Alliance Health Benefit Plan

2003

http://www.ahbp.com

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

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

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

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

Annuitants (retirees) may enroll in this plan.

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

Enrollment codes for this Plan:

1R1 Self Only
1R2 Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

FEHB
Federal Employees Health Benefits Program

RI 71-003

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

Kay Coles James
Director

Notice of the Office of Personnel Management's

Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.

- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice within 60 days of the change. The privacy practices listed in this notice will be effective April 14, 2003.

Table of Contents

Introduction

This brochure describes the benefits of the Alliance Health Benefit Plan under our contract CS 1164 with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by the Alliance Health Benefit Plan. The address for the Alliance Health Benefit Plan administrative office is:

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

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and changes are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance "you" means the enrollee or family member; "we" means the Alliance Health Benefit Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (FEHB) Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
    - Call the provider and ask for an explanation. There may be an error.
    - If the provider does not resolve the matter, call us at 1/800-321-0347 and explain the situation.
    - If we do not resolve the issue:

CALL -THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415.

- Do not maintain as a family member on your policy:
    - your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
    - your child over age 22 (unless he/she is disabled and incapable of self support)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed or with OPM if you are retired.
    - You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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

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

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

We also have a Preferred Provider Organization (PPO):

Our fee-for-service plan offers services through a PPO. When you use our PPO providers, you will receive covered services at reduced cost. The Alliance Health Benefit Plan is solely responsible for the selection of PPO providers in your area. Contact us for the names of PPO providers and to verify their continued participation. You can also go to our web page, which you can reach through the FEHB web site, www.opm.gov/insure. Contact the Alliance Health Benefit Plan to request a PPO directory.

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

How we pay providers

This Plan has a Preferred Provider Organization (PPO). This is a group of doctors, hospitals and other providers who have contracted to provide medical services at reduced cost. This PPO operates in 50 states, 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 $200 deductible and your office visit benefits increase to paid in full after a $15 copayment. Non-PPO benefits for both are 70% after a $400 deductible. Precertification is required as explained on pages 9 and 10 for all inpatient hospitalizations. It is your responsibility to complete this prior notification; however, your PPO doctor may initiate precertification and will file your claims for you. Note: PPO benefits are not payable when the Alliance Health Benefit Plan is not the primary payer.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

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

If you want more information about us, call 1/800-321-0347 or for calls in the Washington, DC metropolitan area (202) 939-6325, or write to Alliance Health Benefit Plan, 1628 11th Street NW, Washington, DC 20001. You may also contact us by fax at 202-939-6389 or visit our website at http://www.ahbp.com.

Section 2. How we change for 2003

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- A notice of the Office of Personnel Management's Privacy Practices is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised.
- The Medically Underserved section is revised.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

Changes to this Plan

- Your share of the non-postal premium will increase by 20.4% for Self Only or 21.5% for Self and Family.
- The Plan will now use PHCS as its PPO Network instead of the First Health Network.
- Your share of the calendar year PPO deductible has increased to $200 per individual, $600 per family and your share of the calendar year Non-PPO deductible has increased to $400 per individual, $1200 per family.
- Your share of the catastrophic protection out-of-pocket maximum for PPO has increased to $3,000 per individual/per family and your share of the catastrophic protection out-of-pocket maximum for Non-PPO has increased to $4,000 per individual/per family.
- Your share of the emergency room co-payment has increased to $50 per visit.
- Your share of the retail prescription drug benefit, after the combined annual $200 deductible, has increased to 10% for the initial fill of a generic prescription and 15% for the initial fill of a brand name prescription and 50% coinsurance for each refill. Your share of the mail order prescription drug benefit has also increased to 20% for generic prescriptions and 25% for brand name medications.
- Your share of the Plan allowance for Non-PPO benefits will be based on the 80th percentile. Previously the Plan allowance was based on the 90th percentile.
- The Plan has eliminated the $100 PPO calendar year deductible, the $300 Non-PPO calendar year deductible, the $150 PPO per admission inpatient hospital copayment, and the $250 Non-PPO per admission inpatient hospital copayment from counting toward the catastrophic protection out-of-pocket maximum.
- The Plan has added the Blood Cholesterol screening (a fasting lipoprotein profile) once every 5 years for adults age 20 and over.
- The Plan has added a screening colonoscopy once every 10 years at age 50.
- The Plan has clarified that in network mental health professional services, preventive care (routine screenings) for adults, and home health nursing services are not subject to the calendar year deductible.
- The Plan has clarified that the 45 annual visits are combined for physical and occupational therapy services.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1/800-321-0347, or write to us at 1628 11th Street NW, Washington, DC, 20001. You may also request replacement cards through our website: http://www.ahbp.com.

Where you get covered care

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

• Covered providers

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

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

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

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are "medically underserved." For 2003, the states are: Alabama, Idaho, Kentucky, Lousiana, Maine, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, Texas, Utah, West Virginia, and Wyoming.

• Covered facilities

Covered facilities include:

- **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. This also includes Christian Science Nursing facilities that are approved by the Commission for the Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

What you must do to get covered care

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

Transitional care:

Specialty care: If you have a chronic or disabling condition and

- lose access to your PPO specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan, or
- lose access to your PPO specialist because we terminate our contract with your specialist for other than cause,

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

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

Hospital care:

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

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

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

These provisions apply only to benefits of the hospitalized person.

How to Get Approval for …

• Your hospital stay

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

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

Warning:

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

How to precertify an admission:

- You, your representative, your doctor, or your hospital must call us at 1/800-321-0347 at least 48 hours before admission.
- If you have an emergency due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Provide the following information:

  —Enrollee's name and Plan identification number;

  —Patient's name, birth date, and phone number;

—Reason for hospitalization, proposed treatment, or surgery;

—Name and phone number of admitting doctor;

—Name of hospital or facility; and

—Number of planned days of confinement.

- We will then tell the doctor and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your doctor, and the hospital.

Maternity care

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

If your hospital stay needs to be extended

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

What happens when you do not follow the precertification rules:

- If no one contacted us, we will decide whether the hospital stay was medically necessary.

  —If we determine that the stay was medically necessary, we will pay the inpatient charges, less the $500 penalty.

  —If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

- If we denied the precertification request, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

- When we precertified the admission but you remained in the hospital beyond the number of days we approved and did not get the additional days precertified, then:

  —for the part of the admission that was medically necessary, we will pay inpatient benefits, but

  —for the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

Exceptions:

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States.

- You have another group health insurance policy that is the primary payer for the hospital stay.

- Your Medicare part A is the primary payer for the hospital stay. Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we will become the primary payer and you **do** need precertification.

• Other services

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

- Right-sided heart catheterization.

- Mental Health and Substance Abuse services and admissions

- Growth Hormone Therapy

Section 4. Your costs for covered services

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

- **Copayments**

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

Example: When you see your PPO physician you pay a copayment of $15 per visit and when you go in a PPO hospital, you pay $150 per admission.

- **Deductible**

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

- The calendar year deductible is $200 per person for PPO benefits and $400 per person for Non-PPO benefits. Under a family enrollment, the deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $600 for PPO benefits and $1,200 for Non-PPO benefits.
- We also have separate deductibles for:
  - There is a combined annual $200 deductible per person for mail order and/or retail prescription drugs.
  - There is a Non-PPO $500 deductible per person, per confinement for inpatient care for mental conditions.

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

- **Coinsurance**

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

Example: You pay 30% of our allowance for non-PPO physician office visits.

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

- 30% for non-PPO inpatient hospital charges for treatment of substance abuse;
- 50% for non-PPO inpatient and outpatient professional charges for treatment of substance abuse;
- 20% for skilled nursing facility

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

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

• Differences between our allowance and the bill

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

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

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

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

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

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

For those services with coinsurance, the Plan pays 100% of the plan allowance for the remainder of the calendar year after the calendar year deductible is met when out-of-pocket expenses for coinsurance in that calendar year exceed $3,000 under the PPO benefit. The Plan pays 100% of the plan allowance, if out-of-pocket expenses for the coinsurance in that calendar year exceed $4,000 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 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:

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

Carryover

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

When government facilities bill us

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

If we overpay you

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

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

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

If you..

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

Then, for your inpatient hospital care,

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

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

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

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

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

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

When you have the Original Medicare Plan (Part A, Part B, or both)

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

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

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

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

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

Section 5. Benefits—OVERVIEW

(See page 7 for how our benefits changed this year and pages 59-60 for a benefits summary.)

Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 1/800-321-0347 or at our website at www.ahbp.com.

Section 5 (a). Medical services and supplies provided by physicians and other health care professionals

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductibles are: PPO $200 per person ($600 per family); Non-PPO $400 per person ($1,200 per family). Calendar year deductibles apply to almost all benefits in this Section. We added "(No deductible)" to show when a calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You Pay After the calendar year deductible...
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply	
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Second surgical opinion	PPO: $15 copayment (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of newborn child covered under a family enrollment • At home	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Lab, X-ray and other diagnostic tests	You pay
Tests, such as • Blood tests • Urinalysis • Non-routine pap smears • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiograms and EEG	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges.
Preventive care, adults	
Routine screenings, limited to: • Blood Cholesterol Screening (a fasting lipoprotein profile) once every 5 years for adults age 20 and over • Chlamydial Infection Screening • Colorectal Cancer Screening, including — Fecal occult blood test annually for members age 40 and older — Sigmoidoscopy, screening—one every five years starting at age 50 — Colonoscopy—once every 10 years at age 50	PPO: (No deductible) Nothing after office visit copayment Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Routine Prostate Specific Antigen (PSA) test—one annually for men age 40 and older	PPO: (No deductible) Nothing after office visit copayment Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Routine pap test—one annually for women age 18 and older	PPO: (No deductible) Nothing after office visit copayment Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Routine mammogram—covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years.	PPO: (No deductible) Nothing after office visit copayment Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Routine physical—one annually every two years Note: The maximum PPO benefit is $150	PPO: $15 copayment (No deductible) Non-PPO: All charges
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster—once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and over	PPO: Nothing after office visit copayment Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not Covered: • *Preventive medical care and services, including;* • *Periodic checkups* • *associated X-ray and lab test* • *immunizations such as polio, flu, mumps and smallpox, except as shown under preventive care, adults and preventive care, children*	*All charges*

Preventive care, children	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics for children under age 22	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
• For well-child care charges for routine examinations, immunizations and care (to age 6) limited to 12 well care visits. • Sickle Cell Screening—for newborns for sickle cell anemia • Blood lead level screening	PPO: $15 copayment (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
• Examinations, limited to: —Examinations for amblyopia and strabismus-limited to one screening (ages 2 through 6) —Examinations done on the day of the immunizations (ages 3 through age 22)	PPO: $15 copayment (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 10 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary, but you, your representative, your doctor, or your hospital must precertify. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b)	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*
Family planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover contraceptive drugs in Section 5(f).	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: Reversal of voluntary surgical sterilization, genetic counseling.	*All charges*

Infertility services	You pay
Diagnosis and treatment of infertility, except as shown in *Not covered.* (Including fertility drugs)	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* *—artificial insemination* *—in vitro fertilization* *—embryo transfer and GIFT* *—intravaginal insemination (IVI)* *—intracervical insemination (ICI)* *—intrauterine insemination (IUI)* • *Services and supplies related to ART procedures.* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*
Allergy care	
Testing and treatment, including materials (such as allergy serum)	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Allergy injections	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: provocative food testing and sublingual allergy desensitization.	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 27. • Dialysis—hemodialysis and peritoneal dialysis • Intravenous (IV) Infusion Therapy—Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. Call 1/800-321-0347 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3. • Respiratory and inhalation therapies	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Physical and occupational therapies	You pay
Physical and Occupational therapy; • Up to 45 combined visits for physical and occupational therapy per calendar year for the services provided by a: —qualified physical therapist; and —occupational therapist Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury and when a physician: 1) orders the care; 2) identifies the specific professional skills the patient requires and the medically necessity for skilled services; and 3) indicates the length of time the service is needed.	PPO: 10% of the Plan allowance and all cost after 45 visits. Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all cost after 45 visits.
• *Not covered:* • *Exercise programs* • *Chelation therapy, except for acute arsenic, gold, lead, or mercury poisoning.* • *Massage therapy*	*All charges*
Speech therapy	
Speech therapy: • Up to 45 visits per calendar year for the services provided by a: • Speech therapist	PPO: 10% of the Plan allowance and all cost after 45 visits. Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all cost after 45 visits.
Hearing services (testing, treatment, and supplies)	
Testing only when necessitated by accidental injury	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *hearing testing, except for accidental injury* • *hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) Note: See Preventive care, children for eye exams for children	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses and examinations for them* • *Eye exercise and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*

Foot care	You pay
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	PPO: $15 copayment and/or 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
• *Not covered:* • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; See Section 5 (c) for payment information. Insertion of the device is paid as surgery, see Section 5 (b).	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not Covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges*
Durable medical equipment (DME)	
Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Durable medical equipment (DME)—*continued on next page*

Durable medical equipment (DME) *(continued)*	You pay
We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Hospital beds; • Wheelchairs, to include medically necessary motorized wheelchairs; • Iron lungs; • Certain types of traction equipment; • Oxygen and rental of equipment for its administration; • Crutches; and • Walkers. Note: Call us at 1/800-321-0347 as soon as your physician prescribes this equipment. We arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *exercise equipment* • *whirlpool baths* • *sun-lamps* • *heating pads* • *air conditioners* • *humidifiers, dehumidifiers, and purifiers*	*All charges*
Home health services	
Nursing services: • 240 units annually up to $15 per unit when rendered by a: • Registered Nurse (R.N.), a licensed practical nurse (L.P.N.) , or a Christian Science Nurse who is listed in the Christian Science Journal Note: One private duty nursing unit consists of up to one hour of private duty nursing care.	PPO: (No deductible) all charges after $15 per unit with the maximum of 240 units Non-PPO: (No deductible) all charges after $15 per unit with the maximum of 240 units

Home health care services:
• 60 home health visits per calendar year up to a maximum plan payment of $40 per visit when:
  • A home health care visit consists of:
  • Less than an 8-hour shift of nursing care; or
  • One therapy session; or
  • One social worker visit; or
  • Less than an 8-hour shift by a home health aide.
  • Covered home health care services are:
  • 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); or
  c) a Christian science nurse
  • Physical, occupational or speech therapy provided by a licensed therapist;
  • Services of a licensed social worker (but not more than 2 visits);
	PPO: (No deductible) all charges after we pay $40 per visit
	
	Non-PPO: (No deductible) all charges after we pay $40 per visit

Home health services—*continued on next page*

Home health services *(continued)*	You pay
• 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. Note: The home health care services must be furnished: • by a home health care agency (or by visiting nurses where services of a home health care agency are not available); • in accordance with a home health care plan, see definition on page 52; and • in the patient's home	PPO: (No deductible) all charges after we pay $40 per visit Non-PPO: (No deductible) all charges after we pay $40 per visit
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*
Chiropractic	
Chiropractor—The Plan pays a maximum of $225 per person annually for outpatient services for: • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application Note: No other services of a chiropractor are covered under any other provision of this Plan.	PPO: 10% of the Plan allowance and all cost after $225. Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all cost after the $225
Alternative treatments	
Acupuncture—by a doctor of medicine or osteopathy for: • anesthesia when used as an anesthesic agent for covered surgery.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Educational classes and programs	
Coverage is limited to: • Cardiac rehabilitation program—Outpatient visits must consist of outpatient cardiac rehabilitative exercise, education, and counseling when: • patient has been diagnosed as having angina pectoris (chest pain); or • patient has been hospitalized for a diagnosed myocardial infarction (heart attack); or • coronary surgery. Note: Services must be provided by an approved hospital-based or hospital-coordinated cardiac rehabilitation program.	PPO: 30% of the Plan allowance Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount
• Smoking Cessation—Up to $100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs.	PPO: all charges after benefits stop at $100 Non-PPO: all charges after benefits stop at $100

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductibles are: PPO $200 per person ($600 per family); Non-PPO: $400 per person ($1,200 per family). Calendar year deductibles apply to almost all benefits in this section. We added "(No deductible)" to show when a calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.)
- **YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification.**

IMPORTANT

Benefit Description	You Pay After the calendar year deductible...
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply	
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by a surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Electroconvulsive therapy • Removal of tumors and cysts • Correction of congenital anomalies (See Reconstructive surgery) • Surgical treatment of morbid obesity—a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a)—Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Surgically implanted contraceptives, and intrauterine devices (IUDs) • Treatment of burns • Assistant surgeons—we cover up to 20% of our allowance for the surgeon's charge	PPO: 10% of the Plan allowance Non-PP0: 30% of the Plan allowance and any difference between our allowance and the billed amount.

Surgical procedures—*continued on next page*

Surgical procedures *(continued)*	You pay
When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are • For the primary procedure —PPO: 90% of the Plan allowance —Non-PPO: 70% of the reasonable and customary charge • For the secondary procedure(s): —PPO: 90% of one-half of the Plan allowance —Non-PPO: 70% of one-half of the reasonable and customary charge Note: Multiple and bilateral surgical procedures performed through the same incision are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.	PPO: 10% of the Plan allowance for the primary procedure; 10% of one-half of the Plan allowance for the secondary procedure(s) and 10% of one-quarter of the Plan allowance for procedure(s) thereafter. Non-PPO: 30% of the Plan allowance for the primary procedure and 30% of one-half of the Plan allowance for the secondary procedure(s) and 30% of one-quarter of the Plan allowance for procedure(s) thereafter and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary sterilization* • *Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standbys are medically necessary* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: —the condition produced a major effect on the member's appearance and —the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: —surgery to produce a symmetrical appearance on the other breast; —treatment of any physical complication, such as lymphedemas; —breast prostheses; and surgical bras and replacements (see Prosthetic devices for coverage)	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Note: We pay for internal breast prostheses as hospital benefits. Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	
Not covered: • *Cosmetic surgery—any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury.* • *Surgeries related to sexual transformations or sexual dysfunction.*	*All charges*

Oral and maxillofacial surgery	You pay
Oral surgical procedures, limited to: • Reduction of fractures of the jaw or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
• *Not covered:* • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva and alveolar bone)*	*All charges*
Organ/tissue transplants	
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Small Intestine, including transplant with multiple organs (liver, stomach or pancreas) • Lung: Single—only for the following end-stage pulmonary diseases: pulmonary fibrosis, primary pulmonary hypertension, or emphysema; Double—only for patients with cystic fibrosis • Pancreas (when condition is not treatable by use of insulin therapy) • Allogeneic bone marrow transplants—only for patients with Acute leukemia, Advanced Hodgkins lymphoma, Advanced non-Hodgkin's lymphoma, Advanced neuroblastoma (limited to children over age one), Aplastic anemia, Chronic myelogenous leukemia, Infantile malignant osteopetrosis, Severe combined immunodeficiency, Thalassemia major, and Wiskott-Aldrich syndrome • Autologous bone marrow transplants—(autologous stem cell and autologous peripheral stem cell support) for Acute lymphocytic or non-lymphocytic leukemia, Advanced Hodgkin's lymphoma, Advanced non-Hodgkin's lymphoma, Advanced neuroblastoma, Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors, Breast cancer, Multiple myeloma, and Epithelial ovarian cancer.	United Resources Transplant Program: 10% of the Plan Allowance PPO: 20% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference between our allowance and the billed amount.

Organ/tissue transplants—*continued on next page*

Organ/tissue transplants *(continued)*	You pay

United Resources 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 United Resources 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 United Resources Transplant 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:
  • If the recipient lives more than 100 miles from a designated transplant facility, the Plan will provide an allowance for pre-approved travel and lodging expenses up to $10,000 per transplant. The allowance will not be subject to the calendar year deductible or coinsurance. The allowance will provide coverage of reasonable travel and temporary lodging expenses for the recipient and one companion (two companions if the recipient is a minor). Covered travel and lodging expenses will be established by the Plan's case manager during the precertification process. Travel and lodging to a designated facility for the pre-transplant evaluation is covered under this benefit even if the transplant is not eventually certified as medically necessary.
PPO benefit:
• If you do not use a United Resources Transplant 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.
Note: Cornea and pancreas transplants are not available through the United Resources Transplant Program; therefore, the Travel/Lodging benefit is not available.
Precertification:
• In order to receive benefits for the transplants listed above, you are required to call United Resources Transplant Program at 1/800-321- 0347 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 United Resources 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 United Resources 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 United Resources Transplant facility. The charges above the maximum payment of $150,000 or $100,000 for transplants provided outside the United Resources Transplant Program do not apply toward your out-of-pocket maximum.
	United Resources Transplant Program: 10% of the Plan allowance
	PPO: 20% of the Plan allowance
	Non-PPO: 30% of the Plan allowance and the difference between our allowance and the billed amount.

Organ/tissue transplants—*continued on next page*

Organ/tissue transplants *(continued)*	**You pay**
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. Note: If the Plan cannot refer a member in need of a transplant to a United Resources Transplant facility, the $100,000/$150,000 maximum will not apply. Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute (NCI) or National Institute of Health (NIH) approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	(See above)
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; and* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in— • Hospital (inpatient)	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Professional services provided in— • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for the anesthesia charges.

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

IMPORTANT

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

- Please remember that all your benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. In that case we added "(calendar year deductible applies)". The PPO calendar year deductible is: $200 per person ($600 per family) and the non-PPO calendar year deductible is $400 per person ($1,200 per family).
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, emergency room physicians, anesthesiologists, and pathologists, may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e. hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e. physicians, etc.) are in Sections 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information in Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	You Pay
NOTE: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)".	
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. If the hospital only has private rooms, we base our payment on the average semiprivate rate of the most comparable hospital in the area. NOTE: When the non-PPO hospital bills a flat rate, we prorate the charge to determine how to pay them, as follows: 30% room and board and 70% other charges.	PPO: $150 per admission and 10% of the covered charges Non-PPO: $250 per admission and 30% of the covered charges Note: If you use a PPO provider and a PPO facility, we may still pay non-PPO benefits if you receive treatment from a radiologist, pathologist or anesthesiologist who is not a PPO provider

Inpatient hospital—*continued on next page*

Inpatient hospital *(continued)*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) NOTE: We base payment on whether the facility or a health care professional bills for the services or supplies. For example, when the hospital bills for its nurse anesthetists' services, we pay Hospital benefits and when the anesthesiologist bills, we pay surgery benefits.	(see above)
• *Not covered:* • *Any part of a hospital admission that is not medically necessary (see definition), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting* • *Custodial care; see definition.* • *Non-covered facilities, such as nursing homes, schools, rest homes, places for the aged, convalescent homes, residential treatment facilities, and any place that is not a hospital* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE:—We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	PPO: 10% of the Plan allowance (calendar year deductible applies) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Not covered: All services not listed	*All charges*

Extended care benefits/Skilled nursing care facility benefits	You pay
Skilled nursing facility (SNF): We cover semiprivate room, board, services, supplies in a SNF for up to 60 days confinement when: 1) you are admitted within 14 days from a precertified hospital stay of at least 3 consecutive days; and 2) you are admitted for the same condition as the hospital stay; and 3) your skilled nursing care is supervised by a physician and provided by an R.N., L.P.N., or L.V.N.; and 4) SNF care is medically appropriate.	PPO: 20% of the Plan allowance Non-PPO: 20% of the Plan allowance
Not covered: Custodial care	*All charges*
Hospice care	
Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan approved independent hospice administration. • We pay $4,500 per lifetime for inpatient and outpatient services.	PPO: Nothing until Plan allowance stops at $4,500 Non-PPO: Nothing until Plan allowance stops at $4,500
• *Not covered:* • *Bereavement counseling* • *Funeral arrangements* • *Pastoral counseling* • *Financial or legal counseling* • *Homemaker or caretaker services*	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate	PPO: 10% of the Plan allowance (calendar year deductible applies) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Section 5 (d). Emergency services/accidents

IMPORTANT

- **Here are some important things to keep in mind about these benefits:**
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductibles are: PPO $200 per person ($600 per family); Non-PPO $400 per person ($1,200 per family). Calendar year deductibles apply to almost all benefits in this Section. We added "(No deductible)" to show when a calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

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

What is an accidental injury?

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

Benefit Description	You Pay After the calendar year deductible...
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply	
Accidental injury	
If you receive care for your accidental injury within 72 hours, we cover: • Non-surgical physician services and supplies • Related outpatient hospital services Note: We pay Hospital benefits if you are admitted.	PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount
If you receive care for your accidental injury after 72 hours, we cover: • Non-surgical physician services and supplies • Surgical care Note: We pay Hospital benefits if you are admitted.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Medical emergency	You pay
Outpatient medical or surgical services and supplies in an emergency room.	PPO: (No deductible) $50 copayment Non-PPO: $50 copayment and the difference between our allowance and the billed amount
Care in a physician's office	PPO: $15 and/or 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount.
Ambulance	
Professional ambulance service Note: If hospital treatment requiring special equipment is necessary but not locally available, the Plan covers transportation within the United States and Canada by professional ambulance, railroad, or scheduled commercial airlines to the nearest hospital equipped to furnish the treatment. Note: See 5 (c) for non-emergency service.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Routine transportation necessary to obtain the services of a doctor or any other practitioner*	*All charges*

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

IMPORTANT

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

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductibles or, for facility care, the inpatient deductibles apply to almost all benefits in this section. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your cost for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES**. See the instructions after the benefits descriptions below.
- In-Network mental health and substance abuse benefits are below, then Out-of-Network benefits begin on page 36.

IMPORTANT

Benefit Description	You Pay After the calendar year deductible...
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply	
In-Network benefits	
All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: In-Network benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$15 per visit (No deductible)
• Diagnostic tests	10% of the Plan allowance
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$150 per admission copayment and 10% of the Plan allowance
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

In Network benefits—*continued on next page*

In Network benefits *(continued)*

Preauthorization

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

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

Network limitation

If you do not obtain an approved treatment plan, we will provide only Out-of-Network benefits.

Out-of-Network benefits	
Inpatient and outpatient professional services to treat mental conditions.	30% of our allowance and any difference between our allowance and the billed amount for up to 45 visits; all charges after 45 visits
Inpatient and outpatient professional services to treat substance abuse conditions.	50% of our allowance and any difference between our allowance and the billed amount and all charges after the $4000 calendar year maximum
Inpatient care to treat mental conditions includes ward or semiprivate accommodations and other hospital charges	After a $500 deductible per admission to a non-PPO hospital, 30% of charges for up to 45 days per calendar year; all charges after 45 days
Inpatient care to treat substance abuse includes room and board and ancillary charges for confinement in a treatment facility for rehabilitative treatment of alcoholism or substance abuse	30% of Plan allowance and any difference between our allowance and the billed amount and all charges after the $4000 calendar year maximum
Not covered out-of-network: • *Services by pastoral and marital counselors* • *Treatment for learning disabilities and mental retardation* • *Services rendered or billed by schools, residential treatment centers or halfway houses or members of their staffs*	*All charges.*

Lifetime maximum

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

Precertification

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

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

- Section 4, *Your costs for covered services,* for information about catastrophic protection for these benefits.
- Section 7, *Filing a claim for covered services,* for information about submitting out-of-network claims.

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on page 38
- All benefits are subject to definitions, limitations , and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The combined annual prescription drug deductible is $200 per person for prescriptions filled through the retail and/or home delivery pharmacy service program.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** A licensed physician or licensed dentist must write the prescription.
- **Prior authorization.** Prior authorization is required for some drugs. To get a list of these drugs please call 1/866-342-3810.
- **Where you can obtain them.** You may fill the prescription at a pharmacy participating in the network, a non-network pharmacy, or by mail. We pay a higher level of benefits when you use a network pharmacy rather than a non-network pharmacy.
- **Network Pharmacy Benefit**. After satisfying your combined annual $200 per person prescription drug deductible, you pay 10% coinsurance for a generic medication or 15% coinsurance for a brand medication for the initial prescription for up to a 30 day supply of medication (as prescribed by your doctor) and 50% for each refill.
- **Eckerd Health Services (EHS) Mail Order Facility (Express Pharmacy Services).** After satisfying your combined annual $200 per person prescription drug deductible, you pay 20% for generic medications or 25% for brand medications of the covered charges per generic medication or per brand name medication. To order by mail, send your prescriptions to Express Pharmacy Services, P.O. Box 270, Pittsburgh, PA 15230-9949
- **Non-Network Pharmacy Benefit.** After satisfying your combined annual $200 per person prescription drug deductible, you pay 10% coinsurance for generic medications or 15% coinsurance for brand medications per prescription for the initial 30 day supply. All refills will require you to pay 50% of the cost of the prescription drug. You will also be responsible for any charges in excess of the participating pharmacy charges. You must pay the full amount of the prescription drug and file a claim with Eckerd Health Services (EHS) as indicated below.
- **We use a formulary.** We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. You may call for the list.
- **These are the dispensing limitations.** For participating and non-participating pharmacies, the dispensing limit is a 30 day supply. For home delivery the dispensing limit is a 90 day supply with the initial home delivery prescription being limited to a 45 day supply.
- **Refilling your prescription.**To be sure you never run short of your prescription medication, you should re-order on or after the refill date indicated on the refill slip or when you have fewer than 14 days of medication left. Refills sent in prior to scheduled or authorized refill will not be filled.
- **Generic Equivalent.** A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **Why use generic drugs?** Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your plan less money than a name-brand drug.
- **When you have to file a claim.** If a participating pharmacy is not available where you reside or if you do not use your prescription drug identification card, you must pay in full for your medication, obtain a prescription drug receipt and submit a claim to: Alliance Health Benefit Plan, Prescription Drug Program, Eckerd Health Services, Post Office Box 2860, Pittsburgh, PA 15230-2860. Reimbursement will be based on Plan cost had you used a participating pharmacy. The Alliance's cost represents a negotiated fee. The actual cost to Alliance may be less than the retail price, so your reimbursement may be less.

Prescription drug benefits—*continued on next page*

Benefit Description	You Pay After the calendar year deductible...
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply	
Covered medications and supplies	
Each new enrollee will receive a description of our prescription drug program, a combined prescription drug/Plan identification card, a home delivery order form/patient profile and a preaddressed reply envelope. You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by home delivery: • Drugs and medicines (including those administered during a non-covered admission or in a non covered facility) that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Diabetic diagnostic supplies used to test blood and urine for glucose levels • Needles and syringes for the administration of covered medications • Contraceptive drugs and devices	• Network Retail: 10% generic or 15% brand name for the initial prescription. For all refills 50% of Plan cost • Non-Network Retail: 10% generic or 15% brand name for initial prescription and any difference between our Plan cost and the cost of the drug. For all refills, 50% of the Plan cost and any difference between our cost and the cost of the drug. • Home Delivery: 20% of the cost for generic or 25% of the cost for brand name.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *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 24* • *Drugs related to treatment of sexual dysfunction, sexual inadequacy or sexual transformation* • *Drugs that are investigational or experimental* • *Drugs prescribed for weight loss*	*All charges.*

Section 5 (g). Special features

Special features	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call 1/800-321-0347 and talk with a nurse who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired	TDD services are available at 1/800-985-2427.
High risk pregnancies	For assistance you should call United Resources at 1/800-321-0347 during the first trimester of your pregnancy. At this time, a Case Manager will ask you questions about your general health and medical history. This information will be discussed with your physician or practitioner to help determine the risk factor of your pregnancy.
Centers of excellence	For assistance with the United Resources Network call us at 1/800-321-0347 for more information.
Travel benefit for organ transplants	United Resources Transplant Program: Travel and lodging must be approved in advance. They include the cost incurred for one companion to travel with the patient to receive services in connection with any approved PPO transplant procedure. Travel and lodging expenses are covered up to a $10,000 maximum.

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductibles are: PPO $200 per person ($600 per family); Non-PPO $400 per person ($1,200 per family). Calendar year deductibles apply to the accidental dental injury benefit only.
- Non-PPO dental benefit is subject to a $25 per person and $50 per family calendar year deductible.
- We added "(No deductible)" to show when a dental deductible does not apply.
- Be sure to read Section 4, *Your cost for covered services,* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Note: We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure. See Section 5 (c) for inpatient hospital benefits.

IMPORTANT

Accidental injury benefit	**You pay**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Services must be received within 12 months from the date of the accident.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Dental benefits	
Preventive services: • Cleanings • Exams • Flouride treatments • Sealants • Diagnostic X-rays Note: Cleanings, exams, flouride treatments and sealants are limited to two visits per person annually.	PPO: Nothing "(No deductible)" Non-PPO: 10% of the Plan allowance and any difference between our allowance and the billed amount
Basic restorative care: • Fillings	PPO: 20% of the Plan allowance "(No deductible)" Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount.
Note: The annual benefit maximum per person (Combined In-Network and Out-of-Network) is $500.	
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*	*All charges*

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

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

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

	PLAN FEATURES	NO CLAIM FORMS!
CIGNA Dental Health Plan	No deductibles No maximums 100% Coverage—Diagnostic and Preventive Care (Exams, X-rays, Cleanings) 50% Coverage—Basic Restorative Care (Fillings, Periodontics, Endodontics, Simple Extractions) 50% Coverage—Major Restorations (Onlays, Dentures, Crowns, Bridgework) Call 1/800-367-1037	
AFLAC (American Family Life Assurance Company of Columbus)	Accident/Sickness/Disability, Hospital Intensive Care; Cancer Insurance Policy These policies provide benefits paid directly to you, unless assigned, that can help you with non-medical expenses. Call 1/800-992-3522 and TDD 1/800-622-2345 or espanol 1/800-742-3522	

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

Call 1/800-321-0347 for General Information

BENEFITS ON THIS PAGE ARE NOT PART OF THE FEHB CONTRACT

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

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

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations, sexual dysfunction, or sexual inadequacy;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services and supplies when furnished without charge while in active military service;
- Services and supplies when furnished by immediate relatives or household members, such as spouse, parent, child, brother, sister by blood, marriage or adoption;
- Services and supplies when furnished or billed by a non-covered facility, except that medically necessary prescription drugs are covered;
- Services and supplies not specifically listed as covered;
- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copay or coinsurance, the Plan will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges the enrollee or Plan has no legal obligation to pay, such as: excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 14), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 15), or State premium taxes however applied;
- Biofeedback;
- Dental services and appliances (except as specified on page 40);
- Exercise equipment, whirlpool baths, sunlamps, heating pads, air conditioners, humidifiers, dehumidifiers, and purifiers;
- Services and supplies to the extent the charge exceeds reasonable and customary charges;
- Services by practitioners who do not meet the definition of "covered provider"; or
- Charges for a stand-by doctor.

Section 7. Filing a claim for covered services

How to claim benefits

To obtain claim forms or other claims filing advise or answers about our benefits, contact us at 1/800-321-0347, or at our website at www.ahbp.com.

In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500 Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at
1/800-321-0347.

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

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

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

In addition:

- You must send a copy of the explanation of benefits (EOB) from any primary payer (such as Medicare Summary Notice (MSN)) with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse or Christian Science nurse who is listed in the Christian Science Journal.
- Claims for rental or purchase of durable medical equipment; private duty nursing; and physical, occupational, and speech therapy require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies that are not ordered through the Express Pharmacy Services must include receipts that include the prescription number, name of drug or supply, prescribing physician's name, date, and charge.

Records

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

Deadline for filing your claim

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

Overseas claims

For covered services you receive in hospitals outside the United States and Puerto Rico and performed by physicians outside the United States, send a completed Claim Form and the itemized bills to: Alliance Health Benefit Plan, P.O. Box 1245, Des Plaines, IL 60017. Obtain Claims Forms from this address and send any written inquiries concerning the processing of overseas claims to this address. For assistance call 1/800-321-0347

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Alliance Health Benefit Plan, 1628 11th Street NW, Washington , D.C. 20001; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to : (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial—go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us—if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Health Benefits Contracts Division 2, 1900 E Street NW, Washington, DC 20415-3620. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of letters we sent to you about the claim; and • Your daytime phone number and the best time to call.

The Disputed Claims process *(Continued)*

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

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

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

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

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

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

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

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

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

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Benefits Contracts Division 2 at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

• What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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

• The Original Medicare Plan (Part A or Part B)

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

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

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

- When we are the primary payer, we process the claim first.
- When Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 1-800/321-0347 or contact us at our website www.ahbp.com.

We waive some costs if the Original Medicare Plan is your primary payer—We will waive some out-of-pocket costs as follows:

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

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

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

- **Medicare managed care plan**

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

If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and another plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area, but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate your benefits with Medicare.

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

- **Private Contract with your physician**

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

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE and CHAMPVA

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

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the program.

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State Program.

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

Section 10. Definitions of terms we use in this brochure

Accidental injury

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

Admission

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

Assignment

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

Calendar year

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

Christian Science Nurses and Practitioners

Christian Science Nurses and Practitioners are those who are listed in the Christian Science Journal.

Christian Science Nursing facility

A Christian Science Nursing facility is a nursing facility that is approved by the Commission for the Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

Congenital anomaly

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See pages 11 and 12.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 11.

Cosmetic surgery

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

Covered services

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

Custodial care

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

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

The Plan determines which services are custodial care and custodial care that lasts 90 days or more is sometimes known as Long term care.

Deductible

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

Durable medical equipment

Equipment and supplies that:

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

Effective date

The date the benefits described in this brochure are effective:

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

Experimental or investigational services

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

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

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

3) Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; written protocol or protocols used by 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.

Group health coverage

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

Home health care

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

Home health care agency

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

Hospice care program

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

Initial emergency treatment

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

Medical emergency

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

Medical necessity

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

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

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

Mental conditions/ substance abuse

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

Plan allowance

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

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

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

- **Non-PPO providers,**on the other hand, have no agreement to limit what they will bill you. When you use a non-PPO provider, you will pay your deductible and coinsurance—**plus—**any difference between our allowance and charges on the bill. Here is an example: You see a non-PPO physician who charges $150 and our allowance is again $100. Because you've met your deductible, you are responsible for your coinsurance, so you pay 30% of the $100 allowance ($30). Plus, because there is no agreement between the non-PPO physician and us, he can bill you for the $50 difference between our allowance and his bill.
- The Plan allowance for any non-PPO service or supply is the charge determined by the Plan on a semiannual basis to be in the 80th 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 are obtained from prevailing health care charge guides such as that prepared by the Health Insurance Association of America (HIAA). In determining the plan allowance for a service or supply that is unusual, or not often provided in the area, or provided by only a small number of providers in the area, the Plan may take into account factors such as: the complexity; the degree of skills needed; the type of specialty of the provider; the range of services or supplies provided by a facility; and the prevailing charge of other areas. When a PPO provider is used, the fee that has been negotiated between the Plan and the PPO provider is considered the plan allowance.

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

Sound natural tooth

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

Us/We

Us and we refer to the Alliance Health Benefit Plan.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the Federal Employees Health Benefits (FEHB) Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;

- if you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- if you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot make any changes after retirement. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under the former spouse's enrollment. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's website, www.opm.gov/insure.

- **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 Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

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

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

- **Converting to individual coverage**

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPPA" frequently asked questions. These highlight HIPPA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under the HIPPA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Still Available!

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, your premiums are based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called "custodial care", long term care helps you perform the activities of daily living—such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

You Can Also Apply Later, But . . .

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action - you won't receive an application automatically. You must request one through the toll-free number or website listed below.
- Open Season ends December 31, 2002 - act NOW so you won't miss the abbreviated underwriting available to employees and their spouses, and the July 1 "age freeze"!

Find Out More – Contact LTC Partners by calling **1-800/LTC-FEDS (1-800/582-3337) (TDD for the hearing impaired: 1-800/842-3557)** or visiting www.ltcfeds.com to get more information and to request an application.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of benefits for the Alliance Health Benefit Plan - 2003

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Below, an asterisk (*) means the item is subject to the $200 or $400 calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: $15 copay per visit and/or 10%* of the Plan allowance Non-PPO: 30%* of the Plan allowance	17
Services provided by a hospital:	PPO: $150 per admission copay and 10% of the Plan allowance	
• Inpatient	Non-PPO: $250 per admission copay and 30% of the Plan allowance	
• Outpatient	PPO: 10%* of the Plan allowance Non-PPO: 30%* of the Plan allowance	30
Emergency benefits:		
• Accidental injury	Within 72 hours: Nothing for non-surgical outpatient care	
• Medical emergency	$50 copay, emergency room	33
Mental health and substance abuse treatment	In-Network: Regular cost sharing.*	
	Out-of-Network: Benefits are limited.*	35
Prescription drugs	After the combined annual deductible of $200 per person: • In-Network: 10% of the generic or 15% of the brand name for the initial prescription. For all refills, 50% of Plan cost. • Non-Network: 10% of the generic or 15% of the brand name for the initial prescription and any difference between our Plan cost and the cost of the drug. For all refills, 50% of Plan cost and any difference between our cost and the cost of the drug. • Mail order: 20% of the generic or 25% of the brand name prescription drug cost.	37

Benefits	You Pay	Page
Dental care	PPO: Nothing for preventive services Non-PPO: After $25 deductible per person or $50 per family, 10% for preventive services	40
Special features: • Flexible benefits option • 24 hour nurseline • Services for deaf and hearing impaired • High risk pregnancies • Centers of excellence for transplant/heart surgery/etc. • Travel benefit for organ transplants		39
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	PPO: Nothing after $3,000/Self Only or $3,000/Family enrollment per year. Non-PPO: Nothing after $4,000/Self Only or $4,000/Family enrollment per year. Some costs do not count toward this protection.	13

2003 Rate Information for Alliance Health Benefit Plan

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	1R1	$109.30	$72.49	$236.82	$157.06	$129.03	$52.76
Self and Family	1R2	$249.62	$135.78	$540.84	$294.19	$294.70	$90.70