

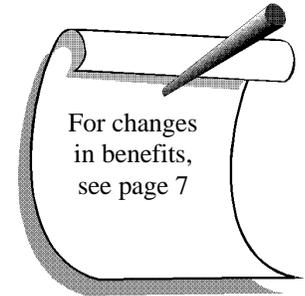


Mercy Health Plans/ Premier Health Plans

<http://www.mercyhealthplans.com>

2001

A Health Maintenance Organization with a point of service product



Serving: East, Central, Southwest Missouri Regions (POS Plan)
South Texas Region (POS Plan not available)

Enrollment in this Plan is limited; see page 6 for requirements.

Enrollment codes for this Plan:

Missouri Regions

7M1 Self Only
7M2 Self and Family

Texas Region

HM1 Self Only
HM2 Self and Family

Authorized for distribution by the:



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
[HTTP://WWW.OPM.GOV/INSURE](http://www.opm.gov/insure)



RI 73-756

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Introduction

Mercy Health Plans
425 South Woods Mill Road
Chesterfield, MO 63017

Premier Health Plans
One Corporate Centre, Suite 200
1949 East Sunshine
Springfield, MO 65804

Mercy Health Plans
5901 McPherson
Suites 1 & 2B
Laredo, TX 78041

This brochure describes the benefits of Mercy Health Plans/Premier Health Plans under our contract (RI 73-756) 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 7. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government'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 *Mercy Health Plans/Premier Health Plans*.

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 fehwebcomments@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 HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

We also have Point-of-Service (POS) benefits in Missouri:

POS is not available in Texas

Our HMO offers Point-of-Service (POS) benefits. This means you can receive covered services from a participating provider without a required referral, or from a non-participating provider. These out-of-network benefits have higher out-of-pocket costs than our in-network benefits.

How we pay providers

For Network benefits, we contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Who provides my health care?

You are required to select a Primary Care Physician (PCP) from Mercy Health Plans/Premier Health Plans participating doctors in the Plan's service area. Your PCP will meet many of your health care needs and arrange for specialist care if the need arises.

Patients' Bill of Rights

You are required to select a Primary Care Physician (PCP) from Mercy Health Plans/Premier Health Plans participating doctors in the Plan's service area. Your PCP will meet many of your health care needs. If the need arises for specialist care, he/she will arrange for this care.

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.

If you want more information about us, call our Member Services department at:

Mercy Health Plans: (Eastern and Central Missouri Regions) at 314-214-8196 or 1-800-327-0763

Mercy Health Plans: (Texas Region) at 956-723-7667 or 1-800-617-3433; or

Premier Health Plans: (Southwest Missouri Region) at 417-836-0402 or 1-800-836-0402,

or write to:

Mercy Health Plans: 425 South Woods Mill Road, Chesterfield, MO 63017 (Eastern and Central Missouri Regions);

Mercy Health Plans: 5901 McPherson, Suites 1 & 2B, Laredo TX 78041 (Texas Region); or

Premier Health Plans: One Corporate Centre, Suite 200, 1949 East Sunshine, Springfield, MO 65804 (Southwest Missouri Region).

You may also contact us by fax at:
(Eastern and Central Missouri Region): 314-214-8102
(Southwest Missouri Region): 417-836-0457 or
(Texas Region) 956-723-8246

or visit our website at www.mercyhealthplans.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. The service area include:

MERCY HEALTH PLANS (Eastern and Central Missouri Regions) include these Missouri counties: Audrain, Boone, Callaway, Chariton, Cole, Cooper, Franklin, Gasconade, Howard, Iron, Jefferson, Lincoln, Linn, Macon, Madison, Maries, Miller, Moniteau, Monroe, Montgomery, Morgan, Osage, Pettis, Pike, Ralls, Randolph, Reynolds, Saline, St. Charles, St. Francois, St. Louis, St. Louis City, Warren and Washington. The Illinois counties are: Clinton, Jersey, Macoupin, Madison, Monroe Randolph and St. Clair.

MERCY HEALTH PLANS (Texas Region) include these Texas counties: Duval, Jim Hogg, Webb and Zapata.

PREMIER HEALTH PLANS (Southwest Missouri Region) include these Missouri counties: Barry, Barton, Benton, Cedar, Christian, Crawford, Dade, Dallas, Dent, Douglas, Greene, Henry, Hickory, Howell, Jasper, Laclede, Lawrence, McDonald, Newton, Oregon, Ozark, Phelps, Polk, Pulaski, Shannon, St. Clair, Stone, Taney, Texas, Vernon, Webster and Wright.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care or point-of-service benefits. We will not pay for any other health care services.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

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 plan 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 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 Mercy Health Plans (Eastern and Central Missouri Regions) at 314-214-8196 or 1-800-327-0763; (Texas Region) at 956-723-7667 or 1-800-617-3433; or Premier Health Plans (Southwest Missouri Region) at 417-836-0402 or 1-800-836-0402, or checking our website www.mercyhealthplans.com. You can find out more 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.

Changes to this Plan

- Prescription Drugs

\$ 7 Copayment for generic drugs on formulary
\$12 Copayment for brand drugs on formulary
\$25 Copayment for non-formulary approved drug

- Mental Health/Alcoholism/Chemical Dependency

The benefits for services are the same as any other illness for treatment.

- Your share of the non-Postal premium will increase by 4.9%.

Expanded Service Area

- This year, the FEHB Program is offered to Members in our Texas region. The service area includes the counties of Duval, Jim Hogg, Webb, and Zapata.

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:
Eastern and Central Missouri Regions: 314-214-8196 or 1-800-327-0763;
Southwest Missouri Region: 417-836-0402 or 1-800-836-0402; or
Texas Region: 956-723-7667 or 1-800-617-3433.

Where you get covered care

You get care from “Plan providers” and “Plan facilities”. You will only pay copayments, deductibles, and/or coinsurance and you will not have to file claims. You can access health care from the point-of-service plan. These services are subject to a calendar year deductible, coinsurance copayments and balance billing. (Balance billing refers to the amount billed by a provider that exceeds the usual, customary and reasonable charges allowed for payment by the Plan). Balanced-billed charges are your responsibility along with the annual deductible and coinsurance and do not apply to out-of-pocket maximums. You are responsible for verifying that the required prior approval is given by the Plan for certain procedures. Please contact Members Services for further details. If you use our point-of-service program, you can also get care from non-Plan providers, or from participating providers without a required referral, but it will cost you more.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards. Log on to <http://www.mercyhealthplans.com> and learn more about our physicians. The site features our Physician Directory, which is updated monthly, so you will be able to find the information you need on our large selection of doctors.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. You should ask yourself some questions before you choose your Primary Care Physician (PCP). What is the doctor’s specialty? Does the PCP have a subspecialty, such as gastroenterology or pulmonology? Is the doctor’s office close to your home, office or school? Are the doctor’s office hours convenient for you? We suggest that you call the doctors you are considering so you can conduct your own interview. You will be one step ahead in ensuring your health and the health of your family.

- **Primary care**

Your primary care physician can be a family practitioner, general practitioner, internist, or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist. Female Members in the Texas Region may also select an Obstetrician or Gynecologist (OB/GYN)

to provide health care services within the scope of their practice. The Member must select the OB/GYN on or before enrollment. If selected, you have direct access to the OB/GYN.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, you may see an OB/GYN without a referral. The OB/GYN must be a participating provider. Female Members are permitted to schedule one appointment annually with the OB/GYN. A nonparticipating OB/GYN is not permitted to deliver this service.

When medically necessary, your PCP will arrange for referrals to a specialist. Your primary care physician and specialist will work together to coordinate your total care. If you access specialty care without an understanding of the number of visits and the amount of time approved for treatment, you may be responsible for the entire bill. Your PCP will arrange a standing referral to a specialist or specialists center (if necessary). Your PCP, the Chief Medical Officer and participating specialist will determine the need and parameters of a standing referral. A standing referral is based on a diagnosis of a life-threatening condition or disease; a degenerative and disabling condition or disease; ongoing care from a specialist or required specialized medical care over a prolonged period of time. Your primary care physician may request standing referrals.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your PCP will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- 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; or
 - reduce our service area 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**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at
Eastern and Central Missouri Regions: 314-214-8196 or 1-800-327-0763;
Southwest Missouri Region: 417-836-0402 or 1-800-836-0402; or
Texas Region: 956-723-7667 or 1-800-617-3433.

If you are new to the FEHB Program, we will arrange for you to receive care.

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 the benefits of the hospitalized person.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process prior approval. Your physician must obtain prior approval for services such as:

- Certain medications
- All inpatient hospitalization
- All skilled nursing facility
- All rehabilitation facility
- Home Health Care
- Physical, Speech, and Occupational Therapy
- Any procedure that may be cosmetic

It is the shared responsibility of both you and your PCP or specialist to assure that referrals are obtained, accurate and current. You are responsible for verifying the approved date range of the referral, number of visits and types of services that have been authorized. When you choose to receive services from a participating provider without a prior referral from your chosen primary care

physician, the specialists will request that you be responsible for payment of the services. When this occurs, you may be responsible for the charges. A referral must be obtained prior to receiving certain services.

It is your responsibility to verify that the required prior approval has been given by the Plan for out-of-network services. If prior approval is not given, eligible charges will be subject to the non-compliance reduction and the amount of the reduction will not apply toward your out-of-pocket maximum or deductible.

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

- **Copayments**

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

Example: When you see your primary care physician you pay a copayment of \$10 per office visit and when you go in the hospital, you pay \$0 per admission.

- **Deductible**

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

You are required to pay a \$500 deductible per member per calendar year and \$1,000 deductible per family per calendar year for out-of-network benefits. Your cost is 30% coinsurance after the deductible. The out-of-pocket maximum per member is \$3,500 (including the deductible) and \$7,000 per family (including deductible). This deductible applies to POS benefits only.

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.

And, if you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to any deductible of your new option.

- **Coinsurance**

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

Example: In our Plan, you pay 50% of our allowance for infertility services up to \$5,000.

Your out-of-pocket maximum for coinsurance and copayments

After your copayments and/or coinsurance total \$1,100 per person or \$3,300 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments or coinsurance for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments or coinsurance for these services:

- *Chiropractic*
- *Infertility*
- *Outpatient Prescription Drugs*

Be sure to keep accurate records of your copayments or coinsurance since you are responsible for informing us when you reach the maximum.

Section 5. Benefits -- OVERVIEW

(See page 7 for how our benefits changed this year and page 62 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:

Mercy Health Plans (Eastern and Central Missouri Regions): (314) 214-8196 or 1-800-372-0763;
Mercy Health Plans (Texas Region): (956) 723-7667 or 1-800-617-3433; or
Premier Health Plans (Southwest Missouri Region): (417) 836-0402 or 1-800-836-0402

or at our website at www.mercyhealthplans.com.

(a) Medical services and supplies provided by physicians and other health care professionals	14-22
•Diagnostic and treatment services	•Hearing services (testing, treatment, and supplies)
•Lab, X-ray, and other diagnostic tests	•Vision services (testing, treatment, and supplies)
•Preventive care, adult	•Foot care
•Preventive care, children	•Orthopedic and prosthetic devices
•Maternity care	•Durable medical equipment (DME)
•Family planning	•Home health services
•Infertility services	•Alternative treatments
•Allergy care	•Educational classes and programs
•Treatment therapies	
•Rehabilitative therapies	
(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	23-25
•Surgical procedures	•Oral and maxillofacial surgery
•Reconstructive surgery	•Organ/tissue transplants
	•Anesthesia
(c) Services provided by a hospital or other facility, and ambulance services	26-27
•Inpatient hospital	•Extended care benefits/skilled nursing care
•Outpatient hospital or ambulatory surgical center	facility benefits
	•Hospice care
	•Ambulance
(d) Emergency services/accidents.....	28-29
•Medical emergency	•Ambulance
(e) Mental health and substance abuse benefits.....	30-31
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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 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.
- Plan physicians must provide or arrange your care.
- *We have no calendar year deductible, however out-of-network benefits services are subject to a calendar year deductible.*
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office 	\$10 per office visit to your primary care physician \$10 per office visit to a specialist
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 a newborn child covered under a family enrollment • Office medical consultations • Second surgical opinion • Chiropractic services 	\$25 Copayment per visit Nothing Nothing Nothing \$10 Copayment per office visit \$10 Copayment per office visit \$10 Office visit - referrals required for Eastern and Central Missouri regions
<i>Not covered:</i> <ul style="list-style-type: none"> ▪ Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending camp or travel ▪ Reversal of voluntary, surgically-induced sterility ▪ Surgery primarily for cosmetic purpose ▪ Homemaker services ▪ Hearing aids ▪ Transplants not listed as covered ▪ Orthopedic shoes and other supportive appliances (orthotics) for the feet ▪ Blood and blood derivatives not replaced by the member 	<i>All charges.</i>

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 tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing
Preventive care, adult	
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> ▪ Hearing and vision screening ▪ Blood pressure testing ▪ Complete Blood Count (CBC) ▪ Total Blood Cholesterol - once every three years, ages 19 through 64 ▪ Colorectal Cancer screening, including <ul style="list-style-type: none"> ••Fetal occult blood test 	\$10 per office visit
<ul style="list-style-type: none"> ••Sigmoidoscopy, screening - every five years starting at age 50 	\$10 per office visit
<p>Prostate Specific Antigen (PSA test) – one annually for men age 40 and older</p>	\$10 per office visit
<p>Routine pap test</p> <p>Note: The office visit is covered if pap test is received on the same day; see <i>Diagnostic and Treatment</i>, above.</p>	\$10 per office visit
<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 • At age 40 and older, one every calendar year 	Nothing
<p><i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i></p>	<i>All charges.</i>
<p>Routine Immunizations, limited to:</p> <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 	Nothing

Preventive care, children	You pay
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics • Examinations, such as: <ul style="list-style-type: none"> ••Eye exams through age 17 to determine the need for vision correction. ••Ear exams through age 17 to determine the need for hearing correction ••Examinations done on the day of immunizations (through age 22) • Well-child care charges for routine examinations, immunizations and care (through age 22) 	<p>Nothing</p> <p>\$10 per office visit</p>
Maternity care	
<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. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • 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 only 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>One time \$10 Copayment for all office visits associated with prenatal care during a single pregnancy.</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex</i></p>	<p><i>All charges</i></p>
Family planning	
<ul style="list-style-type: none"> • Voluntary sterilization and family planning services 	<p>\$10 per office visit</p>
<p><i>Not covered: reversal of voluntary surgical sterilization, genetic counseling,</i></p>	<p><i>All charges.</i></p>

Infertility services	You pay
<p>Diagnosis and treatment of infertility. Diagnosis and treatment of infertility and intravaginal artificial insemination (IVI) is covered.</p>	<p>\$10 per office visit for the diagnosis of infertility</p> <p>You pay 50% of the first \$5,000 of the customary rate of approved charges, charges in excess of the customary rate, and 100% of the charges for infertility services over \$5,000.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Fertility drugs • Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> ••in vitro fertilization ••embryo transfer • Services and supplies related to excluded ART procedures • Cost of donor sperm • Fees for preparation and storage of sperm 	<p><i>All charges.</i></p>
Allergy care	
Office visits	\$10 per office visit
Injections/Treatment	Nothing
Allergy serum	Nothing
<p><i>Not covered: provocative food testing and sublingual allergy desensitization</i></p>	<p><i>All charges.</i></p>
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 25.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: – Before we cover GHT, there are certain guidelines to be performed and documented. There are separate guidelines for children and adults. We will ask you to submit information that establishes that the GHT is medically necessary for that child or adult. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>Nothing</p>

Treatment therapies continued on next page.

Treatment therapies (<i>Continued</i>)	You pay
<i>Not covered: treatments that have no proven clinical benefit for your condition.</i>	<i>All charges.</i>
Rehabilitative therapies	
Physical therapy, occupational therapy and speech therapy -- <ul style="list-style-type: none"> • A maximum of up to 60 consecutive days per calendar year per condition for the services of each of the following: <ul style="list-style-type: none"> ••qualified physical therapists; ••speech therapists; ••occupational therapists; and ••cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction. 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.	\$10 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>long-term rehabilitative therapy</i> • <i>exercise programs</i> • <i>neuro-rehabilitation</i> • <i>work hardening programs</i> or developmental educational therapy 	<i>All charges.</i>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	\$10 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>all other hearing testing</i> • <i>hearing aids, testing and examinations for them</i> • <i>digital hearing aids</i> 	<i>All charges.</i>
Vision services (testing, treatment, and supplies)	
Diagnosis and treatment of diseases of eye, annual eye refractions (to provide a written lens prescription for eyeglasses or contact lenses) may be obtained from Plan providers	\$10 per office visit.
<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) 	\$10 per office visit
<ul style="list-style-type: none"> • Eye exam to determine the need for vision correction for children through age 17 (see preventive care) 	\$10 per office visit

Vision services continued on next page.

Vision services (testing, treatment, and supplies) <i>(Continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses and, after age 17, examinations for them</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<p><i>All charges.</i></p>
Foot care	
<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>\$10 per office visit</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 implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • 	<p>20% Coinsurance</p>

Orthopedic and prosthetic devices continued on next page

Orthopedic and prosthetic devices (<i>Continued</i>)	You pay
<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> ▪ <i>prosthetic replacements provided less than 3 years after the last one we covered</i> ▪ <i>electrical continence aids, anal or urethral</i> ▪ <i>implants for cosmetic or psychologic reasons</i> ▪ <i>other dental appliances</i> ▪ <i>replacement of cataract lenses necessary after cataract surgery</i> ▪ <i>remote control devices</i> ▪ <i>devices employing robotics</i> ▪ <i>all mechanical organs</i> ▪ <i>investigational or obsolete devices and supplies</i> 	<p><i>All charges.</i></p>
Durable medical equipment (DME)	
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • casts, splints, surgical supplies, and appliance, catheters and ileostomy supplies; • wheelchairs or hospital-type bed; • purchase of a truss, brace or support; • oxygen and the equipment necessary for its administration • mechanical equipment required for the treatment of a chronic or acute respiratory illness or failure; such as asthmatic equipment; and • ambulatory dialysis. <p>Note: Call us at: (Eastern and Central Missouri Regions):314-214-8196 or 1-800-327-0763; (Southwest Missouri Region): 417-836-0402 or 1-800-836-0402; or (Texas Region): 956-723-7667 or 1-800-617-3433</p> <p>as soon as your Plan physician prescribes this equipment. We will 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>Nothing</p>

Durable medical equipment (DME) continued on next page.

Durable medical equipment (DME) (Continued)	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>augmentative communication devices (i.e., computer assisted speech devices, speech teaching machines, telephones, TDD equipment, etc.)</i> • <i>automated travel devices (i.e., motor scooters, etc.)</i> • <i>chair lifts and other transfer devices</i> • <i>devices that are primarily non-medical in nature or used primarily for comfort (i.e., foam pads, maternity belts, heating pads, etc.)</i> • <i>elevators</i> • <i>equipment designed to alter the environment (i.e., air filters, humidifiers, dehumidifiers, air conditioners, lighting, etc.)</i> • <i>exercise equipment</i> • <i>hygienic items (i.e., shower chairs, raised toilet seats, sauna baths, incontinence pads, etc.)</i> • <i>massage devices</i> • <i>overhead tables</i> • <i>portable whirlpool pump</i> • <i>telephone alert systems</i> • <i>motorized wheel chairs</i> 	<p><i>All charges.</i></p>
Home health services	
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.</i> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Private duty nursing or nursing assistants.</i> 	<p><i>All charges.</i></p>

Alternative treatments	You Pay
Acupuncture – by a doctor of medicine or osteopathy for: anesthesia, pain relief	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ▪ <i>Biofeedback</i> ▪ <i>Birth Coaches (other prenatal/parenting education classes)</i> ▪ <i>Homeopathy</i> ▪ <i>Hypnotherapy</i> ▪ <i>Massage Therapy</i> ▪ <i>Naturopathic services (i.e., herbal therapy, etc.)</i> 	<i>All charges.</i>
Educational classes and programs	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Smoking Cessation- Services and supplies in connection with the Plan’s smoking cessation program expenses. (Smoking Cessation not available in the Texas Region) • Diabetes self-management 	<p>\$25 per service or supply</p> <p>Consistent with type of services required</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 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.
- Plan physicians must provide or arrange your care.
- *We have no calendar year deductible, however health care services from the point of service plan are subject to a calendar year deductible.*
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. 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.).

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Benefit Description	You pay
Surgical procedures	
<ul style="list-style-type: none"> • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • 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) Note: Devices are covered under 5(a). • Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care.</i> 	<i>All charges.</i>

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; webbed fingers; and webbed 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 complications, such as lymphedemas; •• breast prostheses and surgical bras and replacements (see Prosthetic devices) <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>\$10 per office visit</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 sex transformation</i> • <i>Removal of tattoo</i> • <i>Hair transplant for baldness, lipectomy (operation for removal of adipose tissue (fat) from the abdomen or other part of the body)- unless required by a sickness condition.</i> • <i>Augmentation of mammoplasty (operation for augmentation of the breasts) for cosmetic reasons.</i> 	<p><i>All charges</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws 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; and <p>Other surgical procedures that do not involve the teeth or their supporting structures.</p>	<p>\$10 per office visit</p>

Oral and maxillofacial surgery continued on next page.

Oral and maxillofacial surgery (<i>Continued</i>)	You Pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Oral implants and transplants • Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) 	All charges.
Organ/tissue transplants	
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors <p>Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or 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. Payments are limited to the allowed amount at a participating transplant facility.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered 	All charges
Anesthesia	You pay
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) 	Nothing
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	Nothing

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

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Here are some important things to remember 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.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. 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 covered in Section 5(a) or (b).

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Benefit Description	You pay
Inpatient hospital	
Room and board, such as <ul style="list-style-type: none"> • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • 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 	Nothing
Not covered: <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, extended care facilities, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care 	All charges.

Outpatient hospital or ambulatory surgical center	You Pay
<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>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.</p>	Nothing
<i>Not covered: blood and blood derivatives not replaced by the member</i>	<i>All charges</i>
Extended care benefits/skilled nursing care facility benefits	
<p>Extended care benefit:</p> <p>The Plan provides a comprehensive range of benefits when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan.</p>	Nothing
<i>Not covered: custodial care</i>	<i>All charges</i>
Hospice care	
<p>Services provided either on an inpatient or an outpatient basis, based on approved acceptable medical practices, when approved in advance by the Plan's Chief Medical Officer or designee.</p> <p>This benefit is available once per lifetime for terminally ill person with a life expectancy of less than six months.</p>	Nothing
<i>Not covered: Independent nursing, homemaker services, services received out-of-network.</i>	<i>All charges</i>
Ambulance	
<ul style="list-style-type: none"> • Local professional ambulance service when medically appropriate 	Nothing

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.
- We have no calendar year deductible
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. 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 to do in case of emergency:

Emergencies within our service area: If you are in an emergent or urgent situation, if possible call your Plan physician immediately. If the emergency is so urgent that failure to get immediate medical attention could be life threatening or cause serious harm, go immediately to the nearest emergency facility. Once an urgent or life-threatening situation has been brought under control, you will need to call your Plan physician as soon as reasonably possible, so that any continued care can be arranged and authorized. If you do not report emergency treatment, as soon as reasonably possible thereafter, care may not be covered.

If you need to be hospitalized in a non-Plan facility, the Plan must be notified on the first working day following your admission, unless it is not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition. To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Emergencies outside our service area: If you need to be hospitalized, call Member Services as soon as possible. Member Services will notify your Plan physician and arrange to have your medical records shared with the attending physician. Arrangements will be made for you to be transferred to the care of a Plan doctor and hospital when it is medically appropriate. Your Plan physician will coordinate all follow-up care upon return to the area.

If follow-up care is required outside the area, you must contact your Plan physician to receive authorization for the continued care. To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers. The Plan pays reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> Emergency care at a doctor's office 	\$10 per office visit
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$25 per office visit
<ul style="list-style-type: none"> Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	\$50 per visit, except Copayment charge will be waived when inpatient admission for the same condition occurs within 24 hours
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>
Emergency outside our service area	
<ul style="list-style-type: none"> Emergency care at a doctor's office Emergency care at an urgent care center Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	\$50 per ovisit, except Copayment charge will be waived when inpatient admission for the same condition occurs within 24 hours
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Elective care or non-emergency care</i> Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area 	<i>All charges.</i>
Ambulance	
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>air ambulance (unless Medically necessary)</i> <i>air ambulance transportation out of a foreign country is not covered under any circumstances</i> 	<i>All charges.</i>

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

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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.

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan 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.
- Be sure to read Section 4, *Your costs 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 description below.

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Benefit Description	You pay
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and 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: Plan 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>	Your cost sharing responsibilities are no greater than for other illness or conditions.
<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 	\$10 per visit
<ul style="list-style-type: none"> • Diagnostic tests 	Nothing
<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 	Nothing

Mental health and substance abuse benefits - Continued on next page.

Mental health and substance abuse benefits <i>(Continued)</i>	You pay
<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>	<p><i>All charges.</i></p>

Preauthorization

To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes:

You must obtain services from Participating Providers and authorized in advance by the Plan by calling the Mental Health and Substance Abuse Member Assistance Hotline (MH/SA Hotline)

(Eastern and Central Missouri): (314) 364-3600 or 1-800-413-8008;
 (Southwest Missouri): (417) 836-0402 or 1-800-836-0402; or
 (Texas): (956) 723-7667 or 1-800-617-3433
 for assistance.

Special transitional 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:

- 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 year 2000.

If this condition applies to you, we will allow you reasonable time to transfer your care to a Plan 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.

Limitation

We may limit your benefits if you do not follow your treatment plan.

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 the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There are a handful of medications that require prior authorizations. Your Plan physician has a listing of the specific drugs.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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There are important features you should be aware of. These include:

- **Who can write your prescription?** *A licensed physician must write the prescription.*
- **Where you can obtain them.** *You must fill your prescription at a Plan pharmacy, except in the case of a medical emergency. You have access to over 15,000 pharmacies nationwide. Also, you are covered under the mail service pharmacy benefit. This benefit allows you to obtain covered maintenance prescriptions used to treat chronic or long-term health conditions (high blood pressure or diabetes) through the Walgreen's Healthcare Plus mail service pharmacy.*
- **We use a formulary.** *Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a thirty (30) day supply or one vial of insulin. Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. A "formulary" is a list of drugs approved for use by your physician in connection with specific conditions. You pay a copayment of \$7 in the case of a generic drug, \$12 in the case of a brand drug and \$25 for Non-formulary approved drugs dispensed in accordance with the formulary.*
- **These are the dispensing limitations.** *Prescription drugs prescribed by the Plan or referral doctor will be dispensed for up to a thirty-(30) day supply or one vial of insulin. If you choose to receive the brand drug (with the approval of your physician), you will be responsible for the appropriate copayment plus the cost difference between the "brand" name and the "generic" name drug. Prescriptions filled through the Walgreen's Healthcare Plus mail service pharmacy, is limited up to a ninety-(90) day supply. If an order is placed more than two weeks before the refill date, the order may be returned unfilled with a request to resubmit them at a later date.*
- **When you have to file a claim.** *If you use a participating pharmacy you will not have to file a claim. However, if you receive emergency services out-of-network and purchase prescriptions, you must contact member services for reimbursement.*

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • <i>Disposable needles and syringes needed to inject covered prescribed medication</i> • <i>Diabetic supplies, including insulin syringes needles, glucose test tablets and test tape, Benedict's solution or equivalent, glucose monitors and acetone test tablets</i> • <i>Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase</i> • <i>Drugs for sexual dysfunction (see Section 3 - Services requiring our prior approval)</i> • <i>Insulin; a copay charge applies to each vial</i> • <i>Contraceptive drugs and devices</i> <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. • 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 Mercy Health Plans (Eastern and Central Missouri): 314-214-8196 or 1-800-327-0763; (Southwest Missouri Region): 417-836-0402 or 1-800-836-0402; or (Texas): 956-723-7667 or 1-800-617-3433. <p>You are entitled to receive prescription drugs included on the formulary at the time a prescription written is actually filled by a participating pharmacy. You will pay a copayment of \$7 for generic drugs, \$12 Copayment for brand drugs and \$25 Copayment for non-formulary approved drugs. If the doctor specifies a brand name it must be dispensed (DAW), the Member pays the brand copay, but does <u>not</u> pay the difference in cost between the brand and generic drug. If you request a brand name drug when a generic substitute is on the list, you will be responsible for the generic copayment plus the difference between the brand and the generic drug.</p>	<p>\$ 7 Copayment for generic drugs on Formulary</p> <p>\$12 Copayment for brand drugs on Formulary</p> <p>\$25 Copayment for Non-formulary approved drugs</p> <p>2 Copayments for a 90-day supply for mail-order</p>

Covered medications and supplies 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 available without a prescription or for which there is a nonprescription equivalent available</i> • <i>Prescriptions dispensed by other than a Plan pharmacy, except in the case of a medical emergency</i> • <i>Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies</i> • <i>Vitamins and nutritional substances that can be purchased without a prescription</i> • <i>Medical supplies such as dressing and antiseptics</i> • <i>Drugs for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Appetite suppressants and other drugs taken for the purpose of weight loss</i> • <i>Fertility drugs</i> 	<p><i>All Charges</i></p>

Section 5 (g). Special Features

Feature	Description
<p>Flexible benefits option</p>	<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.
<p>24 hour nurse line (not available in Texas)</p>	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call: (Eastern and Central Missouri): 800-811-1187; or (Southwest Missouri): (417) 866-4374 or 800-595-7167 and talk with a registered nurse who will discuss treatment options and answer your health questions.</p>
<p>Services for deaf and hearing impaired</p>	<p>Mercy Health Plans/Premier Health Plans offers a TDD Line:</p> <ul style="list-style-type: none"> ▪ Mercy Health Plans (Eastern and Central Missouri Region) at 314-214-8299 or 800-698-4807 ▪ Mercy Health Plans (Texas Region) at 877-206-7903 ▪ Premier Health Plans (Southwest Missouri Region) at 417-837-0249 or 800-446-1468

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.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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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.	20% Copayment.

Dental benefits

We have provided for dental care at affordable prices for you and your eligible dependent(s) through CAREington dental network. A list of participating dentists is provided with the provider directory. Following are significant points of the program:

- No claim forms to file. You pay only the copay shown in the schedule of benefits at the time of service.
- To receive significant savings from a participating dentist, merely show your CAREington membership card at each visit and you will receive the discount.
- CAREington only contracts with dentists who meet their credentialing criteria and must continue to meet the high standards of quality established.

Not covered:

- *dental implants*

Section 5 (i). Point of service benefits

I M P O R T A N T	<p>Here are some important things to keep in mind about these benefits:</p> <ul style="list-style-type: none"> • POS benefits are not available in Texas • All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary. 	I M P O R T A N T
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Facts about this Plan's POS option

At your option, you may choose to obtain benefits covered by this Plan from non-Plan doctors and hospitals whenever you need care, except for the benefits listed below under "What is not covered." Benefits not covered under Point of Service must either be received from or arranged by Plan doctors to be covered. When you obtain covered non-emergency medical treatment from a Plan doctor without a referral from a Plan doctor, you are subject to the deductibles, coinsurance and maximum benefit stated below.

What is covered

Benefits subject to UCR limits, precertification required for certain procedures.	
<u>PLAN MAXIMUMS</u>	
Medical Benefit Maximum Per Member (While Covered)	\$2,500,000
Calendar Year Deductible-Member (Family)	\$500 (2 x Member)
Calendar Year Out-of-Pocket Maximum-Member (Family)	\$3,500 Includes Deductible (2 x Member)
<u>MEDICAL SERVICES</u>	
Services and Supplies	30% Coinsurance After Deductible
Surgery performed in a Physician's Office	30% Coinsurance After Deductible
Office Consultations Non-Participating	30% Coinsurance After Deductible
Allergy Services	30% Coinsurance After Deductible
- Office Visits	30% Coinsurance After Deductible
- Injections/Treatment	30% Coinsurance After Deductible
- Allergy serum for home administration	30% Coinsurance After Deductible
Lab and X-ray	30% Coinsurance After Deductible
Maternity (includes prenatal, delivery, and postnatal care)	30% Coinsurance After Deductible
- Office Visits	30% Coinsurance After Deductible
- Lab and Diagnostic	30% Coinsurance After Deductible
<u>INPATIENT HOSPITAL SERVICES</u>	
	30% Coinsurance After Deductible
<u>OUTPATIENT SERVICES</u>	
Emergency Care - Service and Supplies	\$50 Copayment per visit, except Copayment charge will be waived when inpatient admission for the same condition occurs within 24 hours

Benefits subject to UCR limits, precertification required for certain procedures.	
Non-Emergency Services - Outpatient Surgery - Diagnostic tests	30% Coinsurance After Deductible 30% Coinsurance After Deductible
Outpatient Rehabilitative Therapy Services: Physical, Occupational, Speech	30% Coinsurance After Deductible (Max. of up to 60 consecutive days per calendar year, per condition)
MISCELLANEOUS COVERED SERVICES	
Home Health Agency Services (includes intravenous fluids and medications)	30% Coinsurance After Deductible;
Skilled Nursing Facility Services	30% Coinsurance After Deductible
Ambulance	30% Coinsurance After Deductible
Prosthetic Equipment (insertion of internal and external prosthetic devices such as pacemakers and artificial joints)	30% Coinsurance After Deductible
Durable Medical Equipment and Supplies	30% Coinsurance After Deductible
Diabetes Services	30% Coinsurance After Deductible
Nutritional Supplements	30% Coinsurance After Deductible
Accidental Dental	30% Coinsurance After Deductible
Mastectomies (Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure)	30% Coinsurance After Deductible
Surgical treatment of morbid obesity	30% Coinsurance After Deductible
Eyewear Following Cataract Surgery	30% Coinsurance After Deductible
The following services and procedures are not covered under the POS benefit.	
Preventive care, including well-baby care and periodic check-ups.	Covered In-Mercy Network Only
Immunizations for Children from birth to 5 years	Covered In-Mercy Network Only
Urgent Care	Covered In-Mercy Network only
Mental Health (Inpatient and Outpatient)	Covered In-Mercy Network only
Alcoholism/Chemical Dependency (Inpatient and Outpatient)	Covered In-Mercy Network only
Hospice Services	Covered In-Mercy Network Only
Transplant Services	Covered In-Mercy Network Only
Dialysis	Covered In-Mercy Network Only
Mammography (routine screening and when prescribed by the doctor as medically necessary to diagnose or treat illness)	Covered In-Mercy Network Only
Eye Care Services	Covered In-Mercy Network Only
Voluntary sterilization and family planning services	Covered In-Mercy Network Only
Chemotherapy, radiation therapy, and inhalation therapy	Covered In-Mercy Network Only
Chiropractic services	Covered In-Mercy Network Only
Private Duty Nursing	Covered In-Mercy Network Only

Benefits subject to UCR limits, precertification required for certain procedures.	
Infertility Services	Covered In-Mercy Network Only
Smoking Cessation Services	Covered In-Mercy Network Only
Outpatient Prescription Drug Generic Brand Name Mail-Order	Covered in PCS Network Only Covered in PCS Network Only Covered in PCS Network only

When a Member seeks services from a Non-Participating Provider and/or fails to follow pre-established guidelines, reimbursement for HMO Covered Services will be made for "Covered Services". The Member will be required to share a larger part of the "Eligible Charges" by satisfying the annual up front Deductible and paying the required coinsurance. Preventive care or "well care" is not covered and a Pre-existing Condition limitation may apply to limit benefits in certain situations for Covered Services during the first twelve (12) months you are covered, along with other benefit limitations described herein. Finally, when health care is received from a Non-Participating Provider, the Member will be responsible for submitting a completed claim form along with an itemized bill.

"Covered Services" means only the medical care, services and supplies rendered under the following conditions: (a) prescribed by a Physician for the therapeutic treatment of Injury, Illness or pregnancy; (b) deemed Medically Necessary and appropriate in type, level, setting, and length of service by the Plan; (c) rendered in accordance with generally accepted medical practice and professionally recognized standards; (d) not considered to be experimental, investigational, or which are performed for research purposes.

"Eligible Charges or Eligible Expenses" means the Customary Rate for Covered Services rendered by a Provider reduced by any Non-compliance Reduction.

In order to receive certain benefits, Members are required to comply with the specific pre-certification requirements described in connection with the Utilization Management Program as outlined. The Member is responsible for making sure the Plan is contacted before services are rendered. Failure to comply with the requirement of the Utilization Management Program described will result in a reduction in the Benefits Payable.

Services do not need to be obtained within the service area to be eligible for coverage under POS.

Pre-certification

For pre-certification of services call:

(Eastern and Central Missouri): (314) 214-8196 or 1-800-327-0763;
 (Southwest Missouri): (417) 836-0402 or 1-800-836-0402; or
 (Texas): (956) 723-7667 or 1-800-617-3433.

You must obtain authorization before any service is rendered. It is your responsibility to verify that the required pre-certifications have been given by the Plan for coverage. This is called pre-certification. If pre-certification is not given, or you fail to comply with the requirements, eligible charges will be subject to the Non-compliance reduction. Non-compliance reduction means the charges considered for payment are reduced as a result of your failure to comply with the pre-certification. These eligible charges will not be used to meet a deductible or out-of-pocket maximum.

Also, you are required to notify the Plan three (3) days in advance of any hospital admission for a non-emergency. If it is impossible to notify the Plan, you must obtain pre-certification review as soon as reasonably practical prior to the provisions of the service and in no event less than one (1) business day prior to the service. If you fail to comply with the pre-certification requirements, there is a 50% reduction of eligible charges for non-compliance.

Care rendered in connection with a Pregnancy will be treated as an exception to the three (3) day prior notice requirement. The Pre-certification Review requirement will be treated as satisfied if proper notice is given by the Member no later than the fifth month of Pregnancy and the Member notifies the Plan within one (1) business day after admission to the Hospital for delivery.

Services Subject to Pre-Certification Review and Non-compliance Reduction

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| 1. Inpatient Hospitalization. | 50% Reduction in Eligible Charges. |
| 2. Outpatient surgical procedures. | 50% Reduction in Eligible Charges (the Reduction applies to both the facility and the professional charges). |
| 3. Health Services provided during Confinement. | 50% Reduction in Eligible Charges (the Reduction applies to both facility and professional charges). |
| 4. Home health care. | 50% Reduction in Eligible Charges. |
| 5. MRI, RAST tests and CAT scans. | 50% Reduction in Eligible Charges. |
| 6. Prosthetics. | 100% Reduction in Eligible Charges;
No Benefit Payable. |
| 7. Durable Medical Equipment. | 100% Reduction in Eligible Charges;
No Benefit Payable. |
| 8. Physical Therapy, Occupational Therapy and Speech Therapy. | 100% Reduction in Eligible Charges;
No Benefit Payable. |

Note: It is the Member's responsibility to verify that the required certification has been given by the Plan. If certification is not given, or the Member fails to comply with the requirements stated in this Section, Eligible Charges will be subject to the Non-compliance Reduction and the amount of the reduction will not apply toward the Member's Out-of-Pocket Maximum or Deductible.

Deductible

"Deductible" means the amount of Eligible Charges payable by each member before benefits are payable. No Benefit is payable for any part of Eligible Charges used to meet a Deductible.

You will pay a \$500 deductible per member per calendar year and \$1,000 deductible per family per calendar.

Coinsurance

"Coinsurance" means the Member's share of the cost of Eligible Charges stated as a percentage up to the Out-of-Pocket Maximum.

You are responsible for 30% coinsurance after the deductible.

The out-of-pocket maximum per member is \$3,500 (including the deductible) and \$7,000 per family (including deductible). The lifetime limitation is \$2,500,000 per member. The member's out-of-pocket expenses under POS do not qualify for the Plan's in-Plan out-of-pocket maximum.

When you use a non-participating provider and fail to follow preestablished guidelines, reimbursement for covered services, you are responsible for sharing a larger part of the cost for the services. The benefit when a non-participating hospital is used is shown in the POS outline of benefits. The Plan will pay a participating hospital in full even though the POS benefit (and non-Plan doctor) are being used. The hospital charge, sometimes called facility charge, does not cover any charges for doctor's services.

True emergency care is always payable as in in-Plan benefit.

Maximum benefit

The maximum limit is \$2,500,000 lifetime maximum per member.

Hospital/extended care

You are responsible for 30% coinsurance after the deductible.

Emergency benefits

You will pay a \$50 Copayment per visit for service and supplies, except the Copayment charge will be waived when inpatient admission for the same condition occurs within twenty-four (24) hours.

What is not covered

Medical services and procedures that are not covered under the POS benefit:

- Well-child care and immunizations
- Eye and ear examinations to determine the need for vision and hearing correction
- Alcoholism and drug abuse services, including but not limited to diagnosis and medical treatment and services.
- Prescription drugs other than drugs provided by a hospital to a member as an inpatient
- Chiropractic services
- Hemodialysis and dialysis services
- Services for treatment of mental or nervous disorders.
- Non-symptomatic mammography services
- Promotion of conception including, but not limited to, treatment of impotency or infertility, in vitro fertilization, embryo transplantation, reproductive therapy, artificial insemination, or reversal of voluntarily induced sterility.
- Smoking cessation services
- Any organ transplant surgery or procedures, including services rendered on behalf of an organ recipient or an organ donor.
- Charges in excess of the Eligible Charge for the service provided as determined by MHP, or any charges which exceed a calendar year maximum, or other benefit maximum.
- Any loss sustained or contracted during the commission of any crime by a Member, or due to a Member being legally intoxicated, under the influence of intoxicants or under the influence of any non-prescribed narcotic.
- Any types of services, supplies or treatment not specifically provided for herein.

How to obtain benefits

- A. Members have until December 31 of the year following the date of service to file a claim. Failure of the Member to timely furnish such proof of claim to the Plan will result in denial of the Member's claim for reimbursement. Proof of claim includes, but is not limited to, receipt of a duly completed claimant's statement, attending Physician's Statement, itemized provider bills, medical records, and, if applicable, an accident report. A claim form can be obtained from your employer or from the Plan. Submit your claim form along with proof of claim to Mercy Health Plans/Premier Health Plans, P.O. Box 4568, Springfield, Missouri 65808-4568.

B. Failure to Furnish Proof of Claim

Failure to furnish proof within the required time established in paragraph A of this Section shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is provided as soon as reasonably possible.

C. If a claim is denied, a Subscriber may obtain a review of the denial through the Member Complaint and Grievance Resolution Procedure.

D. Payment of Claim

All benefits are payable to the Subscriber unless benefits are assigned. If any such benefits remain unpaid at the Subscriber's death, or if the Subscriber is, or its administrator's opinion, incapable of giving a legally binding receipt for payment of any benefit, or its administrator may, at its option, pay such benefit to any one or more of the Subscriber's relatives as follows: spouse, mother, father, child or children, brother(s), or sister(s) or any other relative of blood or marriage. Any payment so made will constitute a complete discharge of obligations to the extent of such payment under this benefit.

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

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all enrollees and family members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium and any charges for these services do not count toward any FEHB deductibles, or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedure.

Wellness Programs

The following wellness programs are available at the Plan's participating hospitals. Program fees may apply. Members are encouraged to contact the participating hospital nearest you for more information.

- Health Screenings

- Fitness and Weight Management

- Health Education

- Support/Therapy Groups

- Parenting Classes

- Birth/Baby Care Programs

- Children's Health Programs

- Senior Programs

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 your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** and we agree, as discussed under *What Services Require Our Prior Approval* on page 10.

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Educational Services
- Expenses you incurred while you were not enrolled in this Plan.
- Experimental or investigational procedures, treatments, drugs or devices;
- Services provided by a first degree relative;
- Services provided in connection with the reversal of an elective sterilization procedure, or an abortion, except where the life or health of the mother is in jeopardy; or
- Services provided in connection with treatment or surgery to change gender or restore sexual function.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- 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;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical, Hospital and Drug benefits In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at

(Eastern and Central Missouri Regions): 314-214-8196 or 1-800-327-0763;
(Southwest Missouri Region): 417-836-0402 or 1-800-836-0402; or
(Texas Region): 956-723-7667 or 1-800-617-3433.

When you must file a claim -- such as for out-of-area care -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer --such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to: Mercy Health Plans/Premier Health Plans
P.O. Box 4568
Springfield, MO 65808-4568

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 received 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.

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:

Step	Description
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| 1 | Ask us in writing to reconsider our initial decision. You must:
(a) Write to us within 6 months from the date of our decision; and
(b) Send your request to us at: |
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Mercy Health Plans, 425 South Woods Mill Road, Chesterfield, MO 63017 (Eastern and Central MO)
Mercy Health Plans, 5901 McPherson, Suites 1 & 2B, Laredo TX 78041 (Texas); or
Premier Health Plans, One Corporate Centre, Suite 200, 1949 East Sunshine, Springfield, MO 65804 (Southwest MO).

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| | (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
(d) Include 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:
(a) Pay the claim (or arrange for the health care provider to give you the care); or
(b) Write to you and maintain our denial -- go to step 4; or
(c) Ask 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 all 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 lawsuit, benefits, and payment 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 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:

(Eastern and Central Missouri Regions): 314-214-8196 or 1-800-327-0763;
(Southwest Missouri Region): 417-836-0402 or 1-800-836-0402; or
(Texas Region): 956-723-7667 or 1-800-617-3433
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 plan 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 managed care 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.

Your care must continue to be authorized by your Plan PCP. We will not waive any of our copayments, coinsurance, or deductibles.

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.

(Primary payer chart begins on next page.)

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.....		✓

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 314-214-8196 or 1-800-327-0763; (Texas Region) at 956-723-7667 or 1-800-617-3433; or Premier Health Plans (Southwest Missouri Region) at 417-836-0402 or 1-800-836-0402 or visit our website at www.mercyhealthplans.com.

When Medicare is the primary payer, we do not waive any out-of-pocket costs.

- **Medicare managed care plan** If you are eligible for Medicare, you may choose to enroll in and get your Medicare 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 (if you use our Plan providers), 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+Choice service area.

- **Enrollment in Medicare Part B**

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

TRICARE

TRICARE is the 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 filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your benefits. You must use our Providers.

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 injuries or illness caused by another person, you must reimburse us for any expenses 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. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

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.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 12.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See page 12.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Assistance with activities of daily living (bathing, dressing, eating, etc.).
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.
Experimental or Investigational service	Services determined by the Plan to not be generally accepted by health care professional as effective in treating the illness for which their use is proposed. These services are said not be proven scientifically to effectively treat the condition prescribed.
Group health coverage	Any plan on an insured or uninsured basis which provides medical or dental benefits or services: (a) group coverage, (b) services plan contracts, (c) coverage under any trustee plans, welfare plans or employee benefit organization plans, or (d) benefits under Medicare.
Medical necessity	Health care services and supplies that are ordered by a Plan physician and found to be medically appropriate and necessary to meet basic health needs.
Plan allowance	<p>The Plan's determination of charges for medical care, services and supplies that do not exceed the fees and prices generally approved for cases of comparable nature and severity at the time and place. The Plan will use the following guidelines for determining reasonable and customary:</p> <ol style="list-style-type: none">The usual fee frequently charged by the provider for a service or supply;The widely accepted rate of fees charges in the same area by the health professionals of like training and experience; andUnusual circumstances or complication requiring additional time skill and experience in connection with the provided services or supply.
Us/We	Us and we refer to Mercy Health Plans/Premier Health Plans.
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 your 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, or 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 Mercy Health Plans (Eastern and Central Missouri Regions) at 314-214-8196 or 1-800-327-0763; (Texas Region) at 956-723-7667 or 1-800-617-3433; or Premier Health Plans (Southwest Missouri Region) at 417-836-0402 or 1-800-836-0402 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 a 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 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 the 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 regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

The demonstration areas

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

When you can join

You may enroll under the FEHB/DoD 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 seasons. 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 this 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.

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Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

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Summary of benefits for the Mercy Health Plans/Premier Health Plans - 2001

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and 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.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copay: \$10 primary care; \$10 specialist	14
Services provided by a hospital: • Inpatient	Nothing	27
• Outpatient	Nothing	28
Emergency benefits: • In-area	\$50 Copayment per visit, except Copayment charge will be waived when inpatient admission for the same condition occurs within 24 hours	30
• Out-of-area		
Mental health and substance abuse treatment.....	Regular benefits	31
Prescription drugs	\$7/\$12/\$25 Copayment	34
Dental Care.....	Discounted fee schedule	38
Vision Care.....	\$10 per office visit; one pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as cataracts)	19
Special features: • Flexible benefits option • 24 hour nurse line (not available in Texas) • Services for deaf and hearing impaired		37
Point of Service benefits -- Yes (not available in Texas)		39
Protection against catastrophic costs (your out-of-pocket maximum).....	Nothing after \$1,100/Self Only or \$3,300/Family enrollment per year Some costs do not count toward this protection	12

2001 Rate Information for Mercy Health Plans/Premier Health Plans

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. Such persons not subject to postal rates must 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

Missouri Regions (see page 6 for service area)

High Option Self Only	7M1	\$77.73	\$25.91	\$168.41	\$56.14	\$91.98	\$11.66
High Option Self and Family	7M2	\$180.80	\$60.26	\$391.73	\$130.57	\$213.94	\$27.12

Texas Region (see page 6 for service area)

High Option Self Only	HM1	\$84.72	\$28.24	\$183.56	\$61.19	\$100.25	\$12.71
High Option Self and Family	HM2	\$195.82	\$86.60	\$424.28	\$187.63	\$231.17	\$51.25