

AvMed Health Plans

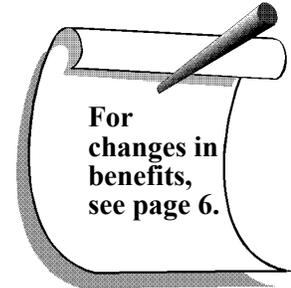
<http://www.avmed.org>

2007

A Health Maintenance Organization (high and standard option)

Serving: *South Florida*

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 6 for requirements.



Enrollment code for this Plan:

- ML1 High Option - Self Only
- ML2 High Option - Self and Family
- ML4 Standard Option - Self Only
- ML5 Standard Option - Self and Family



Authorized for distribution by the:



**United States
Office of Personnel Management**
Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

RI 73-815

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States 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 by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

**Important Notice from AvMed Health Plans About
Our Prescription Drug Coverage and Medicare**

OPM has determined that the AvMed Health Plans' prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you terminate your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of AvMed Health Plans under our South Florida contract (CS 2876) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for AvMed Health Plans administrative offices is:

AvMed Health Plans 9400 South Dadeland Boulevard Miami, FL 33156

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, 2007, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007, 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 AvMed Health Plans.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States 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 U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 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 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 that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits 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) statements 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 1-800-882-8633 and explain the situation. If we do not resolve the issue: CALL ? THE HEALTH CARE FRAUD HOTLINE 202-418-3300 OR WRITE TO: United States Office of Personnel Management Office of the Inspector General Fraud Hotline 1900 E Street NW Room 6400 Washington, DC 20415-1100
- 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, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- 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.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.

- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
 - Exactly what will you be doing?
 - About how long will it take?
 - What will happen after surgery
 - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

Ø www.ahrq.gov/consumer/pathqpack.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

Ø www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

Ø www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

Ø www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

Ø www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Ø www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation’s health care delivery system.

Section 1 Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

We give you a choice of enrollment in a High Option or a Standard Option Plan. HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment. When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms. You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us. General features of our High and Standard Options

How we pay providers We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. Your rights OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB Web site (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.

- AvMed Health Plans is an Individual Practice Association organization in Florida. Member's medical services are provided by a wide array of primary care doctors and specialists with whom AvMed contracts.
- The first and most important decision each member must make is the selection of a primary care doctor.

The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. See Specialty Care below for services that you can receive without a referral from your primary doctor. If you want more information about us, call 1-800-882-8633, or write to 9400 South Dadeland Blvd., Suite 200, Miami, FL 33156. You may also contact us by fax at 305/671-4710 or visit our Web site at www.avmed.org.

Service Area To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is: South Florida area: Services from Plan providers are available in the following areas: Dade, Broward and Palm Beach Counties. Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval. If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2 We are a new plan for 2007

Do not rely on these change descriptions; this Section 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. Changes to High Option only•Your share of the non-Postal premium will increase by 12.9% for Self Only or 41.1% for Self and Family•The office visit copay for the Specialist has increased from \$25 to \$40 per visit•The inpatient Hospital admission copayment has increased from \$100 per day (5 day max) to \$150 per day (5 day max)•The Outpatient surgery facility copayment has increased from \$100 to \$150 per visitChanges to Standard Option only•Your share of the non-Postal premium will increase by 12.7% for Self Only or 12.7% for Self and Family•The office visit copay for the Specialist has increased from \$40 to \$45 per visit•The inpatient Hospital admission copayment has increased from \$125 per day (5 day max) to \$175 per day (5 day max)•The Outpatient surgery facility copayment has increased from \$125 to \$175 per visit

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 letter (for annuitants), or your electronic enrollment system (such as 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 1-800-882-8633 or write to us at 9400 South Dadeland Blvd., Suite 200, Miami, FL 33156. You may also request replacement cards through our Web site at www.avmed.org.

Where you get covered care You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance.

- **Plan providers** Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.

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

What you must do to get covered care It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

- **Primary care** Your primary care physician can be a family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

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

- **Specialty care** Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see .

Here are some other things you should know about specialty care:

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

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
 - Reduce our service area and you enroll in another FEHB Plan,

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

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

• **Hospital care**

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

• **If you are hospitalized when your enrollment begins**

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-882-8633. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

How to get approval for...

• **Your hospital stay**

In the event of an emergency hospitalization for a same day admission, please call our Benefit Coordination department at 1-800-816-5465. The requesting provider may also call the previous number to request authorization.

• **How to precertify an admission**

The requesting provider will complete a Preauthorization request form and fax it in with documentation to support medical necessity to 1-800-552-8633.

• **Maternity care**

Obstetrical care benefits are covered and include Hospital care, anesthesia, diagnostic imaging and laboratory services for conditions related to pregnancy. The requesting obstetrical provider should obtain authorization by faxing a Preauthorization request form to 1-800-552-8633.

Section 4 Your costs for covered services

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

Copayments

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

Example: When you see your primary care physician you pay a copayment of \$15 per office visit and when you go in the hospital, you pay \$150 per day for the first five days per admission.

Deductible

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

· **Under Standard Option**, the calendar year deductible is \$500 per individual. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$1,000.

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

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

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: In our Plan, you pay 20% of our allowance for durable medical equipment is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: In our Plan, you pay 20% of our allowance for durable medical equipment

Your catastrophic protection out-of-pocket maximum

After your total \$1,500 per person or \$3,000 per family enrollment under the High option plan or after your total \$4,000 per person or \$8,000 per family enrollment under the Standard Option plan, in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

For the High Option, copayments for your prescription drugs, injectable drug benefit, and voluntary family planning services do not count toward the out-of-pocket maximum.

For the Standard Option, only inpatient hospital stays, outpatient surgery, outpatient diagnostic care, home health care, DME and Prosthetic copayments/coinsurance apply to the out-of-pocket maximum.

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

High and Standard Option Benefits

See page 7 for how our benefits changed this year. Page 64 and page 65 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5 High and Standard Option Benefits Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled. The High and Standard Option Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about High and Standard Option benefits, contact us at 1-800-882-8633 or at our Web site at www.avmed.org. Each option offers unique features.

- **High Option** The High Option has lower copayments and no deductible.
- **Standard Option** The Standard Option has higher copayments, a calendar year deductible, coinsurance and lower premiums.

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

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.

- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Under High Option, there is no calendar year deductible.
- Under Standard Option, the calendar year deductible is: \$500 per person (\$1,000 per family). The calendar year deductible applies to certain benefits in this Section. We added “(Calendar year deductible applies)” to show when the calendar year deductible does apply.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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	High Option	Standard Option
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office 	\$15 per visit to your primary care physician \$40 per visit to a participating specialist	\$25 per visit to your primary care physician \$45 per visit to a participating specialist
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultation 	Nothing (Facility charge may apply)	Nothing (Facility charge may apply)
<ul style="list-style-type: none"> • Second surgical opinion 	\$15 per visit to your primary care physician \$40 per visit to a participating specialist If the Member chooses a non-Plan Physician, the Member will be responsible for 40% of the amount of reasonable and customary charges for the second medical opinion	\$25 per visit to your primary care physician \$45 per visit to a participating specialist If the Member chooses a non-Plan Physician, the Member will be responsible for 40% of the amount of reasonable and customary charges for the second medical opinion
At home	Nothing	Nothing
<i>Not covered:</i> <i>Injuries received in connection with the commission of a felony</i>	<i>All charges.</i>	<i>All charges</i>

Benefit Description	You pay After the calendar year deductible...	
Lab, X-ray and other diagnostic tests	High Option	Standard Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology 	Tests \$15 per visit to your primary care physician \$40 per visit to a participating specialist	Tests \$25 per visit to your primary care physician \$45 per visit to a participating specialist
<ul style="list-style-type: none"> • X-rays Prior authorization is required for the following: <ul style="list-style-type: none"> • Non-routine mammograms • Ultrasound • Electrocardiogram & EEG 	\$10 per test	20% of the contracted rate (calendar year deductible applies)
Prior authorization is required for the following: <ul style="list-style-type: none"> • CAT Scans/MRI 	\$25 per test	20% of the contracted rate (calendar year deductible applies)
Preventive care, adult	High Option	Standard Option
Routine physical every xx which includes: Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 	Nothing if you receive these services during your office visit; otherwise, \$15 per visit to your primary care physician or \$40 per visit to a participating specialist	Nothing if you receive these services during your office visit; otherwise, \$25 per visit to your primary care physician or \$45 per visit to a participating specialist
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing if you receive these services during your office visit; otherwise, \$15 per visit to your primary care physician or \$40 per visit to a participating specialist	Nothing if you receive these services during your office visit; otherwise, \$25 per visit to your primary care physician or \$45 per visit to a participating specialist
Routine Pap test Note: You do not pay a separate copay for a Pap test performed during your routine annual physical; see <i>Diagnostic and treatment services</i> .	\$15 per visit to your primary care physician \$40 per visit to a participating specialist	\$25 per visit to your primary care physician \$45 per visit to a participating specialist
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year 	\$10 per test	20% of the contracted rate (calendar year deductible applies)

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Preventive care, adult (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> At age 65 and older, one every two consecutive calendar years 	\$10 per test	20% of the contracted rate (calendar year deductible applies)
Routine immunizations, limited to: <ul style="list-style-type: none"> Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) Influenza vaccine, annually Pneumococcal vaccine, age 65 and older 	\$15 per visit to your primary care physician \$40 per visit to a participating specialist	\$25 per visit to your primary care physician \$45 per visit to a participating specialist
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>	<i>All charges.</i>
Preventive care, children	High Option	Standard Option
<ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics 	\$15 per visit to your primary care physician \$40 per visit to a participating specialist	\$25 per visit to your primary care physician \$45 per visit to a participating specialist
<ul style="list-style-type: none"> Well-child care charges for routine examinations, immunizations and care (up to age 22) Examinations, such as: <ul style="list-style-type: none"> Eye exams through age 17 to determine the need for vision correction Ear exams through age 17 to determine the need for hearing correction Examinations done on the day of immunizations (up to age 22) 	\$15 per visit to your primary care physician \$40 per visit to a participating specialist	\$25 per visit to your primary care physician \$45 per visit to a participating specialist
Maternity care	High Option	Standard Option
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> Prenatal care Delivery Postnatal care Note: Here are some things to keep in mind: <ul style="list-style-type: none"> 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 extend your inpatient stay if medically necessary. 	Copayments are waived for maternity care visits to PCP. \$150 per day for the first five days per hospital admission	Copayments are waived for maternity care visits to PCP. \$175 per day for the first five days per hospital admission (calendar year deductible applies)

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Maternity care (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	Copayments are waived for maternity care visits to PCP. \$150 per day for the first five days per hospital admission	Copayments are waived for maternity care visits to PCP. \$175 per day for the first five days per hospital admission (calendar year deductible applies)
<i>Not covered: No more than one routine sonogram per pregnancy</i>	<i>All charges.</i>	<i>All Charges.</i>
Family planning	High Option	Standard Option
A range of voluntary family planning services, limited to: <ul style="list-style-type: none"> 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 oral contraceptives under the prescription drug benefit.	\$100 Copayment \$15 per visit to your primary care physician \$40 per visit to a participating specialist	\$100 copayment \$25 per visit to your primary care physician \$45 per visit to a participating specialist
<i>Not covered:</i> <ul style="list-style-type: none"> Reversal of voluntary surgical sterilization Genetic counseling 	<i>All charges.</i>	<i>All Charges.</i>
Infertility services	High Option	Standard Option
Diagnosis and treatment of infertility such as: <ul style="list-style-type: none"> Artificial insemination: <ul style="list-style-type: none"> intrauterine insemination (IUI) 	\$15 per visit to your primary care physician \$40 per visit to a participating specialist	\$25 per visit to your primary care physician \$45 per visit to a participating specialist
<i>Not covered:</i> <ul style="list-style-type: none"> Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> in vitro fertilization embryo transfer, gamete (GIFT) and zygote (ZIFT) Artificial insemination: <ol style="list-style-type: none"> intracervical insemination (ICI) intrauterine insemination (IUI) 	<i>All charges.</i>	<i>All charges.</i>

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Infertility services (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Services and supplies related to ART procedures • Surgery for the enhancement of fertility • Cost of donor sperm • Cost of donor egg • Fertility drugs 	<i>All charges.</i>	<i>All charges.</i>
Allergy care	High Option	Standard Option
<ul style="list-style-type: none"> • Testing and treatment 	\$50 per course of testing	\$50 per course of testing.
<ul style="list-style-type: none"> • Allergy injections 	\$10 per office visit	\$25 per office visit
Allergy serum	Nothing	Nothing
<i>Not covered:</i> <i>provocative food testing and sublingual allergy desensitization</i>	<i>All charges.</i>	<i>All charges.</i>
Treatment therapies	High Option	Standard Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 28.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We only cover GHT when we preauthorize the treatment. 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 <i>Services requiring our prior approval</i> in Section 3.</p>	\$15 per visit to your primary care physician \$40 per visit to a participating specialist	\$25 per visit to your primary care physician \$45 per visit to a participating specialist
<i>Not covered:</i>	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay After the calendar year deductible...	
Physical and occupational therapies	High Option	Standard Option
<p>Short-term therapy for acute condition for which therapy applied for a consecutive two calendar month period (per condition) can be expected to result in significant improvements for the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>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.</p>	<p>\$15 per visit to your primary care physician</p> <p>\$40 per visit to a participating specialist</p>	<p>\$25 per visit to your primary care physician</p> <p>\$45 per visit to a participating specialist</p>
<p>Cardiac Rehabilitation is covered for the following conditions:</p> <ul style="list-style-type: none"> • Acute myocardial infarction • Percutaneous transluminal coronary angioplasty (PTCA) • Repair or replacement of heart valve(s) • Coronary artery bypass graft (CABG), or • Heart transplant <p>Coverage is limited to 18 visits per year. Benefits limited to \$1,500 per contract year</p>	<p>\$20 per visit</p>	<p>\$25 per visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Speech therapy	High Option	Standard Option
<p>When medically necessary.</p>	<p>\$15 per visit to your primary care physician</p> <p>\$40 per visit to a participating specialist</p>	<p>\$25 per visit to your primary care physician</p> <p>\$45 per visit to a participating specialist</p>
Hearing services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> • Hearing testing for children through age 17, which include; (see <i>Preventive care, children</i>) 	<p>\$15 per visit to your primary care physician</p> <p>\$40 per visit to a participating specialist</p>	<p>\$25 per visit to your primary care physician</p> <p>\$45 per visit to a participating specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> • <i>Hearing aids, testing and examinations for them</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Benefit Description	You pay After the calendar year deductible...	
Vision services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> · Annual eye refractionsto determine the need for vision correction for children through age 17 · Diagnosis and treatment of diseases of the eye <p>Note: See <i>Preventive care, children</i> for eye exams for children.</p>	<p>\$15 per visit to your primary care physician</p> <p>\$40 per visit to a participating specialist</p>	<p>\$25 per visit to your primary care physician</p> <p>\$45 per visit to a participating specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • All other vision testing (eye examinations and refractions) • Eyeglasses or contact lenses (including replacement of lenses provided during the same calendar year) • External lenses following cataract surgery • Eye exercises and orthoptics • <i>Radial keratotomy and other refractive surgery</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Foot care	High Option	Standard Option
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	<p>\$15 per visit to your primary care physician</p> <p>\$40 per visit to a participating specialist</p>	<p>\$25 per visit to your primary care physician</p> <p>\$45 per visit to a participating specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • 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) • Podiatric shoe inserts or foot orthotics 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Orthopedic and prosthetic devices	High Option	Standard Option
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices , such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. <p>Note: See 5(b) for coverage of the surgery to insert the device.</p>	<p>Nothing</p>	<p>20% of the contracted rate (calendar year deductible applies)</p>

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Orthopedic and prosthetic devices (cont.)	High Option	Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> · Orthopedic and corrective shoes · Arch supports · Foot orthotics · Non orthopedic brace · Heel pads and heel cups · Lumbosacral supports · Corsets, trusses, elastic stockings, support hose, and other supportive devices · Penile implants <p>Prosthetic replacements provided less than 3 years after the last one we covered</p>	<p><i>All charges</i></p>	<p><i>All charges.</i></p>
Durable medical equipment (DME)	High Option	Standard Option
<p>We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Hospital beds; • Standard wheelchairs; • Crutches; and • Insulin pumps. <p>Coverage for orthotic appliances is limited to leg, arm, back, and neck custom-made braces when related to a surgical procedure or when used in an attempt to avoid surgery and are necessary to carry out normal activities of daily living, excluding sports activities. Coverage is limited to the first such item; repair and replacement is not covered.</p> <p>Note: Call us at 1-800-882-8633 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>\$50 per episode of illness</p> <p>Benefits are limited to a maximum of \$500 per contract year. You pay anything above that amount.</p>	<p>20% of the contracted rate (calendar year deductible applies)</p> <p>Benefits are limited to a maximum of \$500 per contract year. You pay anything above that amount..</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Medical supplies such as corsets which do not require a prescription</i> • <i>Motorized wheelchairs</i> • <i>Non-standard wheelchairs</i> 	<p><i>All charges.</i></p>	<p><i>All charges</i></p>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible...	
	High Option	Standard Option
Durable medical equipment (DME) (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> All other orthotic appliances 	All charges.	All charges
Home health services	High Option	Standard Option
<ul style="list-style-type: none"> Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. Services include oxygen therapy, intravenous therapy and medications. 	Nothing	20% of the contracted rate (calendar year deductible applies)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> 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.	All charges
Chiropractic	High Option	Standard Option
<ul style="list-style-type: none"> Manipulation of the spine and extremities Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	\$15 per visit to your primary care physician \$40 per visit to a participating specialist	\$25 per visit to your primary care physician \$45 per visit to a participating specialist
<i>Not covered: : As alternative treatment</i>	<i>All Charges:</i>	All charges
Alternative treatments	High Option	Standard Option
No benefit	All charges	All charges
Educational classes and programs	High Option	Standard Option
Coverage is limited to: <ul style="list-style-type: none"> Smoking Cessation – Up to \$100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. Diabetes self management 	\$15 per visit to your primary care physician \$40 per visit to a participating specialist	\$25 per visit to your primary care physician \$45 per visit to a participating specialist
<i>Not covered: Over the counter products</i>	<i>All charges.</i>	<i>All charges.</i>

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

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.
- Plan physicians must provide or arrange your care.
- **Under High Option**, we have **no calendar year deductible**.
- **Under Standard Option**, the calendar year deductible is: \$500 per person (\$1,000 per family). The calendar year deductible applies to certain benefits in this Section. We added "(Calendar year deductible applies)" when it applies.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible...	
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>		
Surgical procedures	High Option	Standard Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see <i>Reconstructive surgery</i>) • Surgical treatment of morbid obesity (bariatric surgery) – 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 	<p>\$15 per visit to your primary care physician</p> <p>\$40 per visit to a participating specialist</p> <p>Nothing for surgery, facility charge may apply.</p>	<p>\$25 per visit to your primary care physician</p> <p>\$45 per visit to a participating specialist</p> <p>Nothing for surgery, facility charge may apply.</p> <p>(Calendar year deductible applies)</p>

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Surgical procedures (cont.)	High Option	Standard Option
<p>Note: 1. Weight loss surgery may be an option for a select group of patients with clinically severe obesity or morbid obesity. When non-invasive methods of weight reduction have been exhausted, surgery will be considered for individuals with a Body Mass Index (BMI) of greater than or equal to 40 or a BMI of 35 or greater, with coexisting conditions. Individuals may qualify for surgery if they have been morbidly obese for a period of five (5) years or more. Morbid obesity is defined as having a BMI in excess of 40 or a BMI in excess of 35 with any of the following severe co-morbidities: coronary heart disease, diabetes mellitus, clinically significant obstructive sleep apnea, and medically refractory hypertension; 2. Member has completed growth (18 years of age or documentation of bone growth completion); 3. Recent psychiatric/psychological evaluation to rule out eating disorder(s) or psychological disturbance, such as Binge Eating Disorder, active drug abuse, active suicidal ideations/thoughts, borderline personality disorder, schizophrenia, terminal illness or uncontrolled depression, which may impede post-operative recovery and dietary restrictions; 4. Documentation (e.g., type, duration, amount of weight loss) of all prior weight control/loss programs including: food supplements, appetite suppressants, dietary regimens/treatments, and exercise programs; 5. Documentation of non-operative, physician supervised integrated weight reduction program consisting of dietary therapy, appropriate exercise, behavior modification and psychological support: Four (4) physician visits are required over a six (6) month period to document supervision; the program must maintain at least a six (6) month duration, within three (3) years of request for surgical intervention.</p> <ul style="list-style-type: none"> • Insertion of internal prosthetic devices. See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>\$15 per visit to your primary care physician</p> <p>\$40 per visit to a participating specialist</p> <p>Nothing for surgery, facility charge may apply.</p>	<p>\$25 per visit to your primary care physician</p> <p>\$45 per visit to a participating specialist</p> <p>Nothing for surgery, facility charge may apply.</p> <p>(Calendar year deductible applies)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> 	<p><i>All Charges.</i></p>	<p>All charges</p>

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Surgical procedures (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> Routine treatment of conditions of the foot; see Foot care 	All Charges.	All charges
Reconstructive surgery	High Option	Standard Option
<ul style="list-style-type: none"> Surgery to correct a functional defect Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> the condition produced a major effect of 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: <ul style="list-style-type: none"> surgery to produce a symmetrical appearance of breasts; treatment of any physical complications, such as lymphedemas; breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	\$15 per visit to your primary care physician \$40 per visit to a participating specialist Nothing for surgery, facility charge may apply.	\$25 per visit to your primary care physician \$45 per visit to a participating specialist Nothing for surgery, facility charge may apply. (Calendar year deductible applies)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> 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 <p>Surgeries related to sex transformation</p>	All Charges.	All Charges.
Oral and maxillofacial surgery	High Option	Standard Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> Reduction of fractures of the jaws or facial bones; Surgical correction of cleft lip, cleft palate or severe functional malocclusion; Removal of stones from salivary ducts; Excision of leukoplakia or malignancies; 	\$15 per visit to your primary care physician \$40 per visit to a participating specialist Nothing for surgery, facility charge may apply.	\$25 per visit to your primary care physician \$45 per visit to a participating specialist Nothing for surgery, facility charge may apply.

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Oral and maxillofacial surgery (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • TMJ (non dental) 	<p>\$15 per visit to your primary care physician</p> <p>\$40 per visit to a participating specialist</p> <p>Nothing for surgery, facility charge may apply.</p>	<p>\$25 per visit to your primary care physician</p> <p>\$45 per visit to a participating specialist</p> <p>Nothing for surgery, facility charge may apply.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> • <i>Impacted wisdom teeth</i> 	<i>All charges.</i>	All charges
Organ/tissue transplants	High Option	Standard Option
<p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	\$150 per day for the first five-days per admission	<p>\$175 a day for the first five-days per admission</p> <p>(Calendar year deductible applies)</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses: The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description.</p> <ul style="list-style-type: none"> • Allogeneic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin’s lymphoma • Advanced non-Hodgkin’s lymphoma • Chronic myelogenous leukemia • Phagocyte deficiency disease (e.g., Wiskott-Aldrich syndrome) • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Autologous transplants for: 	\$150 per day for the first five-days per admission	<p>\$175 a day for the first five-days per admission</p> <p>(Calendar year deductible applies)</p>

Organ/tissue transplants - continued on next page
High and Standard Option Section 5(b)

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin’s lymphoma • Advanced neuroblastoma • Advanced non-Hodgkin’s lymphoma • Breast Cancer • Epithelial ovarian cancer • Multiple myeloma • Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) • National Transplant Program (NTP) <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p> <p>Treatment must be provided in a National Institute of Health (NIH) approved clinical trial at a Plan-designated transplant program network provider. Treatment must be approved by the Plan’s medical director in accordance with the Plan’s protocols. AvMed will request the medical evidence we need to make our coverage determination.</p>	<p>\$150 per day for the first five-days per admission</p>	<p>\$175 a day for the first five-days per admission</p> <p>(Calendar year deductible applies)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Implants of artificial organs</i> 	<p><i>All Charges</i></p>	<p>All Charges</p>
Anesthesia	High Option	Standard Option
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Out patient Surgery • Office 	<p>Covered under Hospital admission copayment</p> <p>Covered under Outpatient copayment</p> <p>Covered under office visit copayment</p>	<p>Covered under Hospital admission copayment</p> <p>Covered under Outpatient copayment</p> <p>Covered under office visit copayment</p>

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

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.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- **Under High Option, we have no calendar year deductible.**
- **Under Standard Option, the calendar year deductible is: \$500 per person (\$1,000 per family).** The calendar year deductible applies to certain benefits in this Section. We added "(Calendar year deductible applies)" when it applies.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).

YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay	
Note: The calendar year deductible applies only when we say below: "(calendar year deductible applies)".		
Inpatient hospital	High Option	Standard Option
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	\$150 a day for the first five days per admission	\$175 a day for the first five days per admission (Calendar year deductible applies)
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen 	Nothing	Nothing
<ul style="list-style-type: none"> • 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.) 	Nothing	Nothing
<i>Not covered:</i>	<i>All Charges</i>	All charges

Inpatient hospital - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Inpatient hospital (cont.)		
<ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care, except when medically necessary • Blood and blood derivatives not replaced by the member 	<i>All Charges</i>	All charges
Outpatient hospital or ambulatory surgical center		
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma , if not donated or replaced • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	\$150 per procedure	\$175 per procedure (Calendar year deductible applies)
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges.</i>	All charges
Extended care benefits/Skilled nursing care facility benefits		
<p>Extended care benefit: We provide a comprehensive range of benefits for up to 30 post-hospital days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. All necessary services are covered, including:</p> <ul style="list-style-type: none"> • Bed, board and general nursing care; • Drugs biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor 	Nothing	Nothing (Calendar year deductible applies)
Not covered: Custodial care, Residential treatment facilities	<i>All Charges.</i>	All charges.

Benefit Description	You pay	
Hospice care	High Option	Standard Option
<p>We provide supportive and palliative care for a terminally ill member in the home or hospice facility. Services include:</p> <ul style="list-style-type: none"> • Inpatient and outpatient care; • Family counseling <p>These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.</p>	Nothing	Nothing
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<i>All Charges</i>	All Charges
Ambulance	High Option	Standard Option
<p>Local professional ambulance service, including air ambulance, when medically appropriate and ordered or authorized by a Plan doctor.</p>	Nothing	Nothing

Section 5(d) Emergency services/accidents

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.
- **Under High Option**, we have **no calendar year deductible**.
- **Under Standard Option**, the calendar year deductible is: \$500 per person (\$1,000 per family). The calendar year deductible applies to certain benefits in this Section. We added "(Calendar year deductible applies)" when it applies.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency room. Be sure to tell the emergency room personnel that you are an AvMed member so they can notify AvMed. You or a family member must notify AvMed within 48 hours unless it was not reasonably possible to do so. It is your responsibility to make sure that AvMed has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following admission, unless it was not reasonably possible to notify AvMed within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan Hospital, you will be transferred when medically feasible with any ambulance charges covered in full. Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

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

Emergencies outside our service area

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

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

High and Standard Option

Benefit Description	You pay After the calendar year deductible...	
Emergency within our service area	High Option	Standard Option
<ul style="list-style-type: none"> Emergency care at a participating doctor's office 	\$15 per visit to your primary care physician \$40 per visit to your participating specialist	\$25 per visit to your primary care physician \$45 per visit to your participating specialist
<ul style="list-style-type: none"> Emergency care at a participating urgent care center 	\$40 per visit	\$40 per visit
<ul style="list-style-type: none"> Emergency care at a non-participating urgent care center 	\$60 per visit	\$60 per visit
<ul style="list-style-type: none"> Emergency care at a participating hospital emergency room 	\$75 per visit	\$75 per visit
<ul style="list-style-type: none"> Emergency care at a non-participating hospital emergency room <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	\$100 per visit	\$100 per visit
<i>Not covered: Elective care or non-emergency care</i>	<i>All Charges.</i>	All charges.
Emergency outside our service area	High Option	Standard Option
<ul style="list-style-type: none"> Emergency care at a doctor's office 	\$60 per visit	\$60 per visit
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$60 per visit	\$60 per visit
<ul style="list-style-type: none"> Emergency care at a hospital emergency room <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	\$100 per visit	\$100 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</i> <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All Charges.</i>	All charges
Ambulance	High Option	Standard Option
Professional ambulance service when medically appropriate. Air ambulance, when medically necessary and preauthorized by Medical Director or Chief Medical Officer. Note: See 5(c) for non-emergency service.	Nothing	Nothing

Section 5(e) Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

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.
- **Under High Option**, we have **no calendar year deductible**.
- **Under Standard Option**, the calendar year deductible is: \$500 per person (\$1,000 per family). The calendar year deductible applies to certain benefits in this Section. We added "(Calendar year deductible applies)" when it applies
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

YOU MUST GET PREAUTHORIZATION OF THESE SERVICES. See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible...	
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.</p>		
Mental health and substance abuse benefits	High Option	Standard Option
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$15 per visit to your primary care physician</p> <p>\$40 per visit to a participating specialist</p>	<p>\$25 per visit to your primary care physician</p> <p>\$45 per visit to a participating specialist</p>
<p>Diagnostic tests</p>	<p>\$15 per visit to your primary care physician</p> <p>\$40 per visit to a participating specialist</p>	<p>\$25 per visit to your primary care physician</p> <p>\$45 per visit to a participating specialist</p>

Mental health and substance abuse benefits - continued on next page

High and Standard Option

Benefit Description	You pay After the calendar year deductible...	
Mental health and substance abuse benefits (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> Services provided by a hospital or other facility 	\$150 a day for the first five-days per admission.	\$175 a day for the first five-days per Hospital admission (Calendar year deductible applies).
<ul style="list-style-type: none"> Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	\$15 per visit to your primary care physician \$40 per visit to a participating specialist	\$25 per visit to your primary care physician \$45 per visit to a participating specialist
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All Charges.</i>	All charges
Preauthorization	To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:	
Limitation	We may limit your benefits if you do not obtain a treatment plan.	

Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option**, we have **no calendar year deductible**.
- **Under Standard Option**, the calendar year deductible does NOT apply to prescriptions filled through the Retail Pharmacy Program or Mail Service prescription Drug Program. We added “(Calendar year Deductible applies)” when it applies.
- Authorization may be required before some medications are dispensed. Authorization criteria are reviewed and approved by AvMed’s Pharmacy and Therapeutics Committee. Approval must be obtained from AvMed by the prescribing physician. The list of medications requiring authorization is subject to periodic review and modification by AvMed. A copy of the list of medications requiring authorization and their authorization criteria are available from Member Services 1-800-882-8633.

Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a plan pharmacy or by mail for a maintenance medication.
- **We use a Preferred Drug List (formulary).** The Three-Tier Preferred Drug List establishes three levels of copayment for medications within Plan-regulated therapeutic classes. Therapeutic classes not regulated by a three-tier schedule are considered open. A copy of the list is available from member services 1-800-882-8633. Levels of copayment are, in general, applied as follows:

Three-Tier Covered Therapeutic Classes

Tier 1 Lowest copay for Preferred Generic medications

Tier 2 Middle copay for Preferred Brand medications

Tier 3 Highest copay for Non-preferred Brand and Non-preferred Generic medications

Preferred brand medications are determined by AvMed’s Pharmacy and Therapeutics Committee and are evaluated based on clinical efficacy, relative safety and cost to the plan in comparison to similar medications within a therapeutic class. Pharmacy and Therapeutics Committee decisions are published in the Physician’s Update which is distributed quarterly. Rarely, medications may be excluded in a regulated therapeutic class. These are medications that offer no clinical or financial advantage compared with other medications in that therapeutic class and are not covered. As new medications in a covered therapeutic class become available, they may be considered excluded until they have been reviewed by AvMed’s Pharmacy and Therapeutics Committee.

- **These are the dispensing limitations.** Prescription drugs dispensed at a Plan pharmacy will be dispensed in an amount to treat an acute illness or within the manufacturer's recommended dosages, but no more than a 30-day supply per copayment (or 90-day supply via Mail Order). Your prescription may be refilled via retail or mail order after 75% of your previous fill has been used. A medication-specific quantity limit may apply for medications that have an increased potential for over-utilization or an increased potential for a patient to experience an adverse effect at higher doses. Quantity limits are set in accordance with U.S. Food and Drug Administration (FDA) approved prescribing limitations, general practice guidelines supported by medical specialty organizations, and/or evidence-based, statistically valid clinical studies without published conflicting data. The list of medications with specific limits less than a 30-day supply is subject to periodic review and modification by AvMed. A copy of this list is available from Member Services 1-800-882-8633. A member who is called to active military duty, as well as a member who needs to obtain prescribed medications during a time of National or other emergency can contact our Member Services department. When traveling outside of Florida please call member services 1-800-882-8633 for the nearest plan pharmacy.
- **Why use Generic drugs?** Generic drugs provide a lower cost alternative to name Brand drugs. Generic drugs contain the same active ingredients as name Brand drugs. They undergo a strict review process by the U.S. Food and Drug Administration to determine they meet the same standards of quality and strength as name Brand drugs.
- **When you have a prescription filled, a Generic equivalent to a name Brand drug will be dispensed.** If you or your physician choose a name Brand drug when there is a FDA-approved Generic equivalent to that name Brand drug, you have to pay the difference in cost between the name Brand drug and the Generic drug plus the applicable Brand copay. For name Brand drugs that do not have an FDA-approved generic equivalent you will pay the applicable Brand copayment.
- **When you do have to file a claim.** If you need a prescription before you receive your Membership card, you can fill the prescription at a participating pharmacy and submit the receipt and a copy of the prescription to AvMed for reimbursement. Claims for reimbursement are subject to all definitions, limitations and exclusions in this brochure and AvMed's authorization criteria, when applicable. The applicable copayment amount will be subtracted from the reimbursement. Please indicate your AvMed Member ID Number on the receipt. See Section 7 for specific information.

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	High Option	Standard Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Diabetic supplies limited to • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see Prior authorization below). Coverage is limited; contact AvMed for dose limits. You pay the drug copayment up to the dosage limit and all charges above that. • Contraceptive drugs and devices 	<p>Retail Drugs</p> <p>\$15 Generic Drugs</p> <p>\$30 Preferred Brand Name Drugs</p> <p>\$50 Non-Preferred Brand Name and Generic Drugs</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>	<p>Retail Drugs</p> <p>\$20 Generic Drugs</p> <p>\$40 Preferred Brand Name Drugs</p> <p>\$60 Non-Preferred Brand Name and Generic Drugs</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>

Benefit Description	You pay After the calendar year deductible...	
Covered medications and supplies (cont.)	High Option	Standard Option
	Mail Order Drugs \$45 Generic Drugs \$90 Preferred Brand Name Drugs \$150 Non-Preferred Brand Name and Generic Drugs	Mail Order Drugs \$60 Generic Drugs \$120 Preferred Brand Name Drugs \$180 Non-Preferred Brand Name and Generic Drugs
Your injectable drug prescription coverage includes the quantity sufficient to treat the acute phase of an illness or established by the manufacturers packaging guidelines but not more than a 30 day supply per coinsurance or actual cost, whichever is less.	30% co-insurance	30% co-insurance
Here are some things to keep in mind about our prescription drug program: <ul style="list-style-type: none"> • When you have a prescription filled, a Generic equivalent to a name Brand drug will be dispensed. If you or your physician choose a name Brand drug when there is a FDA-approved Generic equivalent to that name Brand drug, you have to pay the difference in cost between the name Brand drug and the Generic drug plus the applicable Brand copayment. For name Brand drugs that do not have an FDA-approved Generic equivalent you will pay the applicable Brand copayment. 		
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes.</i> • <i>Drugs to enhance athletic performance.</i> • <i>Fertility drugs.</i> • <i>Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies.</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them.</i> • <i>Nonprescription medicines or medicines for which there is a nonprescription alternative.</i> • <i>Medical supplies, including therapeutic devices, dressings, antiseptics, appliances, and support garments.</i> • <i>Compounded prescriptions, except pediatric preparations.</i> • <i>Prescription and non-prescription appetite suppressants and products for the purpose of weight loss.</i> • <i>Nicotine suppressants and smoking cessation products and services.</i> 	<i>All Charges.</i>	All charges

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Covered medications and supplies (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Medications for non-business related travel, including transdermal scopolamine, i.e. motion sickness patches. • Replacement prescription products resulting from a lost, stolen, expired, broken, or destroyed prescription orders for refill. • Medications that require preauthorization and for which preauthorization is denied or not obtained by a physician. <p>Medications for dental purposes, including fluoride medications, antibiotics and pain medications for dental care.</p>	<p><i>All Charges.</i></p>	<p>All charges</p>

Section 5(g) Special features

<p>Flexible benefits Option</p>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
<ul style="list-style-type: none"> • 24 hour nurse line 	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-888-866-5432 and talk with a registered nurse who will discuss treatment options and answer your health questions.</p>
<ul style="list-style-type: none"> • Centers of Excellence for transplant/heart surgery/etc. 	<p>Consult Member Services at 1-800-882-8633 to obtain a complete list of centers.</p>
<ul style="list-style-type: none"> • Disease Management 	<p>Call 1-800-972-8633 for information and help with the following:</p> <ul style="list-style-type: none"> • Healthy Hearts – congestive heart failure • E-Z Breath'n – asthma • Healthy Expectations – high risk pregnancy • Compass Diabetes Care Program - diabetes
<ul style="list-style-type: none"> • The Healthwise Knowledgebase 	<p>The Healthwise Knowledgebase contains comprehensive, current, evidence-based, and unbiased information to help you make decisions about your health and work in partnership with your doctors by offering easy-to-find and easy-to-understand information about conditions, diseases, medical tests, medications, treatment options, and key decision points.</p> <p>Log onto our Website at www.avmed.org to access the Healthwise site. Click on Healthy Living under Member Services Online.</p>
<ul style="list-style-type: none"> • AvMed Member Services 	<p>Every AvMed member has a friend, 24 hours a day, every day, in our Member Services Department. Representatives are here for you to answer questions regarding benefits, claims, changing physicians – anything involving your AvMed membership. Next to health care coverage itself, every satisfaction survey tells us this is every member's most valued service. Contact them at members@avmed.org or call 1-800-882-8633.</p>

Section 5(h) Dental benefits

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
- Plan dentists must provide or arrange your care.
- Under High Option, we have **no calendar year deductible**.
- Under Standard Option, the calendar year deductible is: \$500 per individual (\$1,000 per family). The calendar year deductible applies to certain benefits in this Section. We added “(Calendar year Deductible applies)” when it applies.
- 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. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
Accidental injury benefit	High Option	Standard Option
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.	Nothing	Nothing

Dental benefits

We have no other dental benefits.

Section 10 Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 11.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 11.
Covered services	Care we provide benefits for, as described in this brochure.
• Custodial Care	Services and supplies that are furnished mainly to train or assist in the activities of daily living, such as bathing, feeding, dressing, walking and taking oral medicines. “Custodial Care” also means services and supplies that can be safely and adequately provided by persons other than licensed health care professionals, such as dressing changes and catheter care or that of ambulatory patients customarily provide for themselves, such as ostomy care, measuring and recording urine and blood sugar levels, and administering insulin. Custodial care that lasts 90 days or more is sometimes know 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
Experimental or investigational service	The Plan’s experimental/investigational determination process is based on authoritative information from medical literature, medical consensus bodies, FDA approval, clinical trials, and health care professionals with specialty expertise in the subject.
Group health coverage	The form of health insurance covering groups of persons under a master group health insurance policy issued to any one group.
Medical necessity	The use of any appropriate medical treatment, service, equipment and/or supply as provided by a hospital, skilled nursing facility, physician or other provider which is necessary for the diagnosis, care and/or treatment of a Member’s illness or injury.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:
Us/We	Us and We refer to AvMed Health Plans.
You	You refers to the enrollee and each covered family member.

Section 11 FEHB Facts

Coverage information

Section 8 The disputed claims process

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or 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.

AvMed Value Added Services:

Massage Therapy, Yoga, Through AvMed partner, American WholeHealth Inc., the nation's leading alternative

Acupuncture & etc. health management company. To locate a practitioner, log-in to their Web site at <http://avmed.wholehealthmd.com> or call American WholeHealth, Inc. at (800) 274-7526.

Weight Watchers Full reimbursement for up to one year of Weight Watchers fees once you reach your goal weight. Contact AvMed Member Services at members@avmed.org, or 1-800-882-8633 for the form to register.

Smokenders Reduced price for the Smokenders booklet/videotape. Get your money back when you quit smoking. To order, call 1-800-828-4357.

Vitamins, Supplements, Great pricing on hundreds of vitamins and natural health supplements available to AvMed

Health-Related Products members through our partner, American WholeHealth Inc. Members may log on to <http://avmed.wholehealthmd.com> or call American WholeHealth, Inc. at (800) 274-7526.

AvMed's Nurse On Call 24-hour telephone line where you can speak confidentially with a registered nurse about any health concern. 1-888-866-5432.

Expanded vision care Discounts on vision services are available to AvMed members. Services include: Eye exams, Eyeglasses, Contact lenses, Designer glasses, sunglasses, etc. To find a provider in your area, call AvMed Member Services any hour of any day at 1-800-882-8633 or e-mail us at members@avmed.org. You can also find a provider through our Online Provider Directory at www.avmed.org.

Medicare prepaid plan enrollment – This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated in Section 9, annuitants and former spouses with FEHB coverage and Medicare Part A and Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later re-enroll in the FEHB program. Most Federal annuitants have Medicare Part A. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on changing your FEHB enrollment and changing to Medicare prepaid plan. Contact us at 1-800-535-9355 for information on the Medicare prepaid plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB Plan, call 1-800-535-9355 for information on the benefits available under the Medicare HMO.

Non-FEHB benefits available to Plan members

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

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

Section 6 General exclusions – things we don't cover

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

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies 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 (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7 Filing a claim for covered services

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 required by Section 3.

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians 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 1-800-882-8633.

When you must file a claim – such as for services you received outside the Plan’s service area – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Submit your claims to: **9400 South Dadeland Blvd., Suite 200, Miami, FL 33156
1-800-882-8633**

Prescription drugs

**Submit your claims to: 9400 South Dadeland Blvd., Suite 200, Miami, FL 33156
1-800-882-8633**

Other supplies or services

Submit your claims to:

9400 South Dadeland Blvd., Suite 200, Miami, FL 33156; 1-800-882-8633

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

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

Section 8 The disputed claims process

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">a) Write to us within 6 months from the date of our decision; andb) Send your request to us at: AvMed Member Relations, P.O. Box 749, Gainesville, FL 32602-0749; andc) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and <p>Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</p>
2	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none">a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orb) Write to you and maintain our denial - go to step 4; orc) 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	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within</p> <ul style="list-style-type: none">• 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. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group x, 1900 E Street, NW, Washington, DC 20415-xxxx.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none">• A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;• Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;• Copies of all letters you sent to us about the claim;• Copies of all letters we sent to you about the claim; and• Your daytime phone number and the best time to call. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p> <p>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.</p>

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

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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 lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Section 11 FEHB Facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition 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/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

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 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 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 cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective 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. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2007 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2006 benefits until the effective date of your coverage with your new plan. 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

Section 8 The disputed claims process

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 xxx 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 Insurance Group x at 202/606-xxxx between 8 a.m. and 5 p.m. eastern time.

Section 11 FEHB Facts

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 (TCC), or a conversion policy (a non-FEHB individual policy.)

Upon divorce

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either 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 Web site, 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 (HIPAA) 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, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

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

Section 12 Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

Second, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Third, the new **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, offers a variety of dental plans and vision plans to anyone who is eligible to enroll in the Federal Employees Health Benefits Program. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents. Premiums are on an enrollee-pays-all basis

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses.

There are four types of FSAs offered by FSAFEDS. The maximum election is \$5,000 per year.

- **Health Care FSA (HCFSA)** –Pays for eligible health care expenses for you and your dependents which are not covered by FEHBP coverage or other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents.

Limited Enrollment Health Care FSA (LEN HCFSA) – Designed for
XX-
XXXXXXXXXXXXXXXXXXXX (we will provide information for the next draft)

What expenses can I pay with an FSAFEDS account?

For the HCFSA and LEN HCFSA – Health plan copayments, deductibles, over-the-counter medications and products, sunscreen, eyeglasses, contacts, other vision and dental expenses (but not insurance premiums).

For the LEX HCFSA – Dental and vision care expenses (but not insurance premiums)

For the DCFSA – daycare expenses (including summer camp) for your child(ren) under age 13, dependent care expenses for dependents unable to care for themselves

AND MUCH MORE! Visit www.FSAFEDS.com

Who is eligible to enroll?

Most Federal employees in the Executive branch and many in non-Executive branch agencies are eligible. For specifics on eligibility, visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., EST. TTY: 1-800-952-0450.

When can I enroll?

If you wish to participate, you must make an election to enroll each year by visiting www.FSAFEDS.com or calling the number above during the FEHB Open Season or within 60 days of employment (for new employees).

Even if you enrolled for 2006, you must make a new election to continue participating in 2007. Enrollment DOES NOT carry over from year to year.

What is an FSAFEDS Debit Card?

XXXXXXXXXXXXXXXXXXXX (we will put in information the next round)

Who is SHPS?

SHPS is the Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is BENEFEDS?

BENEFEDS is the name of the voluntary benefits portal hired by OPM to work with the FSAFEDS Program to set up payroll deductions for FSAFEDS allotments.

The Federal Employees Dental and Vision Insurance Program – FEDVIP

xxx

xxx

Summary of benefits for the High Option of the - 2007

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$15 primary care; \$40 specialist	16
Services provided by a hospital:		
• Inpatient	\$150 per day for the first five days of admission up to a \$750 maximum	31
• Outpatient	\$150 per procedure	32
Emergency benefits:		
• In-area	\$75 per visit (copayment waived if admitted)	35
• Out-of-area	\$100 per visit (copayment waived if admitted)	35
Mental health and substance abuse treatment:	Regular cost sharing	xx
Prescription drugs:		xx
• Retail pharmacy	Generic \$15, Preferred Brand \$30, Non-Preferred Brand \$50	
• Mail order	Generic \$45, Preferred Brand \$90, Non-Preferred Brand \$150	
Dental care:	No benefit.	xx
Vision care: Refractions, including lens prescriptions, limited to children through age 17.	\$40 copayment per visit	22
Special features:	Flexible benefit option, 24-hour nurse line, Disease Management, Centers of Excellence	42
Point of Service benefits:		xx
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$1,500/Self Only or \$3,000/Family enrollment per year	11
	Some costs do not count toward this protection	

Summary of benefits for the Standard Option of the - 2007

- Do not rely on this chart alone. All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the \$500 per individual (\$1,000 per family)calendar year deductible.

Standard Option Benefits	You Pay	You Pay
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$25 primary care; \$45 specialist	16
Services provided by a hospital:		
• Inpatient	\$175 * per day for the first five days of admission up to a \$875 maximum	31
• Outpatient	\$175 * per procedure	32
Emergency benefits:		xx
• In-area	\$75 per visit (copayment waived if admitted)	35
• Out-of-area	\$100 per visit (copayment waived if admitted)	35
Mental health and substance abuse treatment:	Regular cost sharing	37
Prescription drugs:		
• Retail pharmacy	Generic \$20, Preferred Brand \$40, Non-Preferred Brand \$60	
• Mail order	Generic \$60, Preferred Brand \$120, Non-Preferred Brand \$180	
Dental care:	No benefit.	43
Vision care: Refractions, including lens prescriptions, limited to children through age 17.	\$45 copayment per visit	22
Special features:	Flexible benefits option, 24-hour nurse line, disease management, Centers of Excellence	42
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$4000/Self only or \$8000/ Family enrollment per year Some costs do not count toward this protection	11

2007 Rate Information for -

Non-Postal rates apply to most non-Postal employees. 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.

Type of Enrollment	Enrollment Code	Non-Postal Premium			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
		Non-Postal Premium			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share