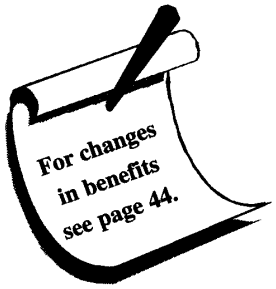
Alliance Health Benefit Plan *(AHBP)*

1999

A Managed Fee-for-Service Plan with a Preferred Provider Organization



Sponsored by: The National Alliance of Postal and Federal Employees

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

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

Membership dues: $**5.00** per month. Members will have the option of paying dues on an annual or semi-annual basis. Dues paid on an annual basis on or before March first of the plan year will receive a 10% discount.

Enrollment code for this Plan:

YQ1 Self only

YQ2 Self and family

Visit the OPM website at http://www.opm.gov/insure

and

this Plan's website at http://www.ahbp.com

Authorized for distribution by the
United States Office of Personnel Management

FEHB
Federal Employees Health Benefits Program

RI 71-3

The National Alliance of Postal and Federal Employees

The National Alliance of Postal and Federal Employees (Carrier) has entered into Contract No. CS1164 with the Office of Personnel Management (OPM) to provide a health benefits plan (Plan) authorized by the Federal Employees Health Benefits (FEHB) law. The Plan is underwritten by Aetna/US Health Care which administers this Plan on behalf of the Carrier and is referred to as Carrier in this brochure. The FEHB contract specifies the manner in which it may be modified or terminated.

This brochure is the official statement of benefits on which you can rely. It describes the benefits, exclusions, limitations, and maximums of the Alliance Health Benefit Plan for 1999 until amended by future benefit negotiations between OPM and the Carrier. It also describes procedures for obtaining benefits. You should use this brochure to determine your entitlement to benefits. Oral statements cannot modify the benefits described in this brochure.

An enrollee does not have a vested right to receive the benefits in this brochure in 2000 or later years, and does not have a right to benefits available prior to 1999 unless those benefits are contained in this brochure.

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD which may result in CRIMINAL PENALTIES.

Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital, pharmacy, etc., charged your Plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider (doctor, hospital, etc.) and ask for an explanation - sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your Carrier at 1-800/321-0347 or for calls in the Washington, DC metropolitan area (202) 939-6325 and explain the situation.
- If the matter is not resolved after speaking to your Carrier (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, D.C. 20415

The inappropriate use of membership identification cards, e.g., to obtain benefits for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

When you need help with Plan benefits, or getting your ID card, call your Alliance Health Benefit Plan at 1-800/321-0347 or for calls in the Washington, DC metropolitan area (202) 939-6325. The Fraud Hotline cannot help you with these.

Using This Brochure

The Table of Contents will help you find the information you need to make the best use of your benefits. To get the best value for your money, you should read Facilities and Other Providers. It will help you understand how your choice of doctors and hospitals will affect how much you pay for services under this Plan.

This brochure explains all of your benefits. It's important that you read about your benefits so you will know what to expect when a claim is filed. Most of the benefit headings are self-explanatory. Other Medical Benefits and Additional Benefits, on the other hand, both include a variety of unrelated benefits. What is different about these benefits is how they are paid: Other Medical Benefits are paid after you satisfy the calendar year deductible and Additional Benefits are generally not subject to the calendar year deductible.

You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on which provider bills for the service. For example, physical therapy is paid one way if it is billed by an inpatient facility and paid another way when it is billed by a doctor, physical therapist or outpatient facility.

The last part of the brochure contains information useful to you under certain circumstances. For example, if you have to go to the hospital you need to read Precertification; hospital stays must be precertified for all payable benefits to apply. If you are enrolled in Medicare, take a look at This Plan and Medicare. The Enrollment Information section tells you about several FEHB enrollment requirements that could affect your future coverage.

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Help Contain Costs

You can help

FEHB plans are expected to manage their costs prudently. All FEHB plans have cost containment measures in place. All fee-for-service plans include two specific provisions in their benefits packages: precertification of all inpatient admissions and the flexible benefits option. Some include managed care options, such as PPO's, to help contain costs.

As a result of your cooperative efforts, the FEHB Program has been able to control premium costs. Please keep up the good work and continue to help keep costs down.

Precertification

Precertification evaluates the medical necessity of proposed admissions and the number of days required to treat your condition. You are responsible for ensuring that the precertification requirement is met. You or your doctor must check with Aetna before being admitted to the hospital. If that doesn't happen, your Plan will reduce benefits by $500. Be a responsible consumer. Be aware of your Plan's cost containment provisions. You can avoid penalties and help keep premiums under control by following the procedures specified on pages 32-33 of this brochure.

Flexible benefits option

Under the flexible benefits option, the Carrier has the authority to determine the most effective way to provide services. The Carrier may identify medically appropriate alternatives to traditional care and coordinate the provision of Plan benefits as a less costly alternative benefit. Alternative benefits are subject to ongoing review. The Carrier may decide to resume regular contract benefits at its sole discretion. Approval of an alternative benefit is not a guarantee of any future alternative benefits. The decision to offer an alternative benefit is solely the Carrier's and may be withdrawn at any time. It is not subject to OPM review under the disputed claims process.

PPO

This Plan offers most of its members the opportunity to reduce out-of-pocket expenses by choosing providers who participate in the Plan's preferred provider organization (PPO). Consider the PPO cost savings when you review Plan benefits and check with the Carrier to see whether PPO providers are available in your area.

Facilities and Other Providers

Covered facilities

Birthing Center

A free-standing facility licensed or certified by the State in which it functions, or Plan approved, which offers comprehensive maternity care in a home-like atmosphere.

Hospice

A facility which provides short periods of stay for a terminally ill person in a home-like setting for either direct care or respite. This facility may either be free-standing or affiliated with a hospital. It must operate as an integral part of the hospice care program.

Hospital

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

Skilled nursing facility

An institution or that part of an institution which provides skilled nursing care 24 hours a day.

Covered providers

For purposes of this Plan, covered providers include:

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

(2) other covered providers include: a Chiropractor, Dentist, Optometrist, Clinical Psychologist, Clinical Social Worker, Nurse Midwife, Nurse Practitioner/Clinical Specialist, Nurse Anesthetist or Nursing School Administered Clinic. **Charges of Christian Science nurses,**

practitioners and providers will be covered under this plan the same as other medical providers. For purposes of this FEHB brochure, the term "doctor" includes all of these providers when the services are performed within the scope of their license or certification.

Coverage in medically underserved areas

Within States designated as medically underserved areas, any licensed medical practitioner will be treated as a covered provider for any covered services performed within the scope of that license. For 1999 the States designated as medically underserved are: Alabama, Idaho, Louisiana, Mississippi, New Mexico, South Carolina, North Dakota, South Dakota, and Wyoming.

PPO arrangements

Benefits under this Plan are available from facilities, such as hospitals, and from providers, such as pharmacies, doctors and other health care personnel, who provide covered services. This Plan covers two types of facilities and providers: (1) those who participate in a preferred provider organization (PPO) and (2) those who do not. Who these health care providers are, and how benefits are paid for their services, are explained below.

PPO facilities and providers have agreed to provide services to Plan members at a lower cost than you'd usually pay a non-PPO provider. Although PPO's are not available in all locations or for all services, when you use these providers you help contain health care costs and reduce what you pay out of pocket. The selection of PPO providers is solely the Plan's responsibility: continued participation of any specific provider cannot be guaranteed. While PPO providers agree with the Carrier to provide covered services, final decisions about health care are the sole responsibility of the doctor and patient and are independent of the terms of the insurance contract.

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

When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, anesthetists and pathologists, may not all be preferred providers. If they are not they will be paid by this Plan as non-PPO providers.

Non-PPO facilities and providers do not have special agreements with the Carrier. The Plan makes its regular payments toward the bills, and you're responsible for any balance.

This Plan's PPO

The Plan has entered into an arrangement with Aetna's Preferred Provider Organization (PPO). This is a group of doctors, hospitals and other providers that have contracted with Aetna to provide medical services at reduced costs. This PPO operates in 43 states plus Puerto Rico. Each time you need medical care you have the choice to use a health care provider who participates in the network or one who does not.

When you use a PPO hospital, your benefits increase from **70%** after the $250 inpatient deductible to **90%** after the $150 inpatient deductible. When you use a PPO doctor, your surgery benefits increase to **90%** after a $100 deductible and your office visit benefits increase to paid **in full** after a **$10** copayment. Non-PPO benefits for both are **70%** after a $300 deductible. Precertification is required as explained on pages 32-33 for all inpatient hospitalizations and the listed non-emergency outpatient surgeries and/or non-emergency diagnostic tests listed on page 32. However, your PPO doctor will initiate precertification and will file your claims for you. Note: PPO benefits are not payable when the Alliance Health Benefit Plan is not the primary payer.

New enrollees living in a PPO area will receive a directory of PPO providers in their service area. Providers who belong to the network must meet specific criteria including location, medical specialty, professional skill and proper credentials. However, inclusion in the network does not represent a guarantee of professional performance nor does it constitute medical advice. The continued availability of any one provider cannot be guaranteed by the Plan. Call 1-800/572-9096 for information on how to nominate or request provider network participation or to obtain a list of PPO providers in your area. A list of PPO providers may also be obtained from Aetna's web site at http://www.aetnaushc.com. When you phone for an appointment, please remember to verify that the physician is still a PPO provider.

Cost Sharing

Deductibles

A deductible is the amount of expense an individual must incur for covered services and supplies before the Plan starts paying benefits for the expense involved. A deductible is not reimbursable by the Plan. When a benefit is subject to a deductible, only expenses allowable under that benefit count toward the deductible.

Calendar year

The calendar year deductible is the amount of expenses an individual must incur for covered services and supplies each calendar year before the Plan pays certain benefits. The deductible for PPO benefits is $100 per person; the deductible for non-PPO benefits is $300. Any expenses incurred through PPO or non-PPO benefits are applied toward both deductibles.

Other

There is a $150 per admission deductible for PPO benefits and a $250 per admission deductible for non-PPO benefits which apply to inpatient hospital benefits (page 12) and a separate $500 deductible per person per confinement which applies to inpatient hospital charges for the treatment of mental conditions (page 19). There is a combined $200 annual deductible applicable to the mail order and/or retail prescription drug programs.

Carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible in the prior year will be covered by your old plan if they are for care you got in January before the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective on January 1.

Family limit

There is a separate calendar year deductible of $100 per person for PPO benefits and $300 per person for non-PPO benefits. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members after three members have met their calendar year deductible. If the PPO deductibles are satisfied, then further deductibles are waived for PPO charges during that calendar year. If the non-PPO deductibles are satisfied, then further PPO and non-PPO deductibles are waived.

Coinsurance

Coinsurance is the stated percentage of covered charges you must pay after you have met any applicable deductible. You are required to pay the following coinsurance on benefits under this Plan:

- **30%** for non-PPO inpatient hospital room/board, and other hospital charges;
- **10%** for PPO inpatient surgical benefits, maternity benefits, and other medical benefits;
- **30%** for non-PPO inpatient and outpatient surgical benefits, maternity benefits, and other medical benefits;
- **20%** for inpatient treatment of mental conditions;
- **50%** for doctors' visits (inpatient and outpatient) for mental conditions;
- **25%** for outpatient treatment of substance abuse;
- **20%** for skilled nursing facility

After you meet any deductible, the coinsurance is the minimum amount you will have to pay. For instance, when a Plan pays 80% of reasonable and customary charges for a covered service, you are responsible for 20% of the reasonable and customary charges, i.e., the coinsurance. In addition, you may be responsible for any excess charge over the Plan's reasonable and customary allowance. For example, if the provider ordinarily charges $100 for a service but the Plan's reasonable and customary allowance is $95, the Plan will pay 80% of the allowance

($76). You must pay the 20% coinsurance ($19), plus the difference between the actual charge and the reasonable and customary allowance ($5), for a total member responsibility of $24. Remember, if you use preferred providers, your share of covered charges (after meeting any deductible) is limited to the stated coinsurance amount.

Copayment

A copayment is the stated amount the Plan may require you to pay for a covered service, such as $8.00 per generic drug, $20 per brand name drug, per prescription by mail or $10.00 per office visit charge at a PPO provider.

If provider waives your share

If a provider routinely waives (does not require you to pay) your share of the charge for services rendered, the Plan is not obligated to pay the full percentage of the amount of the provider's original charge it would otherwise have paid. A provider or supplier who routinely waives coinsurance, copayments or deductibles is misstating the actual charge. This practice may be in violation of the law. The Plan will base its percentage on the fee actually charged. For example, if the provider ordinarily charges $100 for a service but routinely waives the 20% coinsurance, the actual charge is $80. The Plan will pay $64 (80% of the actual charge of $80).

Lifetime maximums

Benefits for inpatient substance abuse treatment are limited to two 30-day treatment programs per person per lifetime.

Smoking cessation benefits are limited to one program per member per lifetime.

General Limitations

All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable when determined by the Carrier to be medically necessary. Coverage is provided only for services and supplies that are listed in this brochure. No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under the Plan or be used in the prosecution or defense of a claim under the Plan. This brochure is the official statement of benefits on which you can rely.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Carrier and complete all necessary documents and authorizations requested by the Carrier.

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, the provisions on coordination of benefits with Medicare described on pages 33-35 apply.

Group health insurance and automobile insurance

Coordination of benefits (double coverage) applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Carrier.

When there is 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. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount that, when added to the benefits payable by the other coverage, will not exceed this Plan's reasonable and customary charge.

The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners (NAIC). When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have.

This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Carrier to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for benefits or services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, medical benefits may be provided for services or supplies covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for benefits paid by the Plan that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities, and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

Subrogation applies when you are sick or injured as a result of the act or omission of another person or party. Subrogation means the Plan's right to recover any benefit payments made to you or your dependent by a third party's insurer, because of an injury or illness caused by the third party. Third party means another person or organization.

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

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

If you need more information about subrogation, the plan will provide you with its subrogation procedures.

Overpayments

The Carrier will make reasonably diligent efforts to recover benefit payments made erroneously but in good faith and may apply subsequent benefits otherwise payable to offset any overpayments.

Vested rights

An enrollee does not have a vested right to receive the benefits in this brochure in 2000 or later years, and does not have a right to benefits available prior to 1999 unless those benefits are contained in this brochure.

Limit on your costs if you're age 65 or older and don't have Medicare

The information in the following paragraphs applies to you when 1) you are not covered by either Medicare Part A (hospital insurance) or Part B (medical insurance), or both, 2) you are enrolled in this Plan as an annuitant or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse, and 3) you are not employed in a position which confers FEHB coverage.

Inpatient hospital care

If you are not covered by Medicare Part A, are age 65 or older or become age 65 while receiving inpatient hospital services, and you receive care in a Medicare participating hospital, the law (5 U.S.C. 8904(b)) requires the Plan to base its payment on an amount equivalent to the amount Medicare would have allowed if you had Medicare Part A. This amount is called the **equivalent Medicare amount**. After the Plan pays, the law prohibits the hospital from charging you for covered services after you have paid any deductibles, coinsurance, or copayments you owe under the Plan. Any coinsurance you owe will be based on the equivalent Medicare amount, not the actual charge. You and the Plan, together, are not legally obligated to pay the hospital more than the equivalent Medicare amount.

The Carrier's explanation of benefits (EOB) will tell you how much the hospital can charge you in addition to what the Plan paid. If you are billed more than the hospital is allowed to charge, ask the hospital to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Alliance Health Benefit Plan at 1-800/572-9096 for assistance.

Physician services

Claims for physician services provided for retired FEHB members age 65 and older who do not have Medicare Part B are also processed in accordance with 5 U.S.C. 8904(b). This law

mandates the use of Medicare Part B limits for covered physician services for those members who are not covered by Medicare Part B.

The Plan is required to base its payment on the **Medicare-approved amount** (which is the Medicare fee schedule for the service), or the actual charge, whichever is lower. If your doctor is a member of the Plan's preferred provider organization (PPO) and participates with Medicare, the Plan will base its payment on the lower of these two amounts and you are responsible only for any deductible and the PPO copayment or coinsurance.

If you go to a PPO doctor who does not participate with Medicare, you are responsible for any deductible and the copayment or coinsurance. In addition, unless the doctor's agreement with the Carrier specifies otherwise, you must pay the difference between the Medicare-approved amount and the **limiting charge** (115% of the Medicare-approved amount).

If your physician is not a Plan PPO doctor but participates with Medicare, the Plan will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's high option surgery benefit, the Plan will pay 75% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 25% of the Medicare-approved amount.

If your physician does not participate with Medicare, the Plan will still base its payment on the Medicare-approved amount. However, in most cases you will be responsible for any deductible, the coinsurance or copayment amount, **and** any balance up to the limiting charge amount (115% of the Medicare-approved amount).

Since a physician who participates with Medicare is only permitted to bill you up to the Medicare fee schedule amount even if you do not have Medicare Part B, it is generally to your financial advantage to use a physician who participates with Medicare.

The Carrier's explanation of benefits (EOB) will tell you how much the physician can charge you in addition to what the Plan paid. If you are billed more than the physician is allowed to charge, ask the physician to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Alliance Health Benefit Plan at 1-800/572-9096 for assistance.

General Exclusions

These exclusions apply to more than one or to all benefits categories. Exclusions that are primarily identified with a single benefit category are listed along with that benefit category, but may apply to other categories. Therefore, please refer to the specific benefit sections as well to assure that you are aware of all benefit exclusions.

Benefits are provided only for services and supplies that are medically necessary (see definition). The Carrier reserves the right to determine medical necessity. The fact that a covered provider has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary.

Benefits will not be paid for services and supplies when:

- No charge would be made if the covered individual had no health insurance coverage
- Furnished without charge (except as described on page 10); while in active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories, or possessions or (2) during combat
- Furnished by immediate relatives or household members, such as spouse, parent, child, brother or sister by blood, marriage or adoption
- Furnished or billed by a provider or facility that has been barred from the FEHB Program
- Furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered
- For or related to sex transformation, sexual dysfunction or sexual inadequacy
- Not specifically listed as covered
- Investigational or experimental
- Not provided in accordance with accepted professional medical standards in the United States

General Exclusions *continued*

Benefits will not be paid for:

- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copay or coinsurance, the Carrier will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
- Charges the enrollee or Plan has no legal obligation to pay, such as: excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 10), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge)(see page 35), or State premium taxes however applied.
- Procedures, services, drugs and 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.
- Biofeedback
- Dental services and appliances (except as specified on pages 21 and 27)
- Exercise equipment, whirlpool baths, sunlamps, heating pads, air conditioners, humidifiers, dehumidifiers and purifiers
- Services and supplies to the extent the charge exceeds reasonable and customary charges
- Services by practitioners who do not meet the definition of "covered provider"
- Services received while not covered by this Plan
- Charges for a stand-by doctor

Benefits

Inpatient Hospital Benefits

What is covered

The Plan pays for inpatient hospital services as shown below.

Precertification

The medical necessity of your hospital admission must be precertified for you to receive full Plan benefits. Emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See page 33 for details.

Waiver

This precertification requirement does not apply to persons whose primary coverage is Medicare Part A or another health insurance policy or when the hospital admission is outside the United States and Puerto Rico. For information on when Medicare is primary, see pages 33-35.

Room and board

Semiprivate room accommodations, including general nursing care, meals, and special diets. If a private room is used, only the hospital's average semiprivate room rate will be considered a covered expense. However, if the patient's isolation is medically necessary to prevent contagion to others, the full charge for a private room will be covered. If a private room is chosen, benefits will be determined based on the hospital's semiprivate room rate, as determined by the Plan. If the hospital has private accommodations only, the Plan will determine benefits based on the lesser of the private room charge or the semiprivate room charge of the hospital which the plan determines to be the most comparable hospital in the area.

PPO benefit

After a $150 deductible per admission, the Plan pays **90%** of room and board charges.

Non-PPO benefit

After a $250 deductible per admission, the Plan pays **70%** of room and board charges.

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Inpatient Hospital Benefits *continued*

Other charges

Other hospital charges include but are not limited to:

- Ancillary services such as electrocardiograms and electroencephalograms
- Intravenous solutions and injections
- Oxygen, including use of equipment and administration
- Use of operating, recovery, intensive care and cystoscopic rooms
- Laboratory tests
- Surgical dressings, plaster casts, and sterile tray service
- Diagnostic X-rays
- Drugs and medicines
- Blood or blood plasma, if not donated or replaced, and its administration
- Radiation therapy and inhalation therapy
- Renal dialysis

PPO benefit

The Plan pays **90%** of other hospital charges.

Non-PPO benefit

The Plan pays **70%** of other hospital charges.

Limited benefits

Pre-admission testing

The Plan pays **100%** of reasonable and customary charges for pre-admission testing within 72 hours of admission to a hospital as an inpatient.

Hospitalization for dental work

The Plan pays hospital benefits as shown on page 12 for covered room and board and covered hospital services for hospitalization in connection with dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient.

Related benefits

Professional charges

Covered professional services of a doctor or any other covered practitioner, even though billed by a hospital as part of hospital services, are covered only under Other Medical Benefits, pages 20-22.

Take-home items

Drugs, medical supplies, appliances, medical equipment and any covered items billed by a hospital but to be used at home are covered only under Other Medical Benefits, pages 20-22.

What is not covered

- A hospital admission, or part of a hospital admission, and inpatient doctor care, that is not medically necessary, i.e., the medical services did not require the acute hospital inpatient overnight setting, but could have been provided in a doctor's office, the outpatient department of a hospital, or some other setting without adversely affecting the patient's condition or the quality of medical care rendered
- Confinement in nursing homes, rest homes, places for the aged, convalescent homes, residential treatment facilities or any place that is not a hospital (see definition on page 5)
- Custodial care, as defined on page 40
- Inpatient private duty nursing
- Personal comfort services of a luxury nature such as radio, telephone, beauty and barber services, ID tags, baby beads, footprints, guest meals, and newspapers
- Admissions for cosmetic services
- Admissions for rehabilitative services that are not covered by this Plan

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Surgical Benefits

What is covered

The Plan pays for the following services:

Hospital inpatient

PPO benefit

After the $100 PPO year deductible has been met, the Plan pays **90%** of reasonable and customary charges.

Non-PPO benefit

After the $300 non-PPO calendar year deductible has been met, the Plan pays **70%** of reasonable and customary charges.

Outpatient

The Plan pays reasonable and customary charges to the extent shown below for outpatient covered services and supplies provided by a doctor in relation to, and on the same day as, the covered outpatient surgery. Covered services and supplies rendered prior to or after the date of surgery are eligible for Other Medical Benefits.

Charges for normal postoperative care by the doctor who performs surgery are considered to be part of the surgical charge.

- Surgery by a doctor, surgeon, or licensed podiatrist
- The initial reconstruction of a breast following mastectomy occurring while covered under the FEHB Program
- Voluntary sterilization

PPO benefit

After the $100 PPO calendar year deductible has been met, the Plan pays **90%** of reasonable and customary charges.

Non-PPO benefit

After the $300 non-PPO calendar year deductible has been met, the Plan pays **70%** of reasonable and customary charges.

Precertification

You must follow the precertification procedure described on pages 32-33 in order to receive full Plan benefits. Precertification is a mandatory requirement for the non-emergency outpatient surgeries list on page 32. If precertification is not obtained, the Plan will reduce benefits by $200 on the outpatient charges otherwise payable.

Waiver

Precertification is not required for any individual who has Medicare Part A and B as primary coverage, or for treatment outside the United States and Puerto Rico. For information on when Medicare is primary, see pages 33-35.

Same-day surgery

The Plan provides benefits for hospital-billed services and supplies when provided by and in a hospital outpatient department or emergency room in connection with in-and-out surgery, where minor surgery is performed and the patient goes home the same day the surgery is performed.

PPO benefit

After the $100 PPO calendar year deductible has been met, the Plan pays **90%** of reasonable and customary charges.

Non-PPO benefit

After the $300 non-PPO calendar year deductible has been met, the Plan pays **70%** of reasonable and customary charges.

Multiple surgical procedures

When multiple or bilateral surgical procedures that add time or complexity to patient care are performed during the same operative session, the Plan pays as follows:

If more than one procedure is performed during one operation, through the same incision or natural body orifice or in the same operative field, payment will be made as follows: 100% for the primary procedure, 50% for the second procedure and 25% for procedures thereafter.

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Incidental procedures

If primary and incidental procedures are performed, the Plan pays the full allowance for the primary procedure only. There are no additional benefits for the incidental procedures. Incidental and subset procedures are considered as part of the primary surgery.

Assistant surgeon (inpatient/outpatient)

PPO benefit After the $100 PPO calendar year deductible has been met, the Plan pays **90%** of reasonable and customary charges.

Non-PPO benefit After the $300 non-PPO calendar year deductible has been met, the Plan pays **70%** of reasonable and customary charges.

Second opinion (voluntary)

See Other Medical Benefits, page 20.

Ambulatory surgical facility (surgicenter)

The Plan pays for covered hospital services and supplies received for covered surgical procedures in an Ambulatory Surgical Facility or Surgi-Center as follows:

PPO benefit After the $100 PPO calendar year deductible has been met, the Plan pays **90%** of reasonable and customary charges.

Non-PPO benefit After the $300 non-PPO calendar year deductible has been met, the Plan pays **70%** of reasonable and customary charges.

Anesthesia

The Plan pays reasonable and customary charges for the administration of anesthesia as follows:

PPO benefit After the $100 PPO calendar year deductible has been met, the Plan pays **90%** of reasonable and customary charges.

Non-PPO benefit After the $300 non-PPO calendar year deductible has been met, the Plan pays **70%** of reasonable and customary charges.

Organ/tissue transplants and donor expenses

All reasonable and customary charges incurred for a covered surgical transplant, whether incurred by the recipient or donor, will be considered expenses of the recipient and will be covered the same as for any other illness or injury when an Institute of Excellence or PPO facility is used. This benefit applies only if the recipient is covered by the Plan, and to the extent the donor's expenses are not otherwise covered.

What is covered

- Cornea, heart, kidney, heart/lung, liver, pancreas (when condition is not treatable by use of insulin therapy)
- Single or double lung transplants for the following end-stage pulmonary diseases: 1) Primary fibrosis, 2) Primary pulmonary hypertension, and 3) Emphysema. Double lung transplant for cystic fibrosis
- Bone marrow and stem cell support as follows:

  Allogeneic bone marrow transplants for 1) Acute leukemia, 2) Advanced Hodgkin's lymphoma, 3) Advanced non-Hodgkin's lymphoma, 4) Advanced neuroblastoma (limited to children over age one), 5) Aplastic anemia, 6) Chronic myelogenous leukemia, 7) Infantile malignant osteopetrosis, 8) Severe combined immunodeficiency, 9) Thalassemia major, and 10) Wiskott-Aldrich syndrome

  Autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support for 1) Acute lymphocytic or non-lymphocytic leukemia, 2) Advanced Hodgkin's lymphoma, 3) Advanced non-Hodgkin's lymphoma, 4) Advanced neuroblastoma, and 5) Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors, Breast cancer, Multiple myeloma; and Epithelial ovarian cancer.

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Related medical and hospital expenses of the donor are covered when the recipient is covered by the Plan. Recipient means an insured person who undergoes an operation to receive an organ transplant. Donor means a person who undergoes an operation for the purpose of donating an organ for transplant surgery.

PPO benefit

After the $100 PPO calendar year deductible has been met, Plan pays **90%** of the reasonable and customary charges for a covered surgical transplant performed in one of the Plan's Institutes of Excellence (IOE) or a PPO facility.

Non-PPO benefit

After the $300 non-PPO calendar year deductible has been met, the Plan pays **70%** of reasonable and customary charges for a covered surgical transplant performed in a non-PPO/IOE facility up to a maximum, per transplant, of $150,000 for a liver transplant and $100,000 for any of the other transplants listed on page 15.

Precertification

The Plan has contracted for access to an Institute of Excellence (IOE) program for transplants. These institutes are located regionally throughout the United States. In order to receive benefits for the transplants listed above, you must follow the precertification procedures described on pages 32-33. When you request precertification, a case management specialist will direct you to one of the Plan's Institutes of Excellence or a PPO hospital in your area.

Travel and lodging

Travel and lodging expenses include the costs incurred by the PPO/IOE patient and one companion for travel to receive services in connection with any approved PPO/IOE procedure or treatment. Maximum lodging expenses are **$50** per night per person. All travel and lodging expenses must be approved by the Plan in advance.

Limitations

For the purposes of the maximum total payment, charges from doctors and hospitals while the patient is confined in a transplant facility will be counted toward the maximum. Charges incurred for prescription drugs and follow-up care outside of the transplant facility/hospital will not be counted toward this maximum. If the Plan cannot refer a member in need of a transplant to a PPO/IOE facility, the $100,000/$150,000 maximum will not apply.

What is not covered

- Transplants not listed as covered.
- Donor screening tests for organ/tissue transplants, except those performed on the actual donor.

Mastectomy surgery

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.

Pre-surgical testing

The Plan pays actual charges for laboratory tests, pathology, radiology and X-rays directly related to the surgery when performed within 10 days prior to the surgery (including the day of surgery) when an outpatient, or within 10 days prior to admission for inpatient surgery.

Oral and maxillofacial surgery

Surgery by an oral surgeon for operations performed on the jaw for non-dental oral surgery in the mouth, including surgical correction of temporomandibular joint (TMJ) dysfunction.

Benefits are limited to the following procedures:

- Reduction of fractures of the jaws or facial bones
- Reduction of dislocations and excision of TMJ joints
- Surgical correction of cleft lip, cleft palate, or protruding mandible
- Removal of stones from salivary ducts
- Excision of tori, leukoplakia, or malignancies
- Excision of cysts and incision of abscesses not involving teeth
- Other procedures that do not involve a tooth structure, alveolar process, peridontal disease, or disease of gingival tissue

What is not covered

- Acupuncture, except when used as an anesthetic agent for covered surgery
- Reversal of sterilization
- Radial keratotomy
- Cosmetic surgery (as defined on page 40), except for the repair of accidental injuries sustained while covered under the FEHBP Program
- Treatment or removal of corns and calluses, or trimming of toenails
- Treatment of TMJ, including dental appliances, study models, splint and other devices or services associated with the treatment of TMJ dysfunction, except as provided for above.

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Maternity Benefits

What is covered

The Plan pays the same benefits for hospital, surgery (delivery), laboratory tests and other medical expenses as for illness or injury. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary.

Inpatient hospital

Hospital bassinet or nursery charges for days on which the mother and child are both confined are considered other hospital charges of the mother and not charges of the child. However, when a newborn requires definitive treatment or evaluation for medical or surgical reasons, during or after the mother's confinement, the newborn is considered a patient in his or her own right. Under these circumstances, expenses of the newborn (including incubation charges by reason of prematurity) are eligible for benefits only if the child is covered by a family enrollment.

Precertification

The medical necessity of your hospital admission must be precertified for you to receive full Plan benefits. Unscheduled or emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Newborn confinements that extend beyond the mother's discharge must also be precertified. If any of the above are not done, the benefits payable will be reduced by $500. See pages 32-33 for details.

Room and board

PPO benefit

After a $150 deductible per admission, the Plan pays **90%** of the charges covered under Inpatient Hospital Benefits.

Non-PPO benefit

After a $250 deductible per admission, the Plan pays **70%** of the charges covered under Inpatient Hospital Benefits.

Other charges

PPO benefit

The Plan pays **90%** of the charges covered under Inpatient Hospital Benefits.

Non-PPO benefit

The Plan pays **70%** of the charges covered under Inpatient Hospital Benefits.

Pregnancy risk management program

During the first trimester of your pregnancy, you should call the toll free number 1-800/572-9096. A nurse consultant will discuss your pregnancy with you and if you do not have a doctor for your maternity care needs, *Healthy Beginnings* can help you find a doctor and send you important educational material on topics such as prenatal care, diet and exercise. However, it is not intended that *Healthy Beginnings* be utilized as a means of obtaining medical advice.

Outpatient care

The Plan pays **100%** of reasonable and customary charges for covered services rendered at the time of delivery when:

- Delivery is on an outpatient basis
- Delivery is at a birthing center

The Plan pays **100%** of reasonable and customary charges for two newborn pediatric visits within five days of a birthing center or outpatient delivery.

If the mother or the newborn child is transferred from a birthing center to a hospital due to medical complications, the birthing center expenses will be paid as shown above.

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Obstetrical care

The Plan pays Surgical Benefits for obstetrical care (see page 14) for delivery by a doctor or State licensed midwife and routine circumcision (as part of the mother's maternity claim). Delivery includes associated obstetrical care, anesthesia, sonograms, amniocentesis and related tests on the unborn child. Benefits are provided for two routine newborn pediatric visits while the mother and child are both confined.

Benefits for pre and postnatal care rendered independently of delivery services are provided under Other Medical Benefits.

Procedures, services, drugs and supplies related to abortions are covered only 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.

Related benefits

Diagnosis and treatment of infertility

Diagnosis and treatment of infertility (except as described below) is covered under Other Medical Benefits, page 20.

Voluntary sterilization

See Surgical Benefits, page 14.

Well child care

See Additional Benefits, page 24.

For whom

Benefits are payable under Self Only enrollments and for family members under Self and Family enrollments.

What is not covered

- Procedures, services, drugs and 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.
- Assisted Reproductive Technology (ART) procedures, such as artificial insemination, in vitro fertilization, embryo transfer and GIFT, as well as services and supplies related to ART procedures are not covered
- Reversal of voluntary surgical sterilization

Mental Conditions/Substance Abuse Benefits

What is covered

The Plan pays for the following services:

Mental conditions

Inpatient care

After a $500 deductible per person, per confinement, the Plan will pay **80%** of reasonable and customary charges. Benefits for inpatient mental conditions will be limited to 45 days per person, per calendar year. The Plan provides benefits for inpatient doctor visits as noted below in the Outpatient Care and Inpatient Visits provision.

Precertification

The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive full Plan benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See page 32 for details.

Inpatient visits and Outpatient care

After the $300 non-PPO calendar year deductible has been met, doctors' visits (inpatient and outpatient) for the treatment of mental conditions are paid at **50%** of covered charges with a maximum benefit of 30 visits per person, per calendar year. In addition, there is a separate calendar year maximum of 10 visits (after the deductible and at 50% coinsurance) for inpatient care. Once this limit is exhausted, the combined 30 visit annual limit for outpatient and inpatient care is utilized. These services are covered only when rendered by a licensed M.D., a licensed clinical psychologist, a clinical social worker, or a licensed psychiatric nurse. Other Medical Benefits are available for related prescription drugs and diagnostic laboratory/X-ray services.

The medical management of mental conditions will be covered under this Plan's Other Medical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits. Office visits for the medical aspects of treatment do not count toward the 30 outpatient Mental Conditions visit limit.

Substance abuse

Inpatient care

The Plan pays **100%** of reasonable and customary charges for substance abuse treatment up to $4,000 for one 30-day inpatient treatment program per calendar year in an approved JCAHO facility. Withdrawal prior to completion constitutes use of one program. All professional fees associated with the inpatient treatment program are included in the $4,000 maximum.

Precertification

The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive full Plan benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See pages 32-33 for details.

Outpatient care

After the $300 non-PPO calendar year deductible has been met, outpatient doctors' visits for the treatment of substance abuse are paid at **75%** of reasonable and customary charges up to a $4,000 maximum per person per calendar year.

Lifetime maximum

- Benefits for inpatient substance abuse treatment are limited to two 30-day treatment programs per person per lifetime.

Related benefits

Psychological testing

Psychological testing is covered under Other Medical Benefits, page 21.

What is not covered

- Any service rendered in relation to a learning disability
- Treatment of mental conditions and substance abuse except as shown above

Other Medical Benefits

What is covered

The Plan pays as follows:

Precertification

You must follow the precertification procedure described on pages 32-33 in order to receive full Plan benefits. Precertification is a mandatory requirement for the non-emergency outpatient surgeries listed on page 32. If precertification is not obtained, the Plan will reduce benefits by $200 on the outpatient charges otherwise payable.

Waiver

Precertification is not required for any individual who has Medicare Part A and B as primary coverage, or for treatment outside the United States and Puerto Rico. For information on when Medicare is primary, see pages 33-35.

PPO benefit

After the $100 PPO calendar year deductible has been met, the Plan pays **90%** of reasonable and customary charges.

Non-PPO benefit

After the $300 non-PPO calendar year deductible has been met, the Plan pays **70%** of reasonable and customary charges.

The Plan provides PPO and non-PPO benefits for the services listed below:

- Doctors' hospital visits
- Services of an independent consulting doctor for a second opinion regarding the necessity for anticipated surgery when not required by the Plan
- Electroshock therapy
- Diagnosis and treatment of infertility except as described on page 18
- Hospital outpatient services and supplies when not covered under other benefit provisions of this Plan
- Allergy treatment, including injections and testing
- B-12 injections for a diagnosis of pernicious anemia
- Drugs, medical supplies, appliances, medical equipment and any covered item billed by a hospital but to be used at home
- Interpretation fees billed by a radiologist or pathologist

Outpatient doctor's visits

The Plan provides benefits for doctors' outpatient services, including office and home visits.

PPO benefit

After the $10 copay per visit, the Plan pays **100%** of reasonable and customary charges for doctors' visits and the routine (screening) services listed below:

Non-PPO benefit

After the $300 non-PPO calendar year deductible has been met, the Plan pays **70%** of reasonable and customary charges.

Routine services

In addition to coverage on pages 20-21 of diagnostic X-rays, laboratory and pathology services and machine diagnostic tests, the following routine (screening) services are covered as preventive care and are not subject to the deductible:

Breast cancer screening

Mammograms are covered for women age 35 and older as follows:

- From age 35 through 39, one mammogram screening during this five year period
- From age 40 through 49, one mammogram screening every one or two consecutive calendar years
- From age 50 through 64, one mammogram screening every calendar year
- At age 65 and older, one mammogram screening every two consecutive calendar years

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Cervical cancer screening

Annual coverage of one pap smear for women age 18 and older

Colorectal cancer screening

Annual coverage of one fecal occult blood test for members age 40 and older

Prostate cancer screening

Annual coverage of one PSA (Prostate Specific Antigen) test for men age 40 and older

Routine physical (PPO only)

After the **$10** PPO office visit copay, the Plan pays, up to a $150 maximum, for charges made by a PPO doctor for one routine physical examination every 24 months.

Sickle cell screening

Screening of newborns for sickle cell anemia

Other services

The Plan provides PPO and non-PPO benefits for the services listed below:

PPO benefit

After the $100 PPO calendar year deductible has been met, the Plan pays **90%** of reasonable and customary charges.

Non-PPO benefit

After the $300 non-PPO calendar year deductible has been met, the Plan pays **70%** of reasonable and customary charges.

- Dentists' services (including initial replacement, repair and dental X-rays) due to accidental injury to jaw or sound natural teeth. Services must be received within 12 months from the date of the accident.
- One pair of eyeglasses or contact lenses, and examinations, if required to correct an impairment directly caused by accidental ocular injury or intraocular surgery and obtained within one year.
- Diagnostic procedures, including laboratory tests, X-rays, and tests such as electrocardiograms, basal metabolism readings, CAT scans, MRI's, and electroencephalograms.
- Local professional ambulance service. If special hospital treatment requiring special equipment is necessary but not locally available, the Plan also covers transportation within the United States and Canada by professional ambulance, railroad, or scheduled commercial airlines to the nearest hospital equipped to furnish the treatment. This benefit does not apply to transportation necessary to obtain the services of a doctor or any other practitioner.
- Rental (or purchase at the option of the Plan) of a hospital-type bed, wheelchair, iron lung, certain types of traction equipment, and other durable medical equipment as determined by the Plan
- Chemotherapy, radium, radioactive isotopes, and X-ray therapy
- Speech, occupational, and physical therapy visits to restore an attained bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury, when the following conditions are met: 1) the care is ordered by the attending doctor; 2) the doctor identifies the specific professional skills required by the patient and the medical necessity for skilled services; and 3) the doctor indicates the length of time the services are needed.
- Oxygen and rental of equipment for its administration
- Artificial eyes and limbs, to replace natural eyes and limbs
- Blood or blood plasma (when not donated or replaced) and its administration
- Renal dialysis not covered under Inpatient Hospital Benefits
- Psychological testing

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Limited benefits

Cardiac rehabilitation program

After the $300 non-PPO calendar year deductible has been met, the Plan pays **70%** of reasonable and customary charges for up to 90 outpatient visits during the course of a cardiac rehabilitative treatment plan, when those visits consist of outpatient cardiac rehabilitative exercise, education, and counseling. Patients must be diagnosed as having angina pectoris (chest pain) or must have been hospitalized for a diagnosed myocardial infarction (heart attack), or coronary surgery to be eligible for cardiac rehabilitation benefits.

To be covered, services must be provided by an approved hospital-based or hospital-coordinated cardiac rehabilitation program. Cardiac rehabilitation benefits are renewed by further hospital admissions for diagnosed infarctions or coronary surgeries.

Childhood immunizations

Childhood immunizations recommended by the American Academy of Pediatrics are covered for eligible members under age 22.

Smoking cessation benefit

After satisfaction of the $300 non-PPO calendar year deductible, the Plan will pay up to $100 for enrollment in one smoking cessation program per member per lifetime.

What is not covered

- Orthopedic shoes, orthotics and other supportive devices for the feet
- Provocative food testing, end point titration techniques and sublingual allergy desensitization
- Preventive medical care and services, except as shown under the routine services benefit and well child care benefit, (including periodic checkups, associated X-ray and lab tests and immunizations such as polio, flu, mumps, and smallpox shots)
- Chelation therapy, except for acute arsenic, gold, lead or mercury poisoning
- Weight control or any treatment of obesity unless obesity is caused by an organic condition
- Nutritional supplements and vitamins, except B-12 injections for pernicious anemia
- Eye exercises and visual training (orthoptics or visual therapy)
- Eyeglasses, contact lenses, or examinations for them when not specifically covered by this Plan
- Hearing aids and examinations for them, including hearing tests
- Spare eyeglasses, spare contact lenses, replacement eyeglasses, or replacement contact lenses
- Routine mammograms for members under age 35
- Charges for speech therapy, physical therapy, and occupational therapy related to services, treatment, educational testing or training related to learning disabilities or developmental delays.

Additional Benefits

Accidental injury

The Plan pays **100%** of reasonable and customary charges incurred within 72 hours after an accidental injury for initial emergency treatment (other than surgery) provided by a doctor and outpatient services furnished by a hospital. Other Medical Benefits are available for covered services and supplies provided for follow-up care or care provided more than 72 hours after the accident.

Medical emergency

The Plan pays **100%** of reasonable and customary charges for initial treatment in the emergency room of a hospital as a result of a **medical emergency** (as defined on page 41). Other Medical Benefits are available for covered services and supplies that are provided in a doctor's office or are not the result of a medical emergency.

24-hour nurse hot line

The Alliance Health Benefit Plan has made available a program to provide a 24-hour nurse advisory service for your use. You may call toll-free at 1-800/783-2006 and reach registered nurses to discuss an existing medical concern or to receive information on numerous health care issues. This is strictly a voluntary program. To validate eligibility and access this program, you will need to provide your name and health plan identification number.

Chiropractor

The Plan pays **100%** of reasonable and customary charges to a maximum of $225 per calendar year for outpatient services rendered by a licensed chiropractor. No other services of a chiropractor are covered under any other provisions of this Plan.

Home health care

The Plan pays **100%** up to **$40** per visit for up to 60 home health care visits in a calendar year.

A home health care visit consists of:

(1) Less than an 8-hour shift of nursing care; or

(2) One therapy session; or

(3) One social worker visit; or

(4) Less than an 8-hour shift by a home health aide

Covered home health care services are:

- Nursing care provided on a part-time basis (less than an 8-hour shift) by:
  a) a registered nurse (RN); or
  b) a licensed practical nurse (LPN)
- Physical, occupational or speech therapy provided by a licensed therapist
- Services of a licensed social worker (but not more than 2 visits)
- Home health aide services provided on a part-time basis (less than an 8-hour shift) that;
  a) are performed by a home health aide under the supervision of a registered nurse (RN); and
  b) consist mainly of medical care and therapy provided solely for the care of the patient.

The home health care services must be furnished:

a) by a home health care agency (or by visiting nurses where services of a home health care agency are not available);

b) in accordance with a home health care plan, see definition on page 41; and

c) in the patient's home.

Hospice care

What is covered

The Plan will pay **100%** of reasonable and customary charges up to a maximum total payment of $4,500 for hospice care provided and billed by a licensed or certified hospice for a terminally ill patient in the final stages of that illness when such care is recommended by a doctor. This benefit does not apply to services shown as covered under any other provisions of this Plan.

What is not covered

- Bereavement counseling
- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling
- Homemaker or caretaker services

Nursing services

Benefits for services rendered out of a hospital by a registered graduate nurse (R.N.) or a licensed practical nurse (L.P.N.) for private duty nursing are provided for a maximum of 240 units in a calendar year at **100%** up to **$15** per unit. One private duty nursing unit consists of up to one hour of private duty nursing care.

Skilled nursing facilities

If a person is confined in a skilled nursing care facility, the Plan will, for a maximum of 60 days, after the deductible is met, pay **80%** of the reasonable and customary charges of the skilled nursing care facility when:

- The confinement begins within 14 days after a covered hospitalization of at least 3 days;
- The confinement is for the purpose of receiving care for the condition which caused the hospitalization; and
- The confinement is under the supervision of a doctor

Skilled nursing facility benefits shown above will be restored for each new period of confinement. There is a new period of confinement when:

- The provisions for coverage listed above are met; and
- At least 60 days have elapsed since the patient was last confined in a skilled nursing facility.

Well child care

The Plan provides coverage for 12 well child care visits, including doctors' visits and routine (screening) services, for children up to (and including) age 6, when covered under a Self and Family enrollment.

PPO benefit

After a **$10** copay per visit, the Plan pays **100%** of reasonable and customary charges.

Non-PPO benefit

After the $300 non-PPO calendar year deductible has been met, the Plan pays **70%** of reasonable and customary charges.

Immunizations

The Plan will pay **100%** of reasonable and customary charges (not subject to a deductible) for the following immunizations for dependent children under age 22: DPT (diphtheria, tetanus, pertussis vaccine); OPV (oral polio vaccine); Hepatitis B vaccine; Haemophilis influenza type b vaccine (flu shot); MMR (measles, mumps, rubella vaccine); and Td (tetanus diphtheria toxoid booster).

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Prescription Drug Benefits

What is covered

The following medications and supplies, when prescribed by a licensed physician may be purchased from either a retail pharmacy or through the mail service pharmacy:

- Drugs, including those for smoking cessation, that by Federal law of the United States require a doctor's prescription for their purchase
- Insulin
- Diabetic diagnostic supplies used to test blood and urine for glucose levels
- Needles and syringes for the administration of covered medications

What is not covered

- Medical supplies such as dressings and antiseptics
- Medication that does not require a prescription under Federal law even if your doctor prescribes it or a prescription is required under your State law.
- Drugs to aid in smoking cessation except those limited to the $100 lifetime maximum as part of the smoking cessation benefit, see page 22
- Drugs related to treatment of sexual dysfunction, sexual inadequacy or sexual transformation
- Drugs that are investigational or experimental
- Drugs prescribed for weight loss
- Vitamins and nutritional supplements
- Drugs and supplies for cosmetic purposes

From a pharmacy

Annual prescription drug deductible. Under this program, there is a combined annual prescription drug deductible of $200 per covered person (for prescriptions filled through the retail and/or mail service programs).

Participating pharmacies

Your Cost: After the annual prescription drug deductible has been met, you pay a **$10** copay for the initial prescription for up to a 30-day supply of medication (as prescribed by your doctor) and $10 each for the first and second refills. After that, for the third and any subsequent refills, the cost increases to **50%** of Alliance's negotiated price for the medication.

Keeping your costs down: use generic drugs. In addition, if you request a brand name when there is a generic equivalent available and your doctor has not required that the brand name drug be dispensed, you will be required to pay the difference in price between the brand name drug and the generic drug, plus the copayment. Any deductible, copayments or costs you are required to pay if you purchase a brand-name drug when a generic equivalent is available – and your doctor has not indicated that the brand-name drug must be dispensed – will not be reimbursed by the Plan and do not count toward the catastrophic protection benefit.

If your doctor prescribes a medication that will be taken over an extended period, you should request two prescriptions: the first for up to a 30 day supply that can be filled at a local participating pharmacy and second for up to a 90 day supply, plus refills that can be filled through the mail service program. The mail service program offers cost savings on long-term medications.

Waiver

When Medicare Part B is the primary payer, and you use the Plan's mail order drug program or retail prescription drug program, your combined annual $200 drug deductible is waived after you have supplied proof of your Medicare Part B enrollment directly to the Plan.

Prescription drug card program

Under the prescription drug card program you will be issued an Alliance/Paid Prescriptions identification card. Present this card at a participating retail pharmacy whenever purchasing prescription medications. The pharmacist will use an electronic system to verify your eligibility for coverage, and tell you the copayment you will be responsible for paying. To locate a participating pharmacy near your home or workplace, call Member Services at 1-800-346-1321.

Non-participating pharmacy

After a combined (retail and/or mail order) $200 annual prescription drug deductible (per person), you pay a $10 copay per prescription or refill, for the initial 30 day supply and two refills. The third and subsequent refills will require that you pay 50% of the cost of the prescription drug. You will also be responsible for any charges in excess of the participating pharmacy charges. You must pay the full amount of the prescription drug and file a claim to PAID prescriptions, L.L.C., as indicated below.

To claim benefits

If a participating pharmacy is not available where you reside or if you do not use your prescription drug identification card, you must pay in full for your medication, obtain a prescription drug receipt and submit a claim to:

PAID Prescriptions, L.L.C.
P.O. Box 702
Parsippany, NJ 07054-0702

Reimbursement will be based on Plan cost had you used a participating pharmacy. The Alliance's cost represents a negotiated fee. The actual cost to Alliance may be less than the retail price, so your reimbursement may be less.

By mail

The mail service pharmacy program

The Mail Service Pharmacy Program is administered by Merck-Medco Managed Care, L.L.C. through its subsidiaries, PAID Prescriptions, L.L.C and Merck-Medco Rx Services, provider of the mail service pharmacy program. This program is designed for medications you take on a long-term basis.

After satisfying your combined annual $200 per person prescription drug deductible the copayment will be $8 per generic medication and $20 per brand-name medication.

Keeping your costs down: use generic drugs. If you request a brand name when there is a generic equivalent available and your doctor has not required that the brand name drug be dispensed, you will be required to pay the difference in price between the brand name drug and the generic drug plus the $20 brand-name drug copayment. Any deductible, copayments or costs you are required to pay if you purchase a brand-name drug when a generic equivalent is available – and your doctor has not indicated that the brand-name drug must be dispensed – will not be reimbursed by the Plan and do not count toward the catastrophic protection benefit.

To claim your benefits

EasyRx makes it easy to order your medications from Merck-Medco Rx Services.

Here's how: 1) Ask your doctor to prescribe needed medication for up to a 90 day supply of medication, plus refills, if appropriate. (Please note: first time prescriptions will be limited to a 45 day supply). 2) Complete the Patient Profile Questionnaire the first time you order under this program. Mail the questionnaire, your original prescription(s) and the appropriate copayment for each prescription ($8 per generic order, $20 per brand-name medication) to Merck-Medco Rx Services in the special mail order envelope. Be certain to complete all of the information requested on the envelope. 3) Refilling your medication: To be sure you never run short of your prescription medication, you should re-order on or after the refill date indicated on the refill slip or when you have fewer than 14 days of medication left.

To order by phone

Call Member Services at 1-800-346-1321 and use the automated refill system. Have your member ID number and refill slip with the prescription information ready.

To order by mail

Simply mail your prescription or refill slip and copayment in the special order envelope. Send all to:

Merck-Medco Rx Services
P.O. Box 650322
Dallas, TX 75265-0322

If you have any questions about your mail order prescription and to also obtain the names of participating pharmacies call Merck Medco Rx Services toll free at 1-800/346-1321. Service is available from 8:00 a.m. to 8:00 p.m. CST on weekdays and from 8:00 a.m. to 12:00 noon on Saturdays.

To order by Internet

You may order mail service prescriptions or check the status of your mail service prescription, obtain names of participating pharmacies, request prescription drug claim forms and mail service envelopes via the Internet at http://www.merck-medco.com. To check the status of your mail service prescription or to order mail service prescription refills, you must enter your member number and the prescription number. Please have your prescription bottle or refill slip handy when utilizing the Internet.

Waiver

When Medicare Part B is the primary payer, and you use the Plan's mail order drug program or retail prescription drug program, your $200 annual (combined) drug deductible is waived after you supply proof of your enrollment in Medicare Part B directly to the Plan.

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Dental Benefits

What is covered

The following are the dental benefits for In-Network (Preferred Providers) and Out-of-Network (Non-Preferred Providers). For Out-of-Network services, the Plan will pay the indicated coinsurance of the reasonable and customary allowance.

	In-Network (Preferred)	Out-of-Network (Non-Preferred)
Annual Deductible	$0	$25 per individual $50 per family
Services	Plan Pays	Plan Pays
Preventive		
Cleanings	100%	90%
Exams	100%	90%
Fluoride Treatments	100%	90%
Sealants	100%	90%
Diagnostic X-Rays	100%	90%
Basic Restorative Care		
Fillings	80%	70%
Annual Benefit Maximum Per Person (Combined In-Network and Out-of-Network)	$500	$500

Related benefits

Accidental injury

Other Medical Benefits (page 21) are available for dentists' services (including initial replacement, repair and dental X-ray) due to accidental injury to the jaw or sound natural teeth. Services must be received within 12 months from the date of the accident

Oral and maxillofacial surgery

For covered oral surgery, see page 16.

What is not covered

- Dental extractions including the removal of impacted teeth
- All dental services and appliances not listed above
- Periodontal prophylaxis
- Emergency exams
- Charges in excess of the combined annual benefit maximum

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

How to Claim Benefits

Claim forms, identification cards and questions

If you do not receive your identification card(s) within 60 days after the effective date of your enrollment, call the Carrier at 1-800/572-9096, (TDD 302/674-7606) to report the delay. In the meantime, use your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM as proof of enrollment when you obtain services. This is also the number to call for claim forms or advice on filing claims.

If you have a question concerning Plan benefits, contact the Carrier at l-800/321-0347 or you may write to the Carrier at Alliance Health Benefit Plan, 1628 11th Street, NW, Washington, DC 20001. You may also contact the Carrier by fax at 202/939-6389, at its website at http://www.ahbp.com or by e-mail at ahbp@patriot.net.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with providers.

How to file claims

Claims filed by your doctor that include an assignment of benefits to the doctor are to be filed on the form HCFA-1500, Health Insurance Claim Form. Claims submitted by enrollees may be submitted on the HCFA 1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

In addition:

- A copy of the explanation of benefits (EOB) from any primary payer (such as Medicare) must be sent with your claim.
- Bills for private duty nurses must show that the nurse is a registered or licensed practical nurse and must include nursing notes.
- Claims for rental or purchase of durable medical equipment, private duty nursing, and physical, occupational and speech therapy require a written statement from the doctor specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and medicines that are not ordered through the mail order drug program or purchased with the prescription card must include receipts that include the prescription number, name of drug, prescribing doctor's name, date and charge.
- Claims for overseas (foreign) services should include an English translation. Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred.

Canceled checks, cash register receipts or balance due statements are not acceptable.

After completing a claim form and attaching proper documentation, send claims to:

Alliance Health Benefit Plan
Aetna Health Plans
Aetna/US Health Care
P.O. Box 7012
Dover, DE 19903-1512

Records

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

Submit claims promptly

You are strongly encouraged to file your claims within 12 months of the date the service was rendered. All claims must be received by the Plan no later than 24 months after the date of service. Claims for Other Medical Benefits preferably should not be submitted more than once

per month. No claims will be considered if received more than 24 months after the date of service unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. Once benefits have been paid there is a three year limitation on the reissuance of uncashed checks.

If the Plan returns a claim or part of a claim for additional information, it must be resubmitted within 90 days, or within 24 months after the date of service, whichever is later.

A finding of custodial care does not preclude benefits for all covered services and supplies. Some services (such as prescription drugs, X-rays, and laboratory) may still be covered. All bills should be routinely submitted to the Plan for consideration.

Direct payment to hospital or provider of care

Claims for services rendered and submitted by a hospital will be paid directly to the hospital, unless the bill is clearly marked paid, or is accompanied by an official receipt for payment. You may authorize direct payment to any other provider of care by signing the assignment of benefits section at the bottom of the claim form, or by using the assignment form furnished by the provider of care. The provider of care's tax identification number must accompany the claim. The Plan reserves the right to make payment directly to the enrollee and to decline to honor the assignment of payment of any health benefits claim to any person or party.

Submit hospital and doctor bills itemized to show—

- Name of the person for whom service was rendered
- Name of the attending doctor and/or admitting hospital and address
- Date charge was incurred, statement of the diagnosis, treatment rendered and amount of the charge for each service

When more information is needed

Reply promptly when the Carrier requests information in connection with a claim. If you do not respond, the Carrier may delay processing or limit the benefits available.

Confidentiality

Medical and other information provided to the Carrier, including claim files, is kept confidential and will be used only: 1) by the Carrier and its subcontractors for internal administration of the Plan coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education. As part of its administration of the prescription drug benefits, the Plan may disclose information about a member's prescription drug utilization, including the names of prescribing physicians, to any treating physicians or dispensing pharmacies.

Disputed claims review

Reconsideration

If a claim for payment is denied by the Carrier, you must ask the Carrier, in writing and within six months of the date of the denial, to reconsider its decision before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Carrier an opportunity to reconsider your claim. Before you ask the Carrier to reconsider, you should first check with your provider or facility to be sure that the claim was filed correctly. For instance, did they use the correct procedure code for the service(s) performed (surgery, laboratory test, X-ray, office visit, etc.)? Indicate any complications of any surgical procedure(s) performed. Include copies of an operative or procedure report, or other documentation that supports your claim. Your written request to the Carrier must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment should have been paid.

Within 30 days after receipt of your request for reconsideration, the Carrier must affirm the denial in writing to you, pay the claim, or request additional information that is reasonably necessary to make a determination. If the Carrier asks a provider for information it will send you a copy of this request at the same time. The Carrier has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Carrier will base its decision on the information it has on hand.

OPM review

If the Carrier affirms its denial, you have the right to request a review by OPM to determine whether the Carrier's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Carrier's letter affirming its initial denial.

You may also ask OPM for a review if the Carrier fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Carrier. In this case, OPM must receive a request for review within 120 days of your request to the Carrier for reconsideration or of the date you were notified that the Carrier needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the Carrier should have paid the denied claim. If the Carrier has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Carrier's requesting reconsideration;
- A copy of the Carrier's reconsideration decision (if the Carrier failed to respond, provide instead (a) the date of your request to the Carrier, or (b) the dates the Carrier requested and you provided additional information to the Carrier);
- Copies of documents that support your claim (such as doctors' letters, operative reports, bills, medical records, explanation of benefit (EOB) forms); and
- Your daytime phone number.

Medical documentation received from you or the Carrier during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, P.O. Box 436, Washington, DC 20044.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Carrier's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Carrier's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement – If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Carrier to determine if the Carrier has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Carrier in support of OPM's decision on the disputed claim.

Protection Against Catastrophic Costs

Catastrophic protection

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

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

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

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

- Expenses in excess of reasonable and customary charges or maximum benefit limitations;
- Expenses for mental conditions, substance abuse or dental care;
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see pages 32-33).
- PPO office visit copayments;
- Expenses for prescription drugs purchased through retail or mail order program; and
- Expenses for skilled nursing facility confinements.

Carryover

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

Other Information

Information you have a right to know

All carriers in the FEHB Program must provide certain information to you. If you did not receive information about this Plan, you can obtain it by calling the carrier at 1-800/321-0347 or you may write the Carrier at Alliance Health Benefit Plan, 1628 11th Street NW, Washington, DC 20001. You may also contact the Carrier by fax at (202) 939-6389, at its website at http://www.ahbp.com or by email at ahbp@patriot.net.

Information that must be made available to you includes:

- Disenrollment rates for 1997.
- Compliance with State and Federal licensing or certification requirements and the dates met. If noncompliant, the reason for noncompliance.
- Accreditations by recognized accrediting agencies and the dates received.
- Carrier's type of corporate form and years in existence.
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

Precertification

Precertify before admission

Precertification is not a guarantee of benefit payments. Precertification of an inpatient admission is a predetermination that, based on the information given, the admission meets the medical necessity requirements of the Plan. It is your responsibility to ensure that precertification is obtained. If precertification is not obtained and benefits are otherwise payable, benefits for the admission will be reduced by $500.

To precertify outpatient surgery and diagnostic tests

Precertification is required for the following non-emergency outpatient surgeries and diagnostic tests: Bunionectomy, Carpal Tunnel Surgery, Cataract Removal, Colonoscopy, Computerized Axial Tomography (CAT Scan) - Spine, Coronary Angiography, Cystourethroscopy, Dilation/Curettage, Hammertoe Repair, Hemorrhoidectomy, Knee Arthroscopy, Laparoscopy (pelvic), Magnetic Resonance Imaging (MRI)-Knee and Spine, Septoplasty, Strabismus Repair, Tonsillectomy/Adenoidectomy, Tympanostomy, and Upper GI Endoscopy. If precertification is not obtained and benefits are otherwise payable, benefits for these outpatient services will be reduced by $200.

The following steps must be followed to obtain precertification:

- A telephone call must be made to Aetna by you, your representative, your doctor, or your hospital prior to admission, or prior to receiving one of the non-emergency outpatient surgeries or non-emergency outpatient diagnostic tests listed above. The toll-free number is 1-800/572-9096, (TDD 302/674-7606.
- The following information must be provided: enrollee's name and Plan identification number; patient's name, birth date and phone number; reason for hospitalization, outpatient surgery or diagnostic test; proposed treatment; name of hospital (facility); name and phone number of admitting doctor; and, if applicable, number of planned days of confinement.

When the above requirements are met, Aetna will tell the doctor and hospital the number of approved days of confinement for the care of the patient's condition. In the case of a listed outpatient surgery and/or diagnostic test(s), Aetna will tell your doctor or other appropriate provider that the services have been approved for coverage as medically necessary.

Written confirmation of the Carrier's precertification decision will be sent to you and your provider. If it is determined that the length of stay needs to be extended, follow the procedures listed below.

Need additional days?

If any additional days are required, your doctor or the hospital must call 1-800/572-9096 and request certification for the additional days. If any additional days are approved, Aetna will contact your doctor before the certified length of stay ends to determine if you will be discharged on time or if additional inpatient days are medically necessary. If the admission is precertified but you remain confined beyond the number of days certified as medically necessary, the Plan will not pay for charges incurred on any extra days that are determined to not be medically necessary by the Carrier during the claim review.

Other Information *continued*

You don't need to certify an admission when:

- Medicare Part A, or another group health insurance policy, is the primary payer for the hospital confinement (see pages 33-35). Precertification is required, however, when Medicare hospital benefits are exhausted prior to using lifetime reserve days.
- You are confined in a hospital outside the United States and Puerto Rico.
- Medicare Part B is the primary payer for one of the non-emergency outpatient surgeries and/or the outpatient non-emergency diagnostic tests listed on page 32 under "Precertify outpatient surgery and diagnostic tests."
- For non-emergency outpatient surgery or diagnostic tests not listed on page 32.

Maternity or emergency admissions

When there is an unscheduled maternity admission or an emergency admission due to a condition that puts the patient's life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone 1-800/572-9096 within two business days following the day of admission, even if the patient has been discharged from the hospital. Otherwise, inpatient benefits otherwise payable for the admission will be reduced by $500.

Newborn confinements that extend beyond the mother's discharge date must also be certified. You, your representative, the doctor or hospital must request certification for the newborn's continued confinement within two business days following the day of the mother's discharge.

Other considerations

An early determination of need for confinement (precertification of the medical necessity of inpatient admission) is binding on the Carrier unless the Carrier is misled by the information given to it. After the claim is received, the Carrier will first determine whether the admission was precertified and then provide benefits according to all of the terms of this brochure.

If you do not precertify

If precertification is not obtained before admission to the hospital (or within two business days following the day of a maternity or emergency admission or, in the case of a newborn, the mother's discharge), a medical necessity determination will be made at the time the claim is filed. If the Carrier determines that the hospitalization was not medically necessary, the inpatient hospital benefits will not be paid. However, medical supplies and services otherwise payable on an outpatient basis will be paid.

If the claim review determines that the admission was medically necessary, any benefits payable according to all of the terms of this brochure will be reduced by $500 for failing to have the admission precertified.

If the admission is determined to be medically necessary, but part of the length of stay was found not to be medically necessary, inpatient hospital benefits will not be paid for the portion of the confinement that was not medically necessary. However, medical services and supplies otherwise payable on an outpatient basis will be paid.

If you do not precertify the non-emergency outpatient surgeries and/or non-emergency outpatient diagnostic tests listed on page 32, a medical necessity determination will need to be made at the time the claim is filed. If the claim review results in the surgery or test being certified, any benefits payable according to all the terms of this brochure will be reduced by $200 for failing to have one of the listed non-emergency outpatient surgeries and/or the non-emergency outpatient diagnostic tests precertified.

This Plan and Medicare

Coordinating benefits

The following information applies only to enrollees and covered family members who are entitled to benefits from both this Plan and Medicare. You must disclose information about Medicare coverage, including your enrollment in a Medicare prepaid plan, to this Carrier; this applies whether or not you file a claim under Medicare. You must also give this Carrier authorization to obtain information about benefits or services denied or paid by Medicare when they request it. It is also important that you inform the Carrier about other coverage you may have as this coverage may affect the primary/secondary status of this Plan and Medicare (see pages 33-35).

This Plan covers most of the same kinds of expenses as Medicare Part A, hospital insurance, and Part B, medical insurance, except that Medicare does not cover prescription drugs.

The following rules apply to enrollees and their family members who are entitled to benefits from both an FEHB plan and Medicare.

This Plan is primary if:

1) You are age 65 or over, have Medicare Part A (or Parts A and B), and are employed by the Federal Government;

2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are employed by the Federal Government;

3) The patient (you or a covered family member) is within the first 30 months of eligibility to receive Medicare Part A benefits due to End Stage Renal Disease (ESRD) except when Medicare (based on age or disability) was the patient's primary payer on the day before he or she became eligible for Medicare Part A due to ESRD; or

4) The patient (you or a covered family member) is under age 65 and eligible for Medicare solely on the basis of disability, and you are employed by the Federal Government.

For purposes of this section, "employed by the Federal Government" means that you are eligible for FEHB coverage based on your current employment and that you do not hold an appointment described under Rule 6 of the following "Medicare is primary" section.

Medicare is primary if:

1) You are an annuitant age 65 or over, covered by Medicare Part A (or Parts A and B) and are not employed by the Federal Government;

2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are not employed by the Federal Government;

3) You are age 65 or over and (a) you are a Federal judge who retired under title 28, U.S.C., (b) you are a Tax Court judge who retired under Section 7447 of title 26, U.S.C., or (c) you are the covered spouse of a retired judge described in (a) or (b);

4) You are an annuitant not employed by the Federal Government, and either you or a covered family member (who may or may not be employed by the Federal Government) is under age 65 and eligible for Medicare on the basis of disability;

5) You are enrolled in Part B only, regardless of your employment status;

6) You are age 65 or over and employed by the Federal Government in an appointment that excludes similarly appointed nonretired employees from FEHB coverage, and have Medicare Part A (or Parts A and B);

7) You are a former Federal employee receiving workers' compensation and the Office of Workers Compensation has determined that you are unable to return to duty;

8) The patient (you or a covered family member) has completed the 30-month ESRD coordination period and is still eligible for Medicare due to ESRD; or

9) The patient (you or a covered family member) becomes eligible for Medicare due to ESRD after Medicare assumed primary payer status for the patient under rules 1) through 7) above.

When Medicare is primary

When Medicare is primary, all or part of your Plan deductibles and coinsurance will be waived as follows:

Inpatient Hospital Benefits: If you are enrolled in Medicare Part A, the Plan will waive the deductible and coinsurance.

Surgical Benefits: If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance.

Mental Conditions/Substance Abuse Benefits: If you are enrolled in Medicare Part A, the Plan will waive the deductible and coinsurance for inpatient care. If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance for outpatient care.

Other Medical Benefits: If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance for medical benefits. For Prescription Drugs, the Plan will waive the deductible only.

Additional Benefits: If you are enrolled in Medicare Part B, the Plan will waive the $200 annual combined drug deductible under the mail order program or the retail prescription drug program.

When Medicare is the primary payer, this Plan will limit its payment to an amount that supplements the benefits that would be payable by Medicare, regardless of whether or not Medicare benefits are paid. However, the Plan will pay its regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

If you are enrolled in Medicare, you may be asked by a physician to sign a private contract agreeing that you can be billed directly for services that would ordinarily be covered by Medicare. Should you sign such an agreement, Medicare will not pay any portion of the charges, and you may receive less or no payment for those services under this plan.

When you also enroll in a Medicare prepaid plan

When you are enrolled in a Medicare prepaid plan while you are a member of this Plan, you may continue to obtain benefits from this Plan. If you submit claims for services covered by this Plan that you receive from providers that are not in the Medicare plan's network, the Plan will not waive any deductibles or coinsurance when paying these claims.

Medicare's payment and this Plan

If you are covered by Medicare Part B and it is primary, you should be aware that your out-of-pocket costs for services covered by both this Plan and Medicare Part B will depend on whether your doctor accepts Medicare assignment for the claim.

Doctors who participate with Medicare accept assignment; that is, they have agreed not to bill you for more than the **Medicare-approved amount** for covered services. Some doctors who do not participate with Medicare accept assignment on certain claims. If you use a doctor who accepts Medicare assignment for the claim, the doctor is permitted to bill you after the Plan has paid only when the Medicare and Plan payments combined do not total the Medicare-approved amount.

Doctors who do not participate with Medicare are not required to accept direct payment, or assignment, from Medicare. Although they can bill you for more than the amount Medicare would pay, Medicare law (the Social Security Act, 42 U.S.C.) sets a limit on how much you are obligated to pay. This amount, called the **limiting charge**, is 115 percent of the Medicare-approved amount. Under this law, if you use a doctor who does not accept assignment for the claim, the doctor is permitted to bill you after the Plan has paid **only** if the Medicare and Plan payments combined do not total the limiting charge. Neither you nor your FEHB Plan is liable for any amount in excess of the Medicare limiting charge for charges of a doctor who does not participate with Medicare. **The Medicare Summary Notice (MSN) form will have more information about this limit.**

If your doctor does not participate with Medicare, asks you to pay more than the limiting charge **and** he or she is under contract with this Plan, call the Plan. If your doctor is **not** a Plan doctor, ask the doctor to reduce the charge or report him or her to the Medicare carrier that sent you the Medicare MSN form. In any case, a doctor who does not participate with Medicare is not entitled to payment of more than 115 percent of the Medicare-approved amount.

How to claim benefits

In most cases, when services are covered by both Medicare and this Plan, Medicare is the primary payer if you are an annuitant and this Plan is the primary payer if you are an employee. When Medicare is the primary payer, your claims should first be submitted to Medicare. The Carrier has contracted with most Medicare Part B claims processors (also known as carriers) to receive electronic copies of your claims after Medicare has paid their benefits. This means you do not need to submit your Part B claims to the claims processor. Call the Carrier at 1-800/572-9096 to find out if your claims are being filed electronically. If they are not, you should initially submit your claims to Medicare. After Medicare has paid its benefits, the Carrier will consider the balance of any covered expenses. To be sure your claims are processed by this Carrier, you must submit the MSN form from Medicare and duplicates of all bills along with a completed claim form. The Carrier will not process your claim without knowing whether you have Medicare and, if you do, without receiving the Medicare MSN.

Enrollment Information

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Carrier. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Carrier. See "How to claim benefits" on page 28.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits begin on the effective date of your enrollment, as set by your employing office or retirement system (see "Effective date" on page 40). Coverage under your new plan for a hospitalized member may be delayed if you are currently enrolled in another FEHB plan and you or a covered family member are hospitalized on the effective date of your enrollment; see "If you are hospitalized" below.

No FEHB plan may refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan. If you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family

coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.

- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period.

- You will not be informed by your employing office (or your retirement system) or your Carrier when a family member loses eligibility.

- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Carrier does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.

- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.

- Report additions and deletions, including divorces, of covered family members to the Carrier promptly.

- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

  Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

  You may also remain enrolled in this Plan when you join a Medicare prepaid plan. See page 35 for how this Plan's benefits are affected when you are enrolled in a Medicare prepaid plan.

  Contact your local Social Security Administration (SSA) office for information on local Medicare plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she will generally be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

> NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date and coverage may not exceed the 18 or 36-month period noted above.

Notification and election requirements

- **Separating employees** — Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.
- **Children** — You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.
- **Former spouses** — You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child

wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices are available — or chosen — when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier re enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Certificate of Creditable Coverage

Under Federal law, if you are no longer covered by this Plan, you should automatically receive a Certificate of Group Health Plan Coverage from the Plan. This certificate, along with any certificates you receive from other FEHB plans you may have been enrolled in, may reduce or eliminate the length of time a preexisting clause can be applied to you by a new non-FEHB insurer. If you do not receive a certificate automatically, you must be given one on request.

Definitions

Accidental injury

An injury caused by an external force such as a blow or a fall and which requires immediate medical attention. Also included are animal bites, poisonings and dental care required as a result of accidental injury to sound natural teeth. An injury to teeth while eating is not considered to be an accidental injury.

Admission

The period from entry (admission) into a hospital or other covered facility until discharge. In counting days of inpatient care, the date of entry and the date of discharge are counted as the same day.

Assignment

An authorization by an enrollee or spouse for the Carrier to issue payment of benefits directly to the provider. The Carrier reserves the right to pay the member directly for all covered services.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Congenital anomaly

A condition existing at or from birth which is a significant deviation from the common form or norm. For purposes of this Plan, congenital anomalies include protruding ear deformities, cleft lips, cleft palates, birthmarks, webbed fingers or toes and other conditions that the Carrier may determine to be congenital anomalies. In no event will the term "congenital anomaly" include conditions relating to teeth or intra-oral structures supporting the teeth.

Cosmetic surgery

Any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.

Custodial care

Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include but are not limited to:

1) personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;

2) homemaking, such as preparing meals or special diets;

3) moving the patient;

4) acting as companion or sitter;

5) supervising medication that can usually be self administered; or

6) treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

The Carrier determines which services are custodial care.

Durable medical equipment

Equipment and supplies that:

1) are prescribed by your attending doctor;

2) are medically necessary;

3) are primarily and customarily used only for a medical purpose;

4) are generally useful only to a person with an illness or injury;

5) are designed for prolonged use; and

6) serve a specific therapeutic purpose in the treatment of an illness or injury.

Effective date

The date the benefits described in this brochure are effective:

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

Experimental or investigational

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

1) If the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished. Approval means all forms of acceptance by the FDA.

2) An FDA-approved drug, device or biological product (for use other than its intended purposes and labeled indications), or medical treatment or procedure is experimental or investigational if 1) reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis

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

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

Determination of experimental/investigational status may require review of appropriate government publications such as those of the National Institute of Health, National Cancer Institute, Agency for Health Care Policy and Research, Food and Drug Administration and National Library of Medicine. Independent evaluation and opinion by Board Certified Physicians may be obtained for their expertise in subspecialty areas.

Group health coverage

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

Home health care

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

Home health care agency

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

Hospice care program

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

Initial emergency treatment

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

Medical emergency

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

Medically necessary

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

1) are appropriate to diagnose or treat the patient's condition, illness or injury;

2) are consistent with standards of good medical practice in the United States;

3) are not primarily for the personal comfort or convenience of the patient, the family, or the provider;

4) are not a part of or associated with the scholastic education or vocational training of the patient; and

5) in the case of inpatient care, cannot be provided safely on an outpatient basis.

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

Mental conditions/ substance abuse

Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD, to be determined by the Carrier; or disorders listed in the ICD requiring treatment for abuse of or dependence upon substances such as alcohol, narcotics, or hallucinogens.

Reasonable and customary

The Plan allows benefits, unless otherwise indicated, to the extent that they are reasonable and customary. The reasonable and customary charge for any non-PPO service or supply is the charge determined by the Plan on a semiannual basis to be in the 90th percentile of the prevailing charges made for a service or supply by providers in the geographic area where it is furnished. The prevailing charges data is obtained from prevailing health care charge guides such as that prepared by the Health Insurance Association of America (HIAA) and the Plan's underwriter, Aetna US Health Care. In determining the reasonable charge for a service or supply that is unusual, or not often provided in the area, or provided by only a small number of providers in the area, the Plan may take into account factors such as: the complexity; the degree of skills needed; the type of specialty of the provider; the range of services or supplies provided by a facility; and the prevailing charge in other areas. When a PPO provider is used, the fee that has been negotiated between the Plan and the PPO provider is considered the reasonable and customary charge.

Sound natural teeth

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

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, out-of-pocket maximum copay charges, etc. These benefits are not subject to the FEHB disputed claims review procedure.

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

	PLAN FEATURES	NO CLAIM FORMS!
CIGNA Dental Health Dental Plan	No deductibles No maximums 100% Coverage- Diagnostic and Preventive Care (Exams, X-rays, Cleanings) 50%* Coverage- Basic Restorative Care (Fillings, Periodontics, Endodontics, Simple Extractions) 50%* Coverage- Major Restorations (Onlays, Dentures, Crowns, Bridgework) Call 1-800-367-1037	
AFLAC (American Family Life Assurance Company of Columbus)	Accident/Sickness/Disability; Hospital Intensive Care; Cancer Insurance Policy These policies provide benefits paid directly to you, unless assigned, that can help you with your non-medical expenses. Call 1-800-992-3522 and TDD 1-800-622-2345 For policies available to residents of CT, MA, NJ and NY, call 1-800-366-3436 for more information.	
Wal-Mart Pharmacy Mail Services	From the nation's leading discount retailer, discount prescription services for <u>any</u> family member whether or not a dependent. No annual fees or deductibles. Call 1-800-321-0347 for more information.	

Call 1-800/321-0347 for General Information!

BENEFITS ON THIS PAGE ARE NOT PART OF THE FEHB CONTRACT.

Notes

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RI 71-3

How the Alliance Health Benefit Plan Changes January 1999

Do not rely on this page; it is not an official statement of benefits.

Program-wide Changes

The medical management of mental conditions will be covered under this Plan's Other Medical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefit. Office visits for the medical aspects of treatment do not count toward the 30 outpatient Mental Conditions visit limit.

The States designated as medically underserved have changed for 1999. Idaho and North Dakota have been added, and West Virginia is no longer underserved. See page 6 for information on medically underserved areas.

If you are enrolled in Medicare, you may be asked by a physician to sign a private contract agreeing that you can be billed directly for services in amounts exceeding Medicare allowable charges. Should you sign such an agreement, Medicare will not pay any portion of the charges, and you may receive less or no payment for those services under this Plan.

The definition of Experimental or Investigational now applies to Biological Products.

Changes to this Plan

Dental Benefits: The plan now offers a dental PPO benefit which has no annual deductible for In-Network services and a $25 per individual/$50 per family deductible for Out-of-Network services. The annual benefit maximum for combined In-Network and Out-of-Network is $500. In-network services covered at 100% and out-of-network services covered at 90% include cleanings, exams, fluoride treatments, sealants and diagnostic X-rays. In-Network dental fillings are covered at 80% and Out-of-Network fillings are covered at 70%.

Contraceptives: The exclusion for contraceptive drugs and devices has been removed.

Prescription Drug Benefit: The copays for Mail Order prescription drugs are $8 per generic drug and $20 per brand name drug.

Summary of Benefits for Alliance Health Benefit Plan 1999

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). All items below with an (*) are subject to the $100 PPO calendar year deductible. Those items designated with a (+) are subject to the $300 Non-PPO calendar year deductible.

	Benefits	Plan pays/provides	Page
Inpatient care	Hospital	**PPO benefit:** After $150 deductible per admission, **90%** Room and board and other hospital charges **Non-PPO benefit:** After $250 deductible per admission, **70%** Room and board and other hospital charges	12-13
	Surgical	**PPO benefit: 90%*** of reasonable and customary charges **Non-PPO benefit: 70%+** of reasonable and customary charges	14-16
	Medical	**PPO benefit: 90%*** of reasonable and customary charges **Non-PPO benefit: 70%+** of reasonable and customary charges	20-22
	Maternity	Same benefit as for illness or injury	17-18
	Mental Conditions	After you pay the $500 deductible for covered hospital charges per person per confinement, the Plan will pay **80%** of the reasonable and customary charges, for treatment of mental conditions, up to 45 days per person per calendar year	19
	Substance Abuse	100% of charges up to $4,000 maximum benefit for one 30-day inpatient treatment program per calendar year in an approved JCAHO facility, limited to two treatment programs per lifetime	19
Outpatient Care	Hospital	**PPO benefit: 90%*** of reasonable and customary charges **Non-PPO benefit: 70%+** of reasonable and customary charges	14
	Surgical	**PPO benefit: 90%*** of reasonable and customary charges **Non-PPO benefit: 70%+** of reasonable and customary charges	14-16
	Medical	**PPO benefit: 90%*** of covered medical expenses; office visits $10 per visit copay **Non-PPO benefit: 70%+** of covered medical expenses	20-22
	Maternity	Same benefits as for illness or injury	17-18
	Home Health Care	Up to $40 per visit for up to 60 home health care visits in a calendar year	23
	Mental Conditions	50%+ of covered charges up to 30 visits per person each calendar year	19
	Substance Abuse	75%+ of covered charges up to a $4,000 maximum, per person each calendar year	19
Emergency care (accidental injury)		100% of reasonable and customary charges for emergency treatment (other than surgery) by a doctor and outpatient services furnished by a hospital when provided within 72 hours after an accidental injury	23
Prescription drugs	**Retail drug program**	After combined $200 annual drug deductible, member pays a $10 copay for the initial prescription and two refills; 50% of charges for the third and subsequent refills; dispensed up to a 30 day supply per prescription or refill	25-26
	Mail order	After combined $200 annual drug deductible, member pays $8 copay per generic drug, $20 copay per name brand drug. Member may receive a new 45 day supply and subsequent refills of up to a 90 day supply	25-26
Dental care		Dental Benefits: The plan now offers a dental PPO benefit which has no annual deductible for in-network and out of network deductible of $25 per individual and $50 per family. The annual benefit maximum for combined in-network and out-network is $500. Listed In-network services covered at 100% and out-of-network services covered at 90%.	27
Additional benefits		Chiropractic services, Home health care, Hospice care, Nursing services, Well child care, and Skilled nursing facilities	23-24
Protection against catastrophic costs		Plan pays **100%** of reasonable and customary charges if your out-of-pocket expenses under Maternity, Surgical and Other Medical benefits exceed $2,000 under PPO; $3,000 under non-PPO, for Self Only or for Self and Family in a calendar year	31

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Federal Employees Health Benefits Program

1999 Rate Information for

Alliance Health Benefit Plan

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

Postal rates apply to most career U.S. Postal Service employees, but do not apply to non-career Postal employees, Postal retirees, certain special Postal employment categories or associate members of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHB Guide for that category.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	YQ1	72.06	62.36	156.13	135.11	84.98	49.44
Self and Family	YQ2	160.39	124.58	347.51	269.93	183.29	101.68