County, IA area
- Commonwealth of Puerto Rico
- Greensboro/Winston Salem/High Point, NC
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA
- Coffee County, GA area

When you can join

You may enroll under the DoD/FEHB Demonstration Project during the 2000 open season, November 13, 2000 through December 11, 2000. Your coverage will begin January 1, 2001. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program Information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877/DOD-FEHB (1-877/363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during the 2000 and 2001 open season. Your coverage will begin January 1 of the year following the open season during which you enrolled.

If you become eligible for the DoD/FEHB Demonstration Project outside of open season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including “The 2001 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project,” on the OPM web site at www.opm.gov.

TCC eligibility

See Section 11, FEHB Facts; it explains temporary continuation of coverage (TCC). Under the DoD/FEHB Demonstration Project the **only** individual eligible for TCC is one who ceases to be eligible as a “member of family” under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHB Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child, or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHB Demonstration Project.

TCC is not available if you move out of a DoD/FEHB Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

Other features

The 31-day extension of coverage and right to convert do not apply to the DoD/FEHB Demonstration Project.

Notes

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Summary of benefits for the Alliance Health Benefit Plan - 2001

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover, for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Below, an asterisk (*) means the item is subject to the \$100 or \$300 calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

Benefits	You Pay	Page
Medical services provided by physicians: <ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office..... 	PPO: \$15 copay per visit and/or 10%* of the Plan allowance Non-PPO: 30%* of the Plan allowance	20
Services provided by a hospital: <ul style="list-style-type: none"> • Inpatient..... • Outpatient..... 	PPO: \$150 per admission copay and 10% of the Plan allowance Non-PPO: \$250 per admission copay and 30% of the Plan allowance PPO: 10%* of Plan allowance Non-PPO: 30%* of Plan allowance	38
Emergency benefits: <ul style="list-style-type: none"> • Accidental injury..... • Medical emergency..... 	Within 72 hours: Nothing for non-surgical outpatient care \$25 copay, regular benefits*	41
Mental health and substance abuse treatment.....	In-Network: Regular cost sharing* Out-of-Network: Benefits are limited*	43
Prescription drugs.....	After the combined annual deductible of \$200 per person: <ul style="list-style-type: none"> • In-Network: Copays of \$10 per medication for initial prescription and 2 refills. Subsequent refills you pay 50% of Plan allowance. • Non-Network: Copays of \$10 per medication for initial prescription and 2 refills. Subsequent refills you pay 50% and any charges in excess of the Plan allowance. • Mail order: 20% of prescription drug cost. 	47

Summary of benefits — Continued

Benefits	You Pay	Page
Dental care	PPO: Nothing for preventive services Non-PPO: After \$25 deductible per person or \$50 per family, 10% for preventive services	52
Special features: <ul style="list-style-type: none"> • Flexible benefits option • 24 hour nurseline • Services for deaf and hearing impaired • High risk pregnancies • Center for excellence for transplant/heart surgery/etc. • Travel benefit for organ transplants 		51
Protection against catastrophic costs (your out-of-pocket maximum)	PPO: Nothing after \$2,000/Self Only or \$2,000/Family enrollment per year. Non-PPO: Nothing after \$3,000/Self Only or \$3,000/Family enrollment per year. Some costs do not count toward this protection.	14

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2001 Rate Information for Alliance Health Benefit Plan

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization. Refer to the applicable FEHB Guide.

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

Self Only	1R1	\$ 86.59	\$ 54.55	\$187.61	\$118.19	\$102.22	\$38.92
Self and Family	1R2	\$195.82	\$103.40	\$424.28	\$224.03	\$231.17	\$68.05