Alliance Health Benefit Plan
(AHBP)

2000

A Fee-for-Service Plan with a Preferred Provider Organization
Administered by the Alliance Health Benefit Plan

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:

1R1 Self only

1R2 Self and family

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

and

our website at http://www.ahbp.com

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UNITED STATES OFFICE OF
PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE

FEHB
Federal Employees
Health Benefits Program

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Introduction

National Alliance of Postal and Federal Employees, 1628 11th Street NW, Washington D.C. 20001

This brochure describes the benefits you can receive from Alliance Health Benefit Plan under its contract CS1164 with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This plan's medical and prescription drug benefits are administered by First Health with Merck-Medco as the pharmacy mail order provider. This plan's dental benefits are administered by Metlife.

This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. Nothing anyone says can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

Because OPM negotiates benefits and premiums annually they change each year. This brochure describes the only benefits available to you under this plan in 2000. Benefit changes are effective January 1, 2000, and are shown on pages 4-5. You do not have a right to benefits that were available before January 1, 2000 unless those benefits are also contained in this brochure. Premiums are listed at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to Alliance Health Benefit Plan as 'this Plan' throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

Sections one, two, four, and ten are now in plain language, as well as portions of sections three and eight. We will rewrite the remaining sections of this brochure, including the benefits section, for year 2001. Please note that the format and organization of this brochure have changed as well.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

How to use this brochure

This brochure has ten sections. Each section has important information you should read. If you want to compare this Plan's benefits with other benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. Fee-for-Service Plan (FFS). This Plan is a FFS Plan. Turn to this section for a brief description of Fee-for-Service plans and how they work.
2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.
3. How to get benefits. Make sure you read this section; it tells you how to get benefits and how we operate.
4. What if we deny your claim or request for pre-authorization. This section tells you what to do if you disagree with our decision not to pay your claim or to deny your request for a service.
5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.
6. How to file a claim. Look here to find specific information on how to file claims with us.
7. General exclusions - Things we don't cover. Look here to see benefits that we will not provide.
8. Limitations - Rules that affect your benefits. This section describes limits that can affect your benefits.
9. Fee-for-Service facts. This section contains information about pre-certification, protection against catastrophic expenses, and a definition section.
10. FEHB facts. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Fee-for-Service Plans

Fee-for-Service plans reimburse you or your provider for covered services. They do not typically provide or arrange for health care. Fee-for-Service plans let you choose your own physicians, hospitals, and other health care providers.

The FFS plan reimburses you for your health care expenses, usually on a percentage basis. These percentages, as well as deductibles, methods for applying deductibles to families, and the percentage of coinsurance you must pay vary by plan. The type and extent of covered services varies by plan. There is a detailed explanation of the benefits we offer in this brochure; you should read it carefully.

This FFS plan offers a preferred provider organization (PPO) arrangement. This arrangement with health care providers gives you enhanced benefits or limits your out-of-pocket expenses.

Section 2. How we change for 2000

Program-wide Changes

To keep your premium as low as possible OPM has set a minimum copay of $10 for all primary care office visits.

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition or are in the second or third trimester of pregnancy, and your provider is leaving our PPO network at our request without cause, we will notify you. You may continue to receive our PPO level benefits for your specialist's services for up to 90 days after you receive notice. We will provide regular non-PPO benefits for the specialist's services after the 90 day period expires.

You may receive and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to This Plan

Your share of the non-postal premium will decrease by 10.9% for Self-Only or 12.5% for Self and Family.

PPO Network-First Health administers this Plan on behalf of the carrier and is referred to as carrier in this brochure. The Plan has entered into an arrangement with First Health to use the First Health Network, a Preferred Provider Organization (PPO). This PPO operates in 49 states plus Puerto Rico and the District of Columbia.

Surgical Benefits; Assistant Surgeon (inpatient/outpatient)
PPO benefit-After the $100 PPO calendar year deductible has been met, the Plan pays 90% of the assistant surgeon expenses not to exceed 20% of the reasonable and customary charge of the surgical procedure.
Non-PPO benefit-After the $300 non-PPO calendar year deductible has been met, the Plan pays 70% of the assistant surgeon expenses not to exceed 20% of the reasonable and customary charge of the surgical procedure.

Organ/tissue transplant and donor expenses. In a Managed Transplant Network facility, transplants are covered at 90% with travel and donor organ procurement covered to a $10,000 maximum
When a facility in the First Health Network is used for a transplant, the Plan pays 80% for the transplant with a $150,000 maximum for a liver transplant and $100,000 maximum for other transplants. The travel and lodging allowance is not covered.
When a non-PPO facility is used, the Plan pays 70% for the transplant with a $150,000 maximum for a liver transplant and $100,000 maximum for other transplants. Travel and lodging allowance is not covered.

Mental conditions-Inpatient care-After a $500 deductible per person, per confinement, the Plan will pay 80% of the PPO contracted rate for a PPO facility or reasonable and customary charges of a non-PPO facility. Benefits for inpatient mental conditions will be limited to 45 days per person, per calendar year.

Section 2. How we change for 2000 *continued*

Mental conditions-Inpatient visits and Outpatient care; PPO benefit-After the $100 PPO calendar year deductible has been met, doctors' visits (inpatient and outpatient) for treatment of mental conditions are paid at 50% of the PPO contracted rate.
Non-PPO benefit-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 reasonable and customary charges.
The maximum number of doctors' visits (inpatient and outpatient) is limited to 45 visits, PPO and non-PPO combined per person, per calendar year.

Substance abuse Inpatient care-PPO benefit-After the $100 PPO calendar year deductible has been met, the Plan pays 100% of the PPO contracted rate for substance abuse treatment up to $4,000 annually.
Non-PPO benefit-After the $300 non-PPO calendar year deductible has been met, the Plan pays 80% of reasonable and customary charges for substance abuse treatment up to $4,000 annually. Lifetime maximum is 60 inpatient days per person.

Substance abuse Outpatient care-PPO benefit-After the $100 calendar year deductible has been met, outpatient doctors' visits for the treatment of substance abuse are paid at 75% of the PPO contracted rate.
Non-PPO benefit-After the $300 non-PPO calendar year deductible has been met, outpatient doctors' visits for the treatment of substance abuse are paid at 50% of reasonable and customary charges.
The maximum benefit for outpatient doctors' visits for treatment of substance abuse is limited to $4,000 maximum per person per calendar year, PPO and non-PPO combined.

Cardiac Rehabilitation Program-PPO benefit-After the $100 PPO calendar year deductible has been met, the Plan pays 70% of the PPO contracted rate.
Non-PPO benefit-After the $300 non-PPO calendar year deductible has been met, the Plan pays 50% of reasonable and customary charges. There is no limitation on the number of visits covered.

Smoking cessation benefit; PPO benefit-After the $100 PPO calendar year deductible has been met, smoking cessation benefits are limited to $100 for one smoking cessation program per member per lifetime.
Non-PPO benefit-After satisfaction of the $300 non-PPO calendar year deductible has been met, smoking cessation benefits are limited to $100 for one smoking cessation program per member per lifetime.

Medical Emergency-After the $25 copay for an emergency room visit, the Plan pays 100% of the PPO contracted rate or the reasonable and customary charges for the initial treatment in the emergency room of a hospital as a result of a medical emergency (as defined on page 24). Other medical benefits are available for covered services and supplies that are provided in a doctor's office or are not a result of a medical emergency.

Chiropractor; PPO benefit-After the $100 PPO calendar year deductible has been met, the plan pays 90% of the PPO contracted rate.
Non-PPO benefit-After the $300 non-PPO calendar year deductible has been met, the Plan pays 70% of reasonable and customary charges.
Benefits are limited to a maximum of $225 per person per calendar year (PPO and non-PPO combined) for outpatient services.

Prescription Drug Benefit; When Medicare is primary- The waiver of the deductible when Medicare is primary is eliminated. Prescription Drug Benefit; By mail- After satisfying your combined annual $200 per person prescription drug deductible, the Plan pays 80% of the charges per generic or brand name medication.

Pre-admission testing - will be paid as Other Hospital Charges or as Other Medical Benefits, depending on how the testing is billed.

The dental benefit provider for this plan is The Metlife Dental Program.

Section 3. How to get benefits

How do I keep my health care expenses down?

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 benefit packages: precertification of all inpatient admissions and the flexible benefits option. Some include managed care options, such as PPOs, 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 contact First Health before being admitted to a 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 page 12 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.

How much do I pay for services?

You must share the cost of some services. These cost sharing measures include deductibles, coinsurance and copayments. These and other measures are described in more detail below.

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 (pages 12 & 13) and a separate $500 deductible per person per confinement which applies to inpatient hospital charges for the treatment of mental conditions (page 20). There is a combined $200 annual deductible applicable to 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 January 1.

Section 3. How to get benefits *continued*

Family limit

There is a separate calendar year deductible of $100 per person for PPO benefits and a $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:

- **10%** for PPO inpatient hospital room/board, and other hospital charges
- **30%** for non-PPO inpatient hospital room/board, and other hospital charges;
- **10%** for PPO inpatient and outpatient surgical benefits, maternity benefits, and other medical benefits;
- **30%** for non-PPO inpatient and outpatient surgical benefits, maternity benefits, and other medical benefits;
- **20%** for inpatient treatment of mental conditions;
- **50%** for doctors' visits (inpatient and outpatient) for mental conditions;
- **20%** for non-PPO inpatient treatment of substance abuse
- **25%** for PPO outpatient treatment of substance abuse;
- **50%** for non-PPO 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 70% of reasonable and customary charges for a covered service, you are responsible for 30% 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 70% of the allowance ($66.50). You must pay the 30% coinsurance ($28.50), plus the difference between the actual charge and the reasonable and customary allowance ($5), for a total member responsibility of $33.50. Remember, if you use network 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 a $10 per office visit charge at a PPO provider.

If a 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 have 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 30% coinsurance, the actual charge is $70. The Plan will pay $49 (70% of the actual charge of $70).

Lifetime maximums

Benefits for inpatient substance abuse treatment are limited to 60 inpatient days per person per lifetime.

Smoking cessation benefits are limited to $100 for one smoking cessation program per member per lifetime.

Do I have to submit claims?

You usually do not have to submit claims to us if you use preferred providers. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this

Section 3. How to get benefits *continued*

deadline if you show that circumstances beyond your control prevented you from filing on time.

Please see section 6, How to file a claim, for specific information you need to know before you file a claim with us.

Who provides my health care?

In a Fee-for-Service Plan, you may choose any covered facility or provider.

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 the purpose 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 the purpose 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 under-served areas

Within States designated as medically under-served areas, any licensed medical practitioner will be treated as a covered provider for any covered services performed within the scope of that license. For 2000 the States designated as medically under-served are: Alabama, Idaho, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, North Dakota, South Carolina, South Dakota, Utah 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 can 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.

Section 3. How to get benefits *continued*

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 specialty in all areas cannot be 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 towards the bills, and you are responsible for any balance.

This Plan's PPO

The Plan has entered into an agreement with First Health to use The First Health Network, a Preferred Provider Organization (PPO). This is a group of doctors, hospitals and other providers who have contracted with First Health to provide medical services at reduced cost. This PPO operates in 49 states plus Puerto Rico and the District of Columbia. Each time you need medical care you have the choice to use a health care provider who participates in the network or one who doesn't.

When you use a PPO hospital, your benefits increase from 70% after the $250 inpatient deductible to 90% after the $150 inpatient deductible. When you use a PPO doctor, your surgery benefits increase to 90% after a $100 deductible and your office visit benefits increase to paid in full after a $10 copayment. Non-PPO benefits for both are 70% after a $300 deductible. Precertification is required as explained on page 12 for all inpatient hospitalizations. It is your responsibility to complete this prior notification; however, your PPO doctor may initiate precertification and will file your claims for you. Note: PPO benefits are not payable when 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 neither represents a guarantee of professional performance nor constitutes medical advice. The continued availability of any one provider cannot be guaranteed by the Plan. Call 1-800/225-4423 24 hours a day, 7 days a week 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 First Health's web site at http://www.firsthealth.com/MainMenu.hcc?polnum=nap. When you phone for an appointment, please remember to verify that the physician is still a PPO provider.

What do I do if I'm in the hospital when I join this Plan?

First, call our customer service department at 1-800/225-4423. If you are new to the FEHB Program, we will reimburse your covered expenses. If you are currently in the FEHB Program and are switching to us, your former plan will pay for the hospital stay until:

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

These provisions only apply to the person who is hospitalized.

What if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. If it is, you may be able to continue seeing your provider for up to 90 days after you receive notice that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

If you continue seeing your specialist or OB/GYN under these conditions, your cost will be no more than you would normally pay for services covered.

Section 3. How to get benefits *continued*

How do I decide if a service is experimental or investigational?

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 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.

Section 4. What if we deny your claim or request for pre-authorization

What should I do before filing a disputed claim?

Before you ask us to reconsider your claim, you should first check with your provider or facility to be sure that the claim was filed correctly. For instance, did the provider use the correct procedure code for the services performed (surgery, laboratory test, X-ray, office visit, etc.)? Have your provider indicate any complications of any surgical procedures performed. Your provider should also include copies of an operative or procedure report, or other documentation that supports your claim.

If we deny your request for pre-authorization or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing;
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Approve your request for pre-authorization; or
4. Ask for more information

Section 4. What if we deny your claim or request for pre-authorization *continued*

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious life threatening condition and you haven't responded to my request for pre-authorization?

Call us at 1-800/321-0347 and we will expedite our review.

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your request, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's health benefits Contract Division II at (202) 606-3818 between 8 a.m. and 5 p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.
2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

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

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

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

Where should I mail my disputed claim to OPM?

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, P.O. Box 436, Washington, D.C. 20004.

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our decision, your only recourse is to sue.

Section 4. What if we deny your claim or request for pre-authorization *continued*

If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services or supplies.

What laws apply if I file a lawsuit?

Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5 United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. Benefits

Inpatient Hospital Benefits

What is covered

The Plan pays for inpatient hospital services as shown below.

Precertification

You are required to call the **First Health**® OnCall toll-free number, 1-800/225-4423, for all inpatient admissions, including any elective admission to a hospital. The medical necessity of your hospital admission must be certified for you to receive full Plan benefits. You must call the toll-free number when a maternity stay extends beyond 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section delivery. For mental health and substance abuse inpatient admissions the medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive full Plan benefits. You are required to call the toll-free number within 48 hours (2 working days) of any emergency admission, even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See pages 36-37 for details.

Waiver

This precertification 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 or Puerto Rico. For information on when Medicare is primary, see pages 32-34.

Room and board

Semiprivate room accommodations, including general nursing care, meals, and special diets are covered. 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 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.

Section 5. 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
- Pre-admission testing

PPO benefit

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

Non-PPO benefit

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

Limited benefits

Hospitalization for dental work

The Plan pays hospital benefits as shown on pages 12 & 13 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, page 21.

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, page 21.

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 8)
- Custodial care, as defined on page 39
- 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.

Section 5. Benefits *continued*

Surgical Benefits

What is covered

The Plan pays for the following services:

Hospital inpatient

PPO benefit

After the $100 PPO calendar year deductible has been met, the Plan pays **90%** of the PPO contracted rate.

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.

- Surgery by a doctor, surgeon, or licensed podiatrist
- Voluntary sterilization

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

PPO benefit

After the $100 PPO calendar year deductible has been met, the Plan pays **90%** of the PPO contracted rate.

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 are required to call the **First Health**® OnCall toll-free number, 1-800/225-4423, before receiving right-sided heart catheterization.

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 37.

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 patient 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 the PPO contracted rate.

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.

Section 5. Benefits *continued*

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 the assistant surgeon expenses not to exceed 20% of the reasonable and customary charge of the surgical procedure.

Non-PPO benefit

After the $300 non-PPO calendar year deductible has been met, the Plan pays **70%** of the assistant surgeon expenses not to exceed 20% of the reasonable and customary charge of the surgical procedure.

Second opinion (voluntary)

See Other Medical Benefits, page 21.

Ambulatory surgical facility (surgicenter)

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

PPO benefit

After the $100 PPO calendar year deductible has been met, the Plan pays **90%** of the PPO contracted rate.

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 the PPO contracted rate.

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, and expenses for covered organ transplants will be considered expenses of the recipient and will be covered the same as for any other illness or injury. When a **First Health** National Transplant Program facility is used, after the $100 PPO calendar year deductible has been met, the Plan pays 90% of the transplant program contracted rate for a covered surgical transplant. When a **First Health** National Transplant Program facility is not used, but a **First Health** Network facility is used, after the $100 PPO calendar year deductible has been met the Plan pays 80% of the PPO negotiated rate. When a non-PPO facility is used, after the $300 calendar year deductible has been met, the Plan pays 70% of reasonable and customary charges.

This benefit applies only if the recipient is covered by the Plan, and to the extent that the donor's expenses are not covered. (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.)

Covered transplants

When all of the provisions of the **First Health**® National Transplant Program are satisfied, the Plan will provide benefits for the procedures and services listed in this section.

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

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.

Section 5. Benefits *continued*

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.

First Health National Transplant Program

Covered Transplant Services

Pre-transplant evaluation

Organ procurement

Transplant procedures and associated hospitalization

Transplant-related follow-up care provided by the designated transplant hospital for up to 1 year

Pharmacy costs provided by the the **First Health**® National Transplant Program for immunosuppressant and other transplant-related medications while hospitalized

Donor expenses, if not covered under any other plan

Transplant-related services provided by the **First Health**® National Transplant Program facility that are associated with the transplant events listed above, including laboratory and other diagnostic services

Physician services related to the transplant events listed above

Travel and lodging benefit–expenses for the patient/donor and one other individual if the patient/donor lives at least 100 miles from the designated facility. If the patient is a minor, the Plan will consider expenses for two individuals to accompany the patient. Benefits also include travel and lodging to a designated transplant facility for the pre-transplant evaluation. Travel and lodging expenses are covered up to a $10,000 maximum.

Transplant Services not covered

Services, supplies, drugs and aftercare for, or related to, artificial or non-human organ implants or transplants

Services that are considered experimental/investigational or not medically necessary

Expenses for services which are specifically excluded under the Medical Expenses Not Covered section of this plan

Transplants not listed as covered

PPO benefit–not designated as National Transplant Program

If you do not use a **First Health** National Transplant Program facility, but you do use a PPO facility 80% benefits will be applied to your expenses. Total benefit payments, including donor expenses, the transplant procedure itself, and transplant-related follow-up care for one year at the transplant facility will be limited to a maximum payment of $150,000 for a liver transplant and $100,000 for any other transplant. The travel and lodging allowance will not be available. Charges incurred for prescription drugs and follow-up care outside of the transplant facility/hospital will not be counted toward this maximum.

Cornea and pancreas transplants are not available through the **First Health** National Transplant Program; therefore, the Travel/Lodging Benefit is not available.

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 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 pages 15-16. Charges incurred for prescription drugs and follow-up care outside of the transplant facility/hospital will not be counted toward this 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.

Section 5. Benefits *continued*

Precertification

In order to receive benefits for the transplants listed above, you are required to call **First Health**® OnCall at 1-800/225-4423 as soon as the need for a transplant is discussed with your physician. When you call, it will be necessary to provide the program with all information needed to complete the review. In order to receive the highest level of benefits, all transplant-related services must be received at one of the designated hospitals within the **First Health**® National Transplant Program. All covered transplant benefits, including pre-transplant evaluation expenses (even if the transplant does not occur) will be provided by the Plan.

If you do not follow the procedures required by the **First Health**® National Transplant Program, the Plan's co-payment will be reduced to the PPO or non-PPO benefit level for all related covered physician/hospital expenses, after any applicable deductible. Also, no coverage will be provided for transportation or lodging and meal expenses if a transplant procedure is not performed at a **First Health**® National Transplant Program facility. The penalty assessed when you do not follow the procedures required by the **First Health**® National Transplant Program does not apply toward your out-of-pocket maximum.

Travel and lodging

If the recipient lives more than 100 miles from a designated transplant facility, the Plan will provide an allowance for pre-approved travel and lodging expenses up to $10,000 per transplant. The allowance will not be subject to the calendar year deductible or coinsurance. The allowance will provide coverage of reasonable travel and temporary lodging expenses for the recipient and one companion (two companions of the recipient is a minor). Covered travel and lodging expenses will be established by the Plan's case manager during the precertification process. Travel and lodging to a designated facility for the pre-transplant evaluation is covered under this benefit even if the transplant is not eventually certified as medically necessary.

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 **First Health**® National Transplant Program facility, the $100,000/$150,000 maximum will not apply.

What is not covered

Transplants not listed as covered.

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.

Benefits will be provided for breast reconstruction surgery following a mastectomy, including surgery to produce a symmetrical appearance on the other breast. Benefits will be provided for all stages of breast reconstruction following a mastectomy, including treatment of any physical complications, including lymphedemas, and for breast prostheses, including surgical bras and replacements.

Pre-surgical testing

The Plan pays 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, periodontal disease, or disease of gingival tissue

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.

Section 5. Benefits *continued*

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 38), 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.

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 Cesarean 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, should the admission exceed 48 hours after a regular vaginal delivery or 96 hours after a Cesarean delivery, must be precertified for you to receive full Plan benefits. Unscheduled or emergency hospital 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 36 & 37 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.

Specialized maternity services

The primary objective of specialized maternity services is to identify high risk pregnancies to promote positive outcomes for the mother and baby, and to assist in coordinating cost-effective care. You should call **First Health**'s toll-free number, 1-800/225-4423, during the first trimester of your pregnancy. At this time, a nurse will ask you questions about your general health and medical history. This information will be discussed with your physician or practitioner to help determine the risk factor of your pregnancy.

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.

Section 5. Benefits *continued*

If your pregnancy is classified as moderate or high risk, **First Health** will follow your case, recommend specialists and/or facilities when applicable and coordinate communication among you and your health care providers. The specialized maternity program is an optional service provided for your benefit. The Plan's copayment will not be reduced if you choose not to participate in the program. If you participate, you will receive incentives which have been identified by your health plan.

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 at 100% of reasonable and customary charges.

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 21.

Voluntary sterilization

See Surgical Benefits, page 14.

Well child care

See Additional Benefits, page 25.

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

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.

Section 5. Benefits *continued*

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 the PPO contracted rate for a PPO facility or reasonable and customary charges of a non-PPO facility. 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 37 for details.

Inpatient visits and Outpatient care

PPO benefit

After the $100 PPO calendar-year deductible has been met, doctors' visits (inpatient and outpatient) for the treatment of mental conditions are paid at 50% of the PPO contracted rate.

Non-PPO benefit

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 reasonable and customary charges.

The maximum benefit for doctors' visits (inpatient and outpatient) is limited to 45 visits, PPO and non-PPO combined, per person, per calendar year. 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 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 45 outpatient Mental Conditions visit limit.

Notification

In order to maximize your benefit under this Plan, you or your provider should call 1-800/225-4423 to provide notification of outpatient mental health care. Through the notification process, clinical staff is available to help maximize your mental health benefits, help ensure you are receiving medically necessary care as well as inform you of the level of benefit coverage you are eligible for.

Substance abuse

Inpatient Care

PPO benefit

After the $100 PPO calendar year deductible has been met, the Plan pays 100% of the PPO contracted rate for substance abuse treatment up to $4,000 annually.

Non-PPO benefit

After the $300 non-PPO calendar year deductible has been met, the Plan pays 80% of reasonable and customary charges for substance abuse treatment up to $4,000 annually.

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.

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.

Section 5. Benefits *continued*

Outpatient Care

PPO benefit After the $100 PPO calendar year deductible has been met, outpatient doctors' visits for the treatment of substance abuse are paid at 75% of the PPO contracted rate.

Non-PPO benefit After the $300 non-PPO calendar year deductible has been met, outpatient doctors' visits for the treatment of substance abuse are paid at 50% of reasonable and customary charges.

The maximum benefit for outpatient doctors' visits for the treatment of substance abuse are limited to $4,000 maximum per person per calendar year, PPO and non-PPO combined.

Notification

In order to maximize your benefit under this Plan, you or your provider should call 1-800/225-4423 to provide notification of outpatient substance abuse treatment. Through the notification process, clinical staff is available to help maximize your benefits, help ensure you are receiving medically necessary care as well as inform you of the level of benefit coverage you are eligible for.

Lifetime maximum

Benefits for inpatient substance abuse treatment are limited to 60 inpatient days per person per lifetime.

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:

PPO benefit

After the $100 PPO calendar year deductible has been met, the Plan pays **90%** of the PPO contracted rate.

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 19
- 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 the PPO contracted rate for doctors' visits and the routine (screening) services listed below:

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.

Section 5. Benefits *continued*

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 page 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

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

One screening sigmoidoscopy every five years for members age 50 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 the PPO contracted rate.

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

Section 5. Benefits *continued*

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

Limited benefits

Cardiac rehabilitation program

PPO benefit	After the $100 PPO calendar year deductible has been met, the Plan pays 70% of the PPO contracted rate.
Non-PPO benefit	After the $300 non-PPO calendar year deductible has been met, the Plan pays 50% of reasonable and customary charges.

Outpatient visits must 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.

Chiropractor

PPO benefit	After the $100 PPO calendar year deductible has been met, the Plan pays 90% of the PPO contracted rate.
Non-PPO benefit	After the $300 non-PPO calendar year deductible has been met, the Plan pays 70% of reasonable and customary charges.

Benefits are limited to a maximum of $225 per person, per calendar year (PPO and non-PPO combined) for outpatient services rendered by a licensed chiropractor. No other services of a chiropractor are covered under any other provisions of this Plan.

Childhood immunizations

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

Smoking cessation benefit

PPO benefit	After the $100 PPO calendar year deductible has been met, smoking cessation benefits are limited to $100 for one smoking cessation program per member per lifetime.
Non-PPO benefit	After satisfaction of the $300 non-PPO calendar year deductible, smoking cessation benefits are limited to $100 for 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

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.

Section 5. Benefits *continued*

- 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 the PPO contracted rate or 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

After the $25 copay for an emergency room visit, the Plan pays 100% of the PPO contracted rate or 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 40). 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.

Round the clock support

The Alliance Health Benefit Plan has made available a program called **First Health®** OnCall to provide you with round-the-clock support. You may call **First Health®** OnCall's toll-free number, 1-800/225-4423, at any time of the day or night to obtain general health care information or to have your questions about health care issues answered. A nurse will provide you with information about your condition, self-care and, if necessary, suggest the names of network providers from whom you may seek health care.

This 24 hour a day, 7 day a week service is a benefit to you, allowing you to be informed about your health care options. There is no penalty for not using it. This service is not meant to replace physician care. If you require medical care, please be sure to see your *physician or practitioner*.

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 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.

Section 5. Benefits *continued*

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 39; 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 the contracted rate.

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.

Section 5. Benefits *continued*

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 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
- Full range of FDA - approved drugs, prescriptions, and devices for birth control

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 23
- 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

There is no waiver of the $200 deductible for enrollees with Medicare Part B when you use the retail and/or mail order program.

Prescription drug card program

Under the prescription drug card program you will be issued an Alliance/**First Health** Rx 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 and any annual deductible you will be responsible for paying. To locate a participating pharmacy near your home or workplace, call Member Services at 1-800/225-4423.

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 **First Health** Rx as indicated below.

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.

Section 5. Benefits *continued*

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:

Alliance Health Benefit Plan
Prescription Drug Program
First Health Rx
Post Office Box 85042
Richmond, VA 23261-5042

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 subsidiary, 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 Plan will pay 80% of the covered charges per generic medication or per brand name medication.

Keeping your costs down: use generic drugs. If you request a brand name drug 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% coinsurance. 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

It is 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) to Merck-Medco Rx Services in the special mail order envelope. You will be billed for the 20% coinsurance (per generic medication and per brand-name medication). Your billed 20% coinsurance will be due upon receipt. 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 refills 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 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 call First Health Rx Services toll free at 1-800/225-4423. Service is available 24 hours a day, 7 days a week.

To order by Internet

You may order mail service prescriptions or check the status of your mail service prescription, 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

There is no waiver of the $200 deductible for enrollees with Medicare Part B when you use the retail and/or mail order program.

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.

Section 5. Benefits *continued*

Dental Benefits

What is covered

The following are the dental benefits for the Metlife Dental Program 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. For questions regarding dental claims or if you would like to request a listing of providers, please call 1-800/942-0854 for assistance.

	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 22) 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 17.

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.

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 or en español 1-800/742-3522 For policies available to residents of CT, MA, NJ and NY, call 1-800/366-3436 for more information.	
Wal-Mart Pharmacy Mail Services	From the nation's leading discount retailer, discount prescription services for <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.

Section 6. How to file a claim

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 1-800/225-4423 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
First Health
P.O. Box 22410
Tucson, AZ 85734

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.

Section 6. How to file a claim *continued*

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.

Section 7. General exclusions – Things we don't cover

The exclusions in this section apply to all benefits. Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness or condition. The fact that one of our providers has prescribed, recommended, or approved a service or supply does not make it medically necessary or eligible for coverage under this Plan.

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice in the United States;
- Experimental or investigational procedures, treatments, drug or devices;
- 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;
- Procedures, services, drugs and supplies related to sex transformation, sexual dysfunction or sexual inadequacy;
- Services or supplies you receive from a provider or facility barred from the FEHB Program;
- Expenses you incurred while you were not enrolled in this Plan;
- Services and supplies when furnished without charge while in active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories, or possessions or (2) during combat
- Services and supplies when furnished by immediate relatives or household members, such as spouse, parent, child, brother, or sister by blood, marriage or adoption;

Section 7. General exclusions – Things we don't cover *continued*

- Services and supplies when furnished or billed by a non-covered facility, except that medically necessary prescription drugs are covered;
- Services and supplies not specifically listed as covered;
- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copay or coinsurance, the 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 35), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 34), or State premium taxes however applied;
- Biofeedback
- Dental services and appliances (except as specified on page 28)
- 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"; and
- Charges for a stand-by doctor.

Section 8. Limitations – Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office, or call SSA at 1-800/683-6833.

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 page 33).

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.

Section 8. Limitations – Rules that affect your benefits *continued*

The following rules apply to enrollees and their family members who are entitled to benefits from both a 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.

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.

Section 8. Limitations – Rules that affect your benefits *continued*

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 1-800/225-4423 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.

Other group insurance coverage

When anyone has coverage with us and with another group health plan it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary, it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine how much of the charge we will pay for. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge.

Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Section 8. Limitations – Rules that affect your benefits *continued*

When others are responsible for injuries

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

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

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

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

TRICARE

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

Workers' compensation

We do not cover services that:

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

Once the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

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

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.

Limits on your cost if you are 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 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 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.

Section 8. Limitations – Rules that affect your benefits *continued*

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 Alliance Health Benefit Plan at 1-800/321-0347 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 scheduled 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 on the Medicare-approved amount. For instance, under this Plan's surgery benefit, the Plan will pay 70% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 30% 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 1-800/321-0347 for assistance.

Section 9. Fee-for Service facts

Precertification

First Health may review a proposed service to determine whether it is medically necessary. If it is determined to be medically necessary, you and your physician will receive a Notice of Certification. If services are proposed to extend beyond the period for which precertification is given, **First Health** will initiate medical necessity reassessment prior to the receipt of additional services.

You are required to call **First Health**'s toll-free number at 1-800/225-4423 for the following:

All inpatient admissions (other than maternity), including any elective admission to a hospital.

Within 48 hours (2 working days) of any emergency admission.

When a maternity stay extends beyond 48 hours following a normal vaginal delivery or 96 hours following a Caesarean section delivery.

You may call at any time, day or night. When you call, it will be necessary to provide **First Health** with your name, the patient's name, the name of the physician and hospital or facility, the reason for the hospitalization and any other information needed to complete the review. You will be advised if precertification of medical necessity is required for the proposed services. If so, the precertification process will be started immediately. When the above requirements are met, **First Health** will tell the doctor and hospital the number of certified days of confinement for the care of the patient's condition.

Section 9. Fee-for Service facts *continued*

Precertification is not a guarantee that benefits are payable by this plan. Also, precertification does not substitute for filing a claim with the plan, if necessary. Payment of benefits is subject to all plan provisions, limitations and exclusions. In addition, verification of coverage neither fulfills precertification requirements nor guarantees payment of benefits. If you are uncertain about whether precertification is required for proposed services, call **First Health's** toll-free number (1-800/225-4423). It is your responsibility to complete the precertification process. If precertification is not made and benefits are otherwise payable, benefits for the admission will be reduced by $500.

Need additional days?

First Health 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 deemed by the Carrier not to be medically necessary.

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 page 33). 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 or Puerto Rico.

Maternity or emergency admissions

When there is an unscheduled maternity admission that extends beyond 48 hours following a normal vaginal delivery or 96 hours following a caesarean section delivery 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 1-800/225-4423 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 48 hours (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 an 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.

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;

Section 9. Fee-For-Service Facts *continued*

- 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 page 37).
- 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.

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.

Section 9. Fee-For-Service Facts *continued*

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

See page 10.

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.

Section 9. Fee-for Service facts *continued*

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 administrator, **First Health**. 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.

Section 10. FEHB Facts

You have a right to the following information

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov) lists specific types of information that we must make available to you.

If you want specific information about us, call 1-800/321-0347, or write to Alliance Health Benefit Plan, 1628 Eleventh Street NW, Washington D.C 20001. You may also contact us by fax at 202-939-6389, or visit our website at www.ahbp.com.

Where do I get information about enrolling in the FEHB Program?

Your employing or retirement office can answer your questions, and give you a "Guide to Federal Employees Health Benefits Plans", brochures for other plans and other materials you need to make an informed decision about:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;

Section 10. FEHB Facts *continued*

- When your enrollment ends; and
- The next Open Season for enrollment.

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

When are my benefits and premiums effective?

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

What happens when I retire?

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

What types of coverage are available for me and my family?

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

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth or add a child to your family. You may change your enrollment 31 days before to 60 days after you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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

If you or one of your family members is enrolled in one FEHB plan, that person may not enroll in another FEHB plan.

Are my medical records and claims records confidential?

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

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

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

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

Section 10. FEHB Facts *continued*

When you lose benefits

What happens if my enrollment in this plan ends?

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

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

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

What is former spouse coverage?

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your spouse's enrollment. But you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your former spouse's employing or retirement office to get more information about your coverage choices.

What is TCC

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

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

Key points about TCC?

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your cost.
- You receive another 31 day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an individual policy if:

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

Section 10. FEHB Facts *continued*

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

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

How can I get a Certificate of Group Health Plan Coverage?

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

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

Department of Defense/FEHB Demonstration Project

What is the Department of Defense (DoD) and FEHB Program Demonstration Project?

The National Defense Authorization Act for 1999, Public Law 105-261, established the DoD/FEHBP Demonstration Project. It allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years beginning with the 1999 Open Season for the year 2000. Open Season enrollments will be effective January 1, 2000. DoD and OPM have set-up some special procedures to successfully implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is Eligible?

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

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

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

Where are the demonstration areas?

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

When can I join?

Your first opportunity to enroll will be during the 1999 Open Season, November 8, 1999, through December 13, 1999. Your coverage will begin January 1, 2000. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877-DOD-FEHB (1-877-363-3342).

You may select coverage for yourself (self only) or for you and your family (self and family) during the 1999, 2000, and 2001 Open Seasons. Your coverage will begin January 1 of the year following the Open Season that you enrolled.

If you become eligible for the DoD/FEHBP Demonstration Project outside of Open Season, con-

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tact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2000 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHBP Demonstration Project," on the OPM web site at www.opm.gov.

Am I eligible for Temporary Continuation of Coverage (TCC)?

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

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

Do I have the 31-Day Extension and Right To Convert?

These provisions do not apply to the DoD/FEHBP Demonstration Project.

Inspector General Advisory: Stop Health Care Fraud!

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-800/321-0347 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE

202/418-3300
U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington D. C. 20415

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Summary of Benefits for Alliance Health Benefit Plan - 2000

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 PPO contracted rate **Non-PPO benefit:** 70%+ of reasonable and customary charges	14-18
	Medical	**PPO benefit:** 90%* of PPO contracted rate **Non-PPO benefit:** 70%+ of reasonable and customary charges	21-23
	Maternity	Same benefit as for illness or injury	18-19
	Mental Conditions	After you pay the $500 deductible for covered hospital charges per person per confinement, the Plan will pay 80% of the PPO contracted rate for a PPO facility or 80% of reasonable and customary charges of a non-PPO facility, for treatment of mental conditions, up to 45 days per person per calendar year	20
	Substance Abuse	100% of charges up to $4,000 maximum benefit per calendar year in an approved JCAHO facility, limited to a lifetime maximum of 60 inpatient days per person	20
Outpatient Care	Hospital	**PPO benefit:** 90%* of the PPO contracted rate **Non-PPO benefit:** 70%+ of reasonable and customary charges	14
	Surgical	**PPO benefit:** 90%* of the PPO contracted rate **Non-PPO benefit:** 70%+ of reasonable and customary charges	14-18
	Medical	**PPO benefit:** 90%* of covered medical expenses; office visits $10 per visit copay **Non-PPO benefit:** 70%+ of covered medical expenses	21-23
	Maternity	Same benefits as for illness or injury	18-19
	Home Health Care	Up to $40 per visit for up to 60 home health care visits in a calendar year	24
	Mental Conditions	50%* or 50%+ of covered charges up to 45 visits (outpatient and inpatient combined) per person each calendar year	20
	Substance Abuse	75%* or 75%+ of covered charges up to a $4,000 maximum, per person each calendar year	21
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	24
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	26-27
	Mail order	After combined $200 annual drug deductible, member pays 20% coinsurance per generic prescription and per brand name prescription. Member may receive a new 45 day supply and subsequent refills of up to a 90 day supply	26-27
Dental care		Dental Benefits: The plan 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%.	28
Additional benefits		Chiropractic services, Home health care, Hospice care, Nursing services, Well child care, and Skilled nursing facilities	23
Protection against catastrophic costs		Plan pays 100% of reasonable and customary charges if your out-of-pocket expenses exceed $2,000 under PPO; $3,000 under non-PPO, for Self Only or for Self and Family in a calendar year	37-38

Notes

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2000 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. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee, but not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees", RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans".

		Non-Postal Premium				**Postal Premium A**		**Postal Premium B**	
		Biweekly		**Monthly**		**Biweekly**		**Biweekly**	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Self Only	**1R1**	**$78.83**	**$55.59**	**$170.80**	**$120.44**	**$93.06**	**$41.36**	**$93.26**	**$41.16**
Self and Family	**1R2**	**$175.97**	**$109.00**	**$381.27**	**$236.17**	**$207.74**	**$77.23**	**$201.02**	**$83.95**