AvMed Health Plans

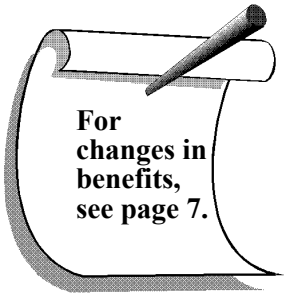
http://www.avmed.org

2009

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.



This Plan has Excellent accreditation from the NCQA.
See the 2009 Guide for more information on accreditation.

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

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

Table of Contents 1
Introduction 3
Plain Language 3
Stop Health Care Fraud! 3
Preventing medical mistakes 4
Section 1 Facts about this HMO plan 6
- General features of our high and standard options 6
- How we pay providers 6
- Your Rights 6
- Service Area 6

Section 2 How we change for 2009 7
- Changes to this Plan 7

Section 3. How you get care 8
- Identification cards 8
- Where you get covered care 8
  - Plan providers 8
  - Plan facilities 8
- What you must do to get covered care 8
  - Primary care 8
  - Specialty care 8
  - Hospital care 9
  - If you are hospitalized when your enrollment begins 9
- How to get approval for… 10
  - Your hospital stay 10
  - How to precertify an admission 10
  - Maternity care 10

Section 4 Your costs for covered services 11
- Copayments 11
- Deductible 11
- Coinsurance 11
- Your catastrophic protection out-of-pocket maximum 11

High and Standard Option Benefits 12
Non-FEHB benefits available to Plan members 42
Section 6 General exclusions – things we don't cover 43
Section 7 Filing a claim for covered services 44
Section 8 The disputed claims process 45
Section 10 Definitions of terms we use in this brochure 52
Section 11 FEHB Facts 53
- No pre-existing condition limitation 53
- Where you can get information about enrolling in the FEHB Program 53
- Types of coverage available for you and your family 53
- Children's Equity Act 53
- When benefits and premiums start 54
- When you retire 54
- When FEHB coverage ends 54
- Upon divorce 55

Temporary Continuation of Coverage (TCC) 55
Converting to individual coverage 55
Getting a Certificate of Group Health Plan Coverage 55
Section 12 Three Federal Programs complement FEHB benefits 56
The Federal Flexible Spending Account Program – FSAFEDS 56
The Federal Long Term Care Insurance Program - FLTCIP 56
The Federal Dental and Vision Insurance Program - FEDVIP 57
Summary of benefits for the High Option 58
Summary of benefits for the Standard Option 59
2009 Rate Information for AvMed Health Plans 60

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, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, 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 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 provider, 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 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.

Visit these web sites for more information about patient safety?

- www.ahrq.gov/path/beactive.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.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- 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 How we change for 2009

Do not rely only 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 this Plan

- We have added an out-of-pocket maximum of $2,500 per member per calendar year to the Tier 4 specialty drug benefit.

Changes to our High Option only

- Your share of the non-Postal premium will increase for Self Only or Self and Family. See page 60.

Changes to our Standard Option only

- Your share of the non-Postal premium will increase for Self Only or Self and Family. See page 60.

Changes to both High and Standard Options

- We have added an out-of-pocket maximum of $2,500 per member per calendar year to the Tier 4 specialty drug benefit.

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: 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 seecertain specialists without a referral. Except in a medical emergency, or when a primary care physician has designated another doctor to see patients when he or she is unavailable, you must receive a referral from your primary care physician before seeing any other doctor or obtaining special services. Referral to a participating specialist is given at the primary care physician's discretion; if specialists or consultants are required beyond those participating in the Plan, the primary care physician will make arrangements for the appropriate referral. A member may obtain covered services from a chiropractor or a podiatrist without a referral; a woman may see her Plan gynecologist directly once a year for an annual check-up, with on need to be referred by her primary care physician; a member may obtain five office visist per calendar year to a Plan dermatologist for covered services.

The treatment plan will permit you to visit your specialist without the need to obtain further referrals. Requests by primary care physicians for referrals to specialists are evaluated based upon medical information given by the provider. The authorization for the referral includes the initial visit as well as the follow-up visits as determined by the medical condition. The authorization is good for 90 days. At the end of 90 days, additional visits can be authorized based on the patient's medical condition.

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**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-882-8633. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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.

What happens when you do not follow the precertification rules when using non-network facilities

If prior approval is not given for services provided by a non-network facility/provider, the Health Plan shall have no liability or obligation whatsoever, on account of services or benefits sought or received by any member from any non-network physician, health professional, hospital or other health care facility, or other person, institution or organization.

Circumstances beyond our control

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

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process preauthorization. Your physician must obtain authorization for the following services such as, but not limited to, consultation by specialists, hospitalization, Growth hormone therapy (GHT), most laboratory testing and other comprehensive diagnostic and treatment services.

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.

· The calendar year deductible is $500 per person under Standard Option. 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 under the Standard Option.

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

Your catastrophic protection out-of-pocket maximum

After your (copayments and coinsurance) 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 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 58 and page 59 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 14
Section 5(a) Medical services and supplies provided by physicians and other health care professionals 15
- Diagnostic and treatment services 15
- Lab, X-ray and other diagnostic tests 16
- Preventive care, adult 16
- Preventive care, children 17
- Maternity care 17
- Family planning 18
- Infertility services 18
- Allergy care 19
- Treatment therapies 19
- Physical and occupational therapies 20
- Speech therapy 20
- Hearing services (testing, treatment, and supplies) 20
- Vision services (testing, treatment, and supplies) 21
- Foot care 21
- Orthopedic and prosthetic devices 21
- Durable medical equipment (DME) 22
- Home health services 23
- Chiropractic 23
- Alternative treatments 23
- Educational classes and programs 23

Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals 24
- Surgical procedures 24
- Reconstructive surgery 26
- Oral and maxillofacial surgery 26
- Organ/tissue transplants 27
- Anesthesia 28

Section 5(c) Services provided by a hospital or other facility, and ambulance services 29
- Inpatient hospital 29
- Outpatient hospital or ambulatory surgical center 30
- Extended care benefits/Skilled nursing care facility benefits 30
- Hospice care 31
- Ambulance 31

Section 5(d) Emergency services/accidents 32
- Emergency within our service area 33
- Emergency outside our service area 33
- Ambulance 33

Section 5(e) Mental health and substance abuse benefits 34
- Mental health and substance abuse benefits 34

Section 5(f) Prescription drug benefits 36
- Covered medications and supplies 37

Section 5(g) Special features 40
- Flexible benefits Option 40

24 hour nurse line....40
Centers of Excellence for transplant/heart surgery/etc. 40
Disease Management 40
The Healthwise Knowledgebase....40
AvMed Member Services....40
Section 5(h) Dental benefits....41
Accidental injury benefit....41
Non-FEHB benefits available to Plan members 42
Summary of benefits for the High Option 58
Summary of benefits for the Standard Option 59

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 *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 • 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 • 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)
• 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
Not covered: *Injuries received in connection with the commission of a felony*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology	$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
• X-rays Prior authorization is required for the following: • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	$10 per test	20% of the contracted rate (calendar year deductible applies)
Prior authorization is required for the following: • CAT Scans/PET Scans/MRI	$25 per test	20% of the contracted rate (calendar year deductible applies)
Preventive care, adult	**High Option**	**Standard Option**
Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including - 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 *Diagnostic and treatment services,* above.	$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: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	$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**
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 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
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**
• 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
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - 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: • Prenatal care • Postnatal care	Copayments are waived for maternity care	Copayments are waived for maternity care
• Delivery Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 10 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.	$150 per day for the first five days per hospital admission	$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**
• 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. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$150 per day for the first five days per hospital admission	$175 per day for the first five days per hospital admission (Calendar year deductible applies)
Not covered: Routine sonogram to determine fetal age, size or sex.	*All charges*	*All charges*
Family planning	**High Option**	**Standard Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b))	$100 Copayment	$100 copayment
• Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Interauterine devices (IUDs) • Diaghragms *Note: We cover oral contraceptives under the prescription drug benefit.*	$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
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: - intravaginal insemination (IVI)	$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
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* *- in vitro fertilization* *- embryo transfer, gamete (GIFT) and zygote (ZIFT)* • *Artificial insemination*: *1. intracervical insemination (ICI)*	*All charges*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Infertility services (cont.)	**High Option**	**Standard Option**
2. intrauterine insemination (IUI) • *Services and supplies related to ART procedures* • *Surgery for the enhancement of fertility* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment	$50 per course of testing	$50 per course of testing.
• Allergy injections	$10 per office visit	$25 per office visit
Allergy serum	Nothing	Nothing
Not covered: *provocative food testing* and s*ublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 28. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: – We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	$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
Not covered:	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Physical and occupational therapies	**High Option**	**Standard Option**
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: • qualified physical therapists and • occupational therapists 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.	$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
Cardiac Rehabilitation is covered for the following conditions: • Acute myocardial infarction • Percutaneous transluminal coronary angioplasty (PTCA) • Repair or replacement of heart valve(s) • Coronary artery bypass graft (CABG), or • Heart transplant Coverage is limited to 18 visits per year. Benefits limited to $1,500 per contract year	$20 per visit	$25 per visit
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
When medically necessary.	$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
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Hearing testing for children through age 17, which include; (see *Preventive care, children)*	$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
Not covered: • *All other hearing testing* • *Hearing aids, testing and examinations for them*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
· Annual eye refractionsto determine the need for vision correction for children through age 17 · Diagnosis and treatment of diseases of the eye Note: See *Preventive care, children* for eye exams for children.	$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
Not covered: • *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* • *Radial keratotomy and other refractive surgery*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$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
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Podiatric shoe inserts or foot orthotics*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• 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. Note: See 5(b) for coverage of the surgery to insert the device.	Nothing	20% of the contracted rate (calendar year deductible applies)
Not covered:	*All charges*	*All charges*

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**
• *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* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician. Covered items include: • Oxygen; • Dialysis equipment; • Hospital beds; • Standard wheelchairs; • Crutches; and • Insulin pumps. 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. 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.	$50 per episode of illness Benefits are limited to a maximum of $500 per contract year. You pay anything above that amount.	20% of the contracted rate (calendar year deductible applies) Benefits are limited to a maximum of $500 per contract year. You pay anything above that amount..
Not covered: • *Medical supplies such as corsets which do not require a prescription* • *Motorized wheelchairs* • *Non-standard wheelchairs* • *All other orthotic appliances*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Home health services	**High Option**	**Standard Option**
• 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)
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**
• 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
Alternative treatments	**High Option**	**Standard Option**
No benefit	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
Coverage is limited to: • 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
Not covered: Over the counter products	*All charges*	*All charges*

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…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • 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 *Reconstructive surgery*) • 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	$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)

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Surgical procedures (cont.)	**High Option**	**Standard Option**
Note: 1. Weight loss surgery may be an option for a select group of patients with clinically severe obesity or morbid obesity. When non-evasive 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. • Insertion of internal prosthetic devices . See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns 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.	$100 copayment	$100 copayment
Not covered: • *Reversal of voluntary sterilization*	*All charges*	*All charges*

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• *Routine treatment of conditions of the foot; see Foot care*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: • 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: • surgery to produce a symmetrical appearance of breasts; • treatment of any physical complications, such as lymphedemas; • breast prostheses and surgical bras and replacements (see *Prosthetic devices*) 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.	$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)
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • 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; • Excision of cysts and incision of abscesses when done as independent procedures; and	$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**
• Other surgical procedures that do not involve the teeth or their supporting structures. • TMJ (non dental)	$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.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Impacted wisdom teeth*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to *Other services* in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description and can safely tolerate the procedure. • Cornea • Heart • Kidney • Liver • Lung: Single/double • Intestinal transplants • 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	$175 a day for the first five-days per admission (Calendar year deductible applies)
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. • Allogeneic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Chronic myelogenous leukemia	$150 per day for the first five-days per admission	$175 a day for the first five-days per admission (Calendar year deductible applies)

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Phagocyte deficiency disease (e.g., Wiskott-Aldrich syndrome) • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Autologous transplants for: • 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 • Autogolous tandem transplants for recurrent germ cell tumors (including testicular cancer) • National Transplant Program (NTP) Note: We cover related medical and hospital expenses of the donor when we cover the recipient. 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.	$150 per day for the first five-days per admission	$175 a day for the first five-days per admission (Calendar year deductible applies)
Not covered: • *Implants of artificial organs*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient)	Covered under Hospital admission copayment	Covered under Hospital admission copayment
• Outpatient surgery	Covered under Outpatient copayment	Covered under Outpatient copayment
• Office	Covered under Office visit copayment	Covered under Office visit copayment

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 • 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 (Calender year deductible applies)
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, only if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen	Nothing	Nothing
• Anesthetics, including nurse anesthetist services • Take-home items	Nothing	Nothing

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	Nothing	Nothing
Not covered: • *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*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$150 per procedure	$175 per procedure (Calendar year deductible applies)
Not covered: Blood and blood derivatives not replaced by the member	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
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: • Bed, board and general nursing care;	Nothing	Nothing (Calender year deductible applies)

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefit Description	You pay	
Extended care benefits/Skilled nursing care facility benefits (cont.)	**High Option**	**Standard Option**
• Drugs biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor	Nothing	Nothing (Calender year deductible applies)
Not covered: Custodial care	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**
We provide supportive and palliative care for a terminally ill member in the home or hospice facility. Services include: • Inpatient and outpatient care; • Family counseling These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing	Nothing
Not covered: Independent nursing, homemaker services	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Local professional ambulance service, including air ambulance, when medically appropriate and ordered or authorized by a Plan doctor.	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 is 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.

Benefit Description	You pay After the calendar year deductible…	
Emergency within our service area	**High Option**	**Standard Option**
• 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
• Emergency care at a participating urgent care center	$40 per visit	$40 per visit
• Emergency care at a non-participating urgent care center	$60 per visit	$60 per visit
• Emergency care at a participating hospital emergency room	$75 per visit	$75 per visit
• Emergency care at a non-participating hospital emergency room Note: We waive the ER copay if you are admitted to the hospital.	$100 per visit	$100 per visit
Not covered: Elective care or non-emergency care	*All charges*	*All charges*
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office	$60 per visit	$60 per visit
• Emergency care at an urgent care center	$60 per visit	$60 per visit
• Emergency care at a hospital emergency room Note: We waive the ER copay if you are admitted to the hospital.	$100 per visit	$100 per visit
Not covered: • *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* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*	*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…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Mental health and substance abuse benefits	**High Option**	**Standard Option**
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. 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.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$15 per visit 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
Diagnostic tests	$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

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Mental health and substance abuse benefits (cont.)	**High Option**	**Standard Option**
• 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).
• 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
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*	*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: Preauthorization is required for most scheduled diagnostic tests/procedures and all scheduled inpatient/ outpatient surgical procedures. It is the responsibility of the requesting physician to obtain authorization prior to scheduling services. In order to check on a referral, call AvMed Link Line at 1-800-806-3623.
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.
- 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 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**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • 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	Retail Drugs $15 Generic Drugs $30 Preferred Brand Name Drugs $50 Non-Preferred Brand Name and Generic Drugs Note: If there is no generic equivalent available, you will still have to pay the brand name copay.	Retail Drugs $20 Generic Drugs $40 Preferred Brand Name Drugs $60 Non-Preferred Brand Name and Generic Drugs Note: If there is no generic equivalent available, you will still have to pay the brand name copay.

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**
Mail service is a benefit option for maintenance medications needed for chronic or long-term health conditions. It's best to get an initial prescription filled at your retail pharmacy. Ask your physician for an additional prescription for up to a 90-day supply of your medication to be ordered through mail service. Pay the following copayment (as well as the cost difference if you or your physician choose a name Brand drug when there is an FDA-approved Generic).	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 We have added an out-of-pocket maximum of $2,500 per member per calendar year to the Tier 4 specialty drug benefit.	30% co-insurance We have added an out-of-pocket maximum of $2,500 per member per calendar year to the Tier 4 specialty drug benefit.
Here are some things to keep in mind about our prescription drug program: • 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.		
Not covered: • *Drugs and supplies for cosmetic purposes.* • *Drugs to enhance athletic performance.* • *Fertility drugs.* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies.* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them.* • *Nonprescription medicines or medicines for which there is a nonprescription alternative.* • *Medical supplies, including therapeutic devices, dressings, antiseptics, appliances, and support garments.* • *Compounded prescriptions, except pediatric preparations.* • *Prescription and non-prescription appetite suppressants and products for the purpose of weight loss.*	*All charges*	*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**
• *Nicotine suppressants and smoking cessation products and services.* • *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.* • *Medications for dental purposes, including fluoride medications, antibiotics and pain medications for dental care.*	*All charges*	*All charges*

Section 5(g) Special features

Flexible benefits Option

Under the flexible benefits option, we determine the most effective way to provide services.

- We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit.
- Alternative benefits are subject to our ongoing review.
- By approving an alternative benefit, we cannot guarantee you will get it in the future.
- The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits.
- Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.

- **24 hour nurse line**

For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-888-866-5432 and talk with a registered nurse who will discuss treatment options and answer your health questions.

- **Centers of Excellence for transplant/heart surgery/etc.**

Consult Member Services at 1-800-882-8633 to obtain a complete list of centers.

- **Disease Management**

Call 1-800-972-8633 for information and help with the following:

- Healthy Hearts – congestive heart failure
- E-Z Breath'n – asthma
- Healthy Expectations – high risk pregnancy
- Compass Diabetes Care Program - diabetes

- **The Healthwise Knowledgebase**

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.

Log onto our Website at www.avmed.org to access the Healthwise site. Click on Healthy Living under Member Services Online.

- **AvMed Member Services**

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.

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 Desription	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.

Non-FEHB benefits available to Plan members

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. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at, 1-800-882-8633 or visit their website at www.avmed.org.

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.

Section 6 General exclusions – things we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **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 *Emergencyservices/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

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:

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

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.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: AvMed Member Relations, P.O. Box 749, Gainesville, FL 32602-0749; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or b) Write to you and maintain our denial - go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

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

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

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

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

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

You may not sue until you have completed the disputed claims process. Further, Federal law governs your 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.

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

a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-882-8633 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 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

What is Medicare?

Medicare is a health insurance program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security

Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

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

If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-800-882-8633 or see our Web site at www.avmed.org.

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

- Medical services and supplies provided by physicians and other health care professionals.
- We do not waive any costs if the Original Medicare Plan is your primary payer.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

This Plan and our Medicare Advantage plan:

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

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

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payer for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payer before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payer before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
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.

Coverage information

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 family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorcé, or when your child under age 22 marries.

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 2009 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 2008 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

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.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

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 Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents, which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **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 which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Day Care FSA (DCFSA) (formerly known as the Dependent Care FSA)** – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

Where can I get more information about FSAFEDS?

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., Eastern time. TTY: 1-800-952-0450.

The Federal Empolyees Dental and Vision Insurance Program –*FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans provide a comprehensive range of services, including all the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877- 889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. 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. 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. You must apply to know if you will be approved for enrollment. To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Summary of benefits for the High Option

- **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	15
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)	36
Mental health and substance abuse treatment:	Regular cost sharing	37
Prescription drugs:		39
• 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.	43
Vision care: Refractions, including lens prescriptions, limited to children through age 17.	$40 copayment per visit	21
Special features: Flexible benefit option, 24-hour nurse line, Disease Management, Centers of Excellence		44
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $1,500/Self Only or $3,000/ Family enrollment per year	11
We have added an out-of-pocket maximum of $2,500 per member per calendar year to the Tier 4 specialty drug benefit.	Some costs do not count toward this protection	

Summary of benefits for the Standard Option

- 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	15
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:		34
• In-area	$75 per visit (copayment waived if admitted)	35
• Out-of-area	$100 per visit (copayment waived if admitted)	36
Mental health and substance abuse treatment:	Regular cost sharing	37
Prescription drugs:		39
• 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	21
Special features: Flexible benefit option, 24-hour nurse line, Disease Management, Centers of Excellence		44
Protection against catastrophic costs (out-of-pocket maximum)**:** We have added an out-of-pocket maximum of $2,500 per member per calendar year to the Tier 4 specialty drug benefit.	Nothing after $4,000/Self only or $8,000/ Family enrollment per year Some costs do not count toward this protection	11

2009 Rate Information for AvMed Health Plans

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* 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 *Guide to Benefits for Career United States Postal Service Employees,* RI 70-2, and to the rates shown below.

The rates shown below do not apply to Postal Service Inspectors, Office of Inspector General (OIG) employees and Postal Services Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

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 *Guide to Federal Benefits.*

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	ML1	$149.36	$49.78	$323.60	$107.87	$172.26	$26.88
High Option Self and Family	ML2	$352.56	$125.40	$763.88	$271.70	$406.42	$71.54
Standard Option Self Only	ML4	$115.23	$38.41	$249.67	$83.22	$132.90	$20.74
Standard Option Self and Family	ML5	$276.58	$92.19	$599.25	$199.75	$318.99	$49.78