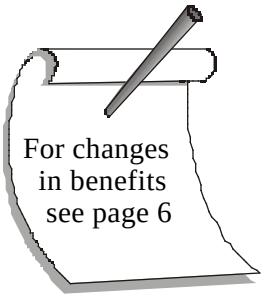
Mercy Health Plans / Premier Health Plans

2000

A Health Maintenance Organization



Serving: East, Central and Southwest Missouri Regions

Enrollment in this Plan is limited; see page 8 for requirements.

Enrollment code:

7M1 Self only
7M2 Self and family

Visit the OPM website at http://www.opm.gov/insure
and
Our website at http://www.mercyhealthplans.com

Authorized for distribution by the:

UNITED STATES OFFICE OF
PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE

RI 73-756

Table of Contents

Introduction

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

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

This brochure describes the benefits you can receive from Mercy Health Plans/Premier Health Plans under its contract RI 73-756 with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. 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.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on page five (5). 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 Mercy Health Plans/Premier Health Plans as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

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

We have not re-written the Benefits section of this brochure. You will find new benefits language next year.

How to use this brochure

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

1. Health Maintenance Organizations (HMO). This Plan is an HMO. Turn to this section for a brief description of HMOs 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 services and how we operate.

4. What to do if we deny your claim or request for service. This section tells you what to do if you disagree with our decision not to pay for 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. General exclusions – Things we don't cover. Look here to see benefits that we will not provide.

7. Limitations – Rules that affect your benefits. This section describes limits that can affect your benefits.

8. FEHB facts. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organizations

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventive care such as routine office visits, physical exams, well-baby care and immunizations, as well as treatment for illness and injury.

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay copayments and coinsurance listed in this brochure. When you receive emergency services or point-of-service benefits (POS) you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital or other provider will be available and/or remain under contract with us. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How we change for 2000

Program-wide changes

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 and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program. (See Section 3, How to get benefits, for more information).

You may review 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

New Benefits

Diabetes Services
Equipment, supplies and self-management training for the management and treatment of diabetes are covered benefits. The Plan covers expenses for nutritional counseling for up to three (3) visits in a calendar year if recommended by a physician and received from a participating provider. Other services which are covered include physician visits, lab work and other testing, glucose monitors, test strips and lancets.

Nutritional Supplements
You will pay a $0 copayment for a thirty (30) day supply of the recommended formula for the treatment of a patient with pheylketonuria (PKU) or any inherited disease of amino and organic acids.

Out-of-Network Benefits
You can access health care from the point-of-service plan. These services are subject to a calendar year deductible, coinsurance copayments and balance billing. (Balance billing refers to the amount billed by a provider that exceeds the usual, customary and reasonable charges allowed for payment by the Plan). Balanced-billed charges are your responsibility along with the annual deductible and coinsurance and do not apply to out-of-pocket maximums. You are responsible for verifying that the required pre-certification is given by the Plan for certain procedures. Please contact Member Services for further details.

If pre-certification is not given, eligible charges will be subject to the non-compliance reduction, and the amount of the reduction will not apply toward your out-of-pocket maximum or deductible.

You will be required to pay a $500 deductible per member per calendar year and $1,000 deductible per family per calendar year. Your cost is 30% coinsurance after the deductible. The out-of-pocket maximum per member is $3,500 (including the deductible) and $7,000 per family (including deductible).

Your share of the standard option Mercy Health Plans/Premier Health Plans 2000 premium will increase by 12.1% for Self Only or 12.1% for Self and Family.

Section 3. How to get benefits

What is this Plan's service area?

To enroll with us, you must live or work in our service area. This is where our providers practice. Our service area is:

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

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

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

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

How much do I pay for services?

You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services, except for those services listed in Section 5 that do not require a copayment.

After you pay $1,100 in copayments or coinsurance for one family member or $3,300 for two or more family members, you do not have to make any further payments for certain services for the calendar year for in-network services. This is called a catastrophic limit. However, copayments or coinsurance for your prescription drugs and dental services do not count toward these limits and you must continue to make these payments.

Be sure to keep accurate records of your copayments and coinsurance, since you are responsible for informing us when you reach these limits.

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us, or you use point-of-service benefits. Services delivered by non-network providers will require you to fill out and submit a claim form for payment and/or reimbursement. Claim forms may be obtained from your employer or from the Plan. You must complete the claim form, attach the itemized bills and mail to Mercy Health Plans/Premier Health Plans, P. O. Box 4568, Springfield, MO 65808-4568. Any claim for reimbursement must be made in writing to the Plan and accompanied

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

Who provides my health care?

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

What do I do if my primary care physician leaves the Plan?

Call us. We will help you select a new one.

What do I do if I need to go into the hospital?

Talk to your Plan physician. If you need to be hospitalized, your primary care physician or specialist will make the necessary hospital arrangements and supervise your care. Hospital services are provided at participating hospitals in the Plan's network.

If you need hospitalization for obstetrical/gynecological related care, your OB/GYN will arrange for your admission to a Plan hospital. If you require special hospitalization that is not available within the Plan network, your PCP will request approval by the Plan's Chief Medical Officer for an appropriate out-of-network hospital. If the request is approved, benefits will be provided as if the hospital were in the network. If the authorization is denied for out-of-network hospitalization, services will be subject to a calendar year deductible, coinsurance and balance billing. Some services are available in-network only and other services require prior authorization.

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

First, call our Member Services department at Mercy Health Plans (Eastern and Central Missouri Regions) at 314-214-8196 or 1-800-327-0763; or Premier Health Plans (Southwest Missouri Region) at 417-836-0402 or 1-800-836-0402.
If you are new to the FEHB Program, we will arrange for you to receive care. 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
- The day your benefits from your former plan run out 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.

How do I get specialty care?

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

If you need to see a specialist frequently because of a chronic, complex or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan. Your Plan physician must authorize visits to specialists.

What do I do if I am seeing a specialist when I enroll?

Your primary care physician will decide what treatment you need. If they decide to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

What do I do if my specialist leaves the Plan?

Call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

But, 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. You may be able to continue seeing your provider for up to 90 days after we notify you 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.

How do you authorize medical services?

Your physician must get our approval before sending you to a hospital, referring you to a specialist or recommending follow-up care. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice.

It is the shared responsibility of both you and your PCP or specialist to assure that referrals are obtained, accurate and current. You are responsible for verifying the approved date range of the referral, number of visits and types of services that have been authorized. When you choose to receive services from a participating provider without a prior referral from your chosen primary care physician, the specialists will request that you be responsible for payment of the services. When this occurs, you may be responsible for the charges. A referral must be obtained prior to receiving certain services.

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

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

The criteria for determining whether or not a procedure or treatment will be considered experimental or investigational includes, but is not limited to the following:

1) whether the patient meets the criteria treatment or other procedure with regard to age, general health and determined to be a good candidate by an accredited facility;
2) whether the procedure or treatment is commonly performed on a widespread geographic basis and/or
3) whether the medical profession generally accepts the procedure or treatment (based on the opinions of organizations such as the American Medical Association).

Appropriate members of the medical profession will review procedures in question for their experimental or investigational nature. A final decision regarding coverage is at the sole discretion of the Chief Medical Officer.

Section 4. What to do if we deny your claim or request for service

If we deny services 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 limit 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. Arrange for a health care provider to give you the service or
4. Ask for more information.

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 or life threatening condition and you haven't responded to my request for service?

Call us at Mercy Health Plans (Eastern and Central Missouri Regions) at 314-214-8196 or 1-800-327-0763; or Premier Health Plans (Southwest Missouri Region) at 417-836-0402 or 1-800-836-0402 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 claim, 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 of service. You may also ask OPM to review your claim if:

1. We did 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 do 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.

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.

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, supplies 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

Summary of Benefits

These services and benefits are only available if they are provided, prescribed or directed by a primary care physician and received at a participating provider. Members are entitled to receive the services and benefits outlined in this Schedule of Coverage and Benefits and other Medically Necessary benefits. This is only a partial listing of plan benefits and their associated copayments.

SERVICES	In-Mercy Network (Member Costs)	Out-of-Network Benefits (Member Costs) Underwritten by First Allmerica
BENEFIT REQUIREMENTS	Benefits are accessed on a referred access basis. All care must be rendered by a network physician or provider and directed by your Primary Care Physician. Precertification required for certain procedures.	Benefits subject to UCR limits. Precertification required for certain procedures. See Out-of Network section for further details.
PLAN MAXIMUMS Medical Benefit Maximum Per Member (While Covered) Calendar Year Deductible - Member (Family) Calendar Year Out-of-Pocket Maximum - Member (Family)	 Unlimited None (None) $1,100 Per Member (3 x Member)	 $2,500,000 $500 (2 x Member) $3,500 Includes Deductible (2 x Member)
MEDICAL SERVICES Services and Supplies	$10 Copayment per visit for Primary care $10 Copayment per visit for Specialist care	30% Coinsurance After Deductible
Surgery performed in a Physician's Office	$0 Copayment	30% Coinsurance After Deductible
Preventive care, including well-baby care and periodic check-ups.	$10 Copayment	Covered In-Mercy Network Only
Immunizations for Children from birth to 5 years	$0 Copayment	Covered In-Mercy Network Only
Office Consultations Non-Participating- (If approved in advance by Mercy Health Plans)	$10 Copayment per office visit	30% Coinsurance After Deductible
Allergy Services - Office Visits - Injections/Treatment - Allergy serum for home administration	 $10 Copayment $0 Copayment $0 Copayment	 30% Coinsurance After Deductible 30% Coinsurance After Deductible 30% Coinsurance After Deductible
Lab and X-ray	$0 Copayment	30% Coinsurance After Deductible
Maternity (includes prenatal, delivery, and postnatal care) - Office Visits (One Time In-Network Copayment) - Lab and Diagnostic	 One time $10 Copayment for all office visits associated with prenatal care during a single pregnancy. $0 Copayment	 30% Coinsurance After Deductible 30% Coinsurance After Deductible
INPATIENT HOSPITAL SERVICES	$0 Copayment per admission	30% Coinsurance After Deductible
OUTPATIENT SERVICES Emergency Care - Service and Supplies	$50 Copayment per visit, except Copayment charge will be waived when inpatient admission for the same condition occurs within 24 hours	$50 Copayment per visit, except Copayment charge will be waived when inpatient admission for the same condition occurs within 24 hours
Non-Emergency Services - Outpatient Surgery - Diagnostic tests	 $0 Copayment $0 Copayment	 30% Coinsurance After Deductible 30% Coinsurance After Deductible

SERVICES	In-Mercy Network (Member Costs)	Out-of-Network Benefits (Member Costs) Underwritten by First Allmerica
Urgent Care	$25 Copayment per visit	Covered In-Mercy Network only
Outpatient Rehabilitative Therapy Services: Physical, Occupational, Speech	$10 Copayment (Max. of up to 60 consecutive days per calendar year, per condition)	30% Coinsurance After Deductible (Max. of up to 60 consecutive days per calendar year, per condition)
MENTAL HEALTH/ALCOHOLISM/ CHEMICAL DEPENDENCY	In Eastern and Central Missouri, you must obtain authorization prior to service by calling 1-800-413-8008	
Outpatient Mental Health Services (Maximum of up to 20 visits per calendar year)		
- Individual Outpatient Services	$20 Copayment per session	Covered In-Mercy Network only
- Group Outpatient Services	$10 Copayment per session	Covered In-Mercy Network only
Outpatient Substance Abuse (Maximum of up to 20 visits per calendar year)		
- Individual Outpatient Services	$20 Copayment per session	Covered In-Mercy Network only
- Group Outpatient Services	$10 Copayment per session	Covered In-Mercy Network only
Inpatient Mental Health Services	$0 Copayment per admission	Covered In-Mercy Network only
Inpatient Alcoholism and Chemical Dependency Services (Maximum of up to 2 episodes of inpatient services per calendar year).	$0 Copayment per admission	Covered In-Mercy Network only
MISCELLANEOUS COVERED SERVICES		
Home Health Agency Services (includes intravenous fluids and medications)	$0 Copayment	30% Coinsurance After Deductible;
Skilled Nursing Facility Services	$0 Copayment	30% Coinsurance After Deductible
Hospice Services	$0 Copayment	Covered In-Mercy Network Only
Ambulance	$0 Copayment	30% Coinsurance After Deductible
Prosthetic Equipment (insertion of internal and external prosthetic devices such as pacemakers and artificial joints)	20% Copayment	30% Coinsurance After Deductible
Durable Medical Equipment and Supplies	$0 Copayment	30% Coinsurance After Deductible
Diabetes Services	Copayment consistent with type of service required	30% Coinsurance After Deductible
Transplant Services - Specialist office visits	$0 Copayment $10 copay	Covered In-Mercy Network Only
Dialysis	$0 Copayment	Covered In-Mercy Network Only
Mammography (routine screening and when prescribed by the doctor as medically necessary to diagnose or treat illness)	$0 Copayment	Covered In-Mercy Network Only
Eye Care Services	$10 Copayment - One eye exam and/or eye refraction performed by a Participating Provider during calendar year.	Covered In-Mercy Network Only
Nutritional Supplements	$0 Copayment for 30 day supply	30% Coinsurance After Deductible

Mercy Health Plans / Premier Health Plans, 2000

SERVICES	In-Mercy Network (Member Costs)	Out-of-Network Benefits (Member Costs) Underwritten by First Allmerica
Accidental Dental	20% Copayment	30% Coinsurance After Deductible
Voluntary sterilization and family planning services	$10 Copayment	Covered In-Mercy Network Only
Mastectomies (Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure)	$0	30% Coinsurance After Deductible
Chemotherapy, radiation therapy, and inhalation therapy	$0	Covered In-Mercy Network Only
Surgical treatment of morbid obesity	$0	30% Coinsurance After Deductible
Chiropractic services	$10 office visit - referrals required for Eastern and Central Missouri regions	Covered In-Mercy Network Only
Private Duty Nursing	20% of covered charges	Covered In-Mercy Network Only
Eyewear Following Cataract Surgery	Initial pair of lenses or glasses following cataract surgery; 20% of charges	30% Coinsurance After Deductible
Infertility Services	$10 Copayment per visit for the diagnosis of infertility. Diagnosis and treatment of infertility and intravaginal artificial insemination (IVI) is covered. Member pays 50% of the first $5,000 of the customary rate of approved charges, charges in excess of the customary rate, and 100% of the charges for infertility services over $5,000.	Covered In-Mercy Network Only
Outpatient Prescription Drug Generic Brand Name Mail-Order	Filled at PCS Network Pharmacies · $7 Copayment per prescription drug on Formulary · $12 Copayment per prescription drug on Formulary · 2 copayments for a 90 Day Supply	 Covered in PCS Network Only Covered in PCS Network Only Covered in PCS Network Only

The following provides more detailed information about your benefits:

Medical and Surgical Benefits

Limited Benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Transplants are covered in-network only when approved by the Medical Director and include: cornea, heart, kidney and liver transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. You pay $10.00 for all specialist office services.

Reconstructive surgery following sickness and correction of functional birth defects are not cosmetic and expenses for such are covered by the Plan. Also covered by the Plan is reconstructive surgery or treatment to remedy a deformity, disfigurement or defect resulting from a disease, injury (sustained while covered by the Plan) or congenital anomaly. An anomaly is defined as a marked deviation beyond the range of normal human variation.

A patient and her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.

Augmentation mammoplasty is covered if performed following: surgical removal of a breast because of breast cancer, any breast cancer prevention intervention (in accordance with Plan guidelines) or other illness or to correct asymmetrical breasts resulting from such mastectomies. This service is covered whether provided at the time of the original mastectomy or after the completion of radiation or other therapies. Coverage for post-mastectomy breast prostheses includes one (1) prosthesis (per breast removed) and 2 bras per calendar year. You will pay a $0 copayment for in-network services or 30% coinsurance after deductible and any amounts over usual and customary charges for out-of-network benefits.

Short-term rehabilitative therapy (physical, speech, occupational, pulmonary and cardiac) is provided on an inpatient or outpatient basis for up to 60 consecutive days per calendar year per condition for care that is reasonably expected to result in a material improvement in the physical functioning of the member within a 60-day period. All therapy must be medically necessary and restorative to an injury or illness suffered by the member. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and

maintain self-care and improved functioning in other activities of daily living. You pay $10 copayment per outpatient session.

Diagnosis and treatment of infertility is covered; you pay a $10 copay per visit for the diagnosis of infertility. In addition, intravaginal artificial insemination (IVI) is a covered benefit — you pay 50% of the first $5,000 of the customary rate of approved charges, charges in excess of the customary rate and 100% of the charges for infertility services over $5,000. The cost of donor sperm and fees for preparation and storage of sperm are not covered. Fertility drugs are not covered. Other assisted reproductive technology (ART) procedures, such as in vitro fertilization and embryo transfer are not covered.

Services and supplies that are not Covered Benefits

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending camp or travel
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purpose
- Homemaker services
- Hearing aids
- Transplants not listed as covered
- Long-term rehabilitative therapy
- Orthopedic shoes and other supportive appliances (orthotics) for the feet
- Blood and blood derivatives not replaced by the member

Hospital/Extended Care Benefits

Hospital Care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. You pay nothing. All necessary services are covered, including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care
- Specialized care units, such as intensive care or cardiac care units

Extended Care

The Plan provides a comprehensive range of benefits when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. You pay nothing. All necessary services are covered, including:

- Bed, board and general nursing care
- Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor

Hospice Care

Supportive and palliative care for a terminally ill member is covered in the home or a hospice facility. Services include inpatient and outpatient care and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance Service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor.

Limited Benefits

Dental Anesthesia: Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition. The Chief Medical Officer or his designee must approve all requests and prior authorization is required.

Hospitalization for medical treatment of substance abuse is limited to emergency care and medical management of withdrawal symptoms.

What is not covered during a hospital stay*:*

- Personal comfort items, such as telephone and television
- Blood and blood derivatives not replaced by the member
- Custodial care, rest cures, domiciliary or convalescent care

Emergency Benefits

The Plan has adopted the following definition for "Emergency Medical Condition":

The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate care is required, which may include, but shall not be limited to:

a. placing the person's health in significant jeopardy;
b. serious impairment to a bodily function;
c. serious dysfunction of any bodily organ or part;
d. inadequately controlled pain;
e. pregnant women having contractions and/or
f. injury to self or others.

If you are in an emergent or urgent situation, if possible call your Plan physician immediately. If the emergency is so urgent that failure to get immediate medical attention could be life threatening or cause serious harm, go immediately to the nearest emergency facility.

Once an urgent or life-threatening situation has been brought under control, you will need to call your Plan physician within 48 hours or as soon as reasonably possible, so that any continued care can be arranged and authorized. If you do not report emergency treatment with 48 hours or as soon as reasonably possible thereafter, care provided after that point may not be covered.

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

The Plan pays reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay $50 copayment per hospital emergency room visit or $25 copayment per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the copay is waived.

Emergencies outside the service area

If you need to be hospitalized, call Member Services as soon as possible. Member Services will notify your Plan physician and arrange to have your medical records shared with the attending physician.

Arrangements will be made for you to be transferred to the care of a Plan doctor and hospital when it is medically appropriate. Your Plan physician will coordinate all follow-up care upon return to the area.

If follow-up care is required outside the area, you must contact your Plan physician within 48 hours to receive authorization for the continued care.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

The Plan pays reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay $50 per hospital emergency room visit or $25 per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the copay is waived.

What is covered

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service approved by the Plan

What is not covered

- Elective care or nonemergency care
- Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area

Mental Conditions/ Substance Abuse Benefits (in-network only)

Mental Health

To the extent shown below, the Plan provides the following services if deemed medically necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorder.

What is Covered

- Psychological testing
- Psychiatric treatment (including individual and group therapy)

- Diagnostic evaluation
- Hospitalization (including inpatient professional services)
- Care for psychiatric conditions that in the professional judgement of Plan doctors are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate

Outpatient care is covered up to a combined total of 20 outpatient visits per calendar year for covered services obtained from a Plan physician and authorized in advance. You pay a $20 copay per session for individual services and a $10 copay per session for group services.

Diagnosis and treatment of inpatient and outpatient services for mental health and chemical dependency is covered. You pay nothing.

Substance Abuse (in-network only)

This Plan provides medical necessary substance abuse services (including detoxification).

Inpatient services for detoxification are limited to two episodes of inpatient services per calendar year, unless authorized in advance by the Chief Medical Officer. This limitation shall not apply to medical complications of detoxification.

Outpatient care is covered up to a combined total of 20 outpatient visits per calendar year for covered services obtained from a Plan physician and authorized in advance. You pay a $20 copay per session for individual services and a $10 copay per session for group services.

Services for detoxification limited to no more than 5 consecutive days unless authorized in advance by the Chief Medical Officer. You pay nothing.

Treatment that is not authorized by a Plan doctor is not covered.

Prescription Drug Benefits

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply or one vial of insulin. Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. "Formulary" is the list of drugs approved for use in connection with specific conditions. You pay a copayment of $7 in the case of a generic drug dispensed in accordance with the formulary or a copayment of $12 in the case of a brand name drug dispensed in accordance with the formulary.

If your physician prescribes a brand name drug when a generic substitute is available or if you choose to receive the brand drug, you will be responsible for the generic copayment plus the cost difference between the "brand" and the "generic" name drug.

No benefits are available for non-formulary products.

Covered medications and accessories include:

- Drugs for which a prescription is required by Federal law

- Oral contraceptive drugs; contraceptive diaphragms
- Insulin: a copay charge applies to each vial
- Disposable needles and syringes needed to inject covered prescribed medication
- Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape, Benedict's solution or equivalent, glucose monitors and acetone test tablets
- Mail service prescription drug program allows you and your dependents to obtain covered prescriptions through Walgreens Healthcare Plus mail service pharmacy. You are allowed up to a 90-day supply. Each mail service prescription will be subject to a copayment equal to two times the retail copayment. This copayment applies to both generic and brand name drugs. If your physician prescribes a brand name drug when a generic substitute is available or if you choose to receive the brand drug (with the approval of your physician), you will be responsible for the higher and the generic name drug. All brand copayments plus the cost difference between the brand name mail orders are to Walgreens Healthcare Plus, P. O. Box 29061, Phoenix, AZ 85038-9061.

Intravenous fluids and medication for home use, implantable drugs, such as Norplant, and some injectable drugs, such as Depo Provera, are covered under Medical and Surgical Benefits.

What is not covered

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

Other Benefits

Dental Care

Expenses incurred to natural teeth in connection with an accidental injury. Coverage is limited to damage from external trauma to face and mouth. All services must be provided within six months from the date of the accidental injury. You pay a 20% copayment and any expenses above the customary rate. All services must be obtained from a Plan physician.

Unless shown in this section, other dental services are not covered.

Dental Services

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

- No claim forms to file. You pay only the copay shown in the schedule of benefits at the time of service.

- To receive significant savings from a participating dentist, merely show your CAREington membership card at each visit and you will receive the discount.
- CAREington only contracts with dentists who meet their credentialing criteria and must continue to meet the high standards of quality established.

Vision Care

In addition to the medical and surgical benefits provided for the diagnosis and treatment of diseases of the eye, annual eye refractions (to provide a written lens prescription for eyeglasses or contact lenses) may be obtained from Plan providers; you pay a $10 copay.

Orthoptics (vision exercises and training), or any supplemental testing is not covered.

Out-of-Network-Benefits

You can access health care from the point-of-service plan. These services are subject to a calendar year deductible, coinsurance copayments and balance billing. (Balance billing refers to the amount billed by a provider that exceeds the usual, customary and reasonable charges allowed for payment by the Plan). Balanced-billed charges are your responsibility along with the annual deductible and coinsurance and do not apply to out-of-pocket maximums. You are responsible for verifying that the required pre-certification is given by the Plan for certain procedures. Please contact Member Services for further details. If pre-certification is not given, eligible charges will be subject to the non-compliance reduction, and the amount of the reduction will not apply toward your out-of-pocket maximum or deductible.

You will be required to pay a $500 deductible per member per calendar year and $1,000 deductible per family per calendar year. Your cost is 30% coinsurance after the deductible. The out-of-pocket maximum per member is $3,500 (including the deductible) and $7,000 per family (including deductible).

What is not covered

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

- Non-symptomatic Mammography Services
- Any types of services, supplies or treatment not specifically provided for herein

Section 6. General exclusions -- Things we don't cover

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

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;
- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits) or eligible self-referred services (see Out-of-Network benefits);
- Experimental or investigational procedures, treatments, drugs or devices;
- Services provided in connection with the reversal of an elective sterilization procedure, or an abortion, except where the life or health of the mother is in jeopardy;
- Services provided by a first degree relative;
- Procedures, services, drugs and supplies related to sex transformations;
- Services provided in connection with treatment or surgery to change gender or restore sexual function;
- Services or supplies you receive from a provider or facility barred from the FEHB Program and
- Expenses you incurred while you were not enrolled in this Plan.

Section 7. 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 we 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 request it from SSA at 1-800/638-6833.

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 what the reasonable charge for the benefit should be. 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. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember, even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Circumstances beyond our control

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. We will cover the cost of treatment that exceeds the amount you received in the settlement. If you do not seek damages, you

must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

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.

Section 8. FEHB FACTS

You have a right to information about your HMO.

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 the specific types of information that we must make available to you.

If you want specific information about us, call Mercy Health Plans (Eastern and Central Missouri Regions) 314/214-8196 or 1-800-327-0763; Premier Health Plans (Southwest Missouri Region) 417-836-0402 or 1-800-836-0402 or write to the Plan at:

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

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

You may also contact Mercy Health Plans (Eastern and Central Missouri Regions) by fax at 314-214-8102 or Premier Health Plans (Southwest Region) by fax at 417-836-0457, or visit our website at www.mercyhealthplans.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;
- 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 my family and me?

Self-Only coverage is for you alone. *Self and Family* coverage is for you, your spouse and your unmarried dependent children under age 22, including any foster 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 is incapable of self-support.

If you have a Self-Only enrollment, you may change to a Self and Family enrollment if you marry, give birth or add a child to your family. You may change your enrollment 31 days before to 60 days after 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 be enrolled in another FEHB plan.

Are my medical 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 subcontractors when they administer this contract;
- 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.

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 former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get 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 costs;
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium and
- 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 or
- 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 that 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.

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.

Inspector General Advisory: Stop Health Care Fraud!

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call Mercy Health Plans (Eastern and Central Missouri Regions) at 314-214-8196 or 1-800-327-0763 or Premier Health Plans (Southwest Missouri Region) at 417-836- 0402 or 1-800-836-0402 and explain the situation.
- If we do not resolve the issue, call 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 Mercy Health Plans/Premier Health Plans - 2000

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the 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 SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY A PRIMARY CARE PHYSICIAN AND RECEIVED AT A PARTICIPATING PROVIDER.**

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** nothing.	18
	Extended care	All necessary services. **You pay** nothing	18
	Mental conditions	Diagnosis and treatment of inpatient and outpatient services for mental health dependency. **You pay** nothing	20
	Substance abuse	Services for detoxification limited to no more than five consecutive days unless authorized in advance by the Chief Medical Officer. **You pay** nothing.	21
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care (in-network only), well-baby care, periodic check-ups, laboratory tests and X-rays and complete maternity care (one time copay). **You pay** a $10 copay per office visit.	18
	Home health care	All necessary visits by skilled nursing professional services when medically necessary. **You pay** nothing.	18
	Mental conditions	Up to a combined total of 20 outpatient visits per calendar year for covered services obtained from a Plan physician and authorized in advance. **You pay** a $20 copay per session for individual services and a $10 copay per session for group services.	20
	Substance abuse	Up to a combined total of 20 outpatient visits per calendar year for covered services obtained from a Plan physician and authorized in advance. **You pay** a $20 copay per session for individual services and a $10 copay per session for group services.	21

Emergency care	Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $50 copay per visit for each emergency room visit. The copayment charge is waived when admitted on an inpatient basis for the same condition within 24 hours. 19
Prescription drugs	Drugs prescribed by a Plan doctor or a referral doctor and obtained at a Plan pharmacy. **You pay** a $7 copay for generic or a $12 copay for brand name drug that is included on the formulary. 21
Dental care	Expenses incurred to natural teeth in connection with an accidental injury. **You pay** a 20% Copayment. 22
Vision care	One eye examination annually. **You pay** a $10 Copay. . . . 23
Out-of-pocket maximum (in-network)	Copayments are required for various benefits; After your out-of-pocket expenses reach a maximum of $1,100 per Self Only or $3,300 per Self and Family during a calendar year, covered benefits will be provided at 100%. 14
Out-of-Network Benefits	You will be required to pay a $500 deductible per member per calendar year and $1,000 deductible per family per calendar year. Your cost is 30% coinsurance after the deductible. The out-of-pocket maximum per member is $3,500 (including the deductible) and $7,000 per family (including deductible). . . 23

2000 Rate Information for Mercy Health Plans of Missouri (Premier Health Plans in SW Missouri)

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	**7M1**	**$74.10**	**$24.70**	**$160.55**	**$53.52**	**$87.69**	**$11.11**	**$87.69**	**$11.11**
Self and Family	**7M2**	**$172.36**	**$57.45**	**$373.44**	**$124.48**	**$203.96**	**$25.85**	**$201.02**	**$28.79**