

AmeriHealth HMO

<http://www.amerihealth.com>

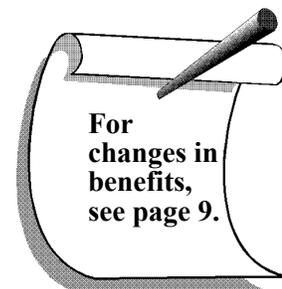


2008

A Health Maintenance Organization

Serving: *All of New Jersey*

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 8 for requirements.



Enrollment codes for this Plan:

- FK1 Self Only
- FK2 Self and Family
- FK3 Self Only
- FK4 Self and Family



This Plan has excellent accreditation from the NCQA. See the 2008 Guide for more information on accreditation.

Special Notice: This plan is offering a Standard Option for the first time under the Federal Employees Health Benefits Programs during the 2008 Open Season.



Authorized for distribution by the:



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

RI 73-065

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

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

**Important Notice from AmeriHealth HMO About
Our Prescription Drug Coverage and Medicare**

OPM has determined that the AmeriHealth HMO prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. 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 will coordinate benefits with Medicare.

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

Please be advised

If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug 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 most other people pay. You may also have to wait until the next open enrollment period 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.

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Introduction

This brochure describes the benefits of under our contract (CS 1893) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for administrative offices is:

AmeriHealth New Jersey
1901 Market Street
Philadelphia, PA 19103

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, 2008, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2008, and changes are summarized on page 9. 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.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 800/444-6282 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, DC20415-1100

- 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); o
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.

3. Get the results of any test or procedure.

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

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

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

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

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

Visit these websites for more information on patient safety:

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

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

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

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

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

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

Section 1. Facts about this HMO Plan

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

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

Our HMO reimbursement programs for health care providers are intended to encourage the provision of quality, cost-effective care for our members. Set forth below is a general description of our HMO reimbursement programs, by type of participating health care provider. These programs vary by state. Please note that these programs may change from time to time, and the arrangements with particular providers may be modified as new contracts are negotiated. If after reading this material you have any questions about how your health care provider is compensated, please speak with them directly or contact us.

Professional providers

Primary Care Physicians: Most Primary Care Physicians (PCPs) are paid in advance for their services, receiving a set dollar amount per member, per month for each member selecting that PCP. This is called a capitation payment and it covers most of the care delivered by the PCP. Services not included under capitation are paid fee-for-service according to the HMO fee schedule.

Specialists: Most specialists are paid on a fee-for-service basis, meaning that payment is made according to our HMO fee schedule for the specific medical services that the specialist performs. Obstetricians are paid global fees that cover most of their professional services for prenatal care and for delivery.

Institutional providers

Hospitals: For most inpatient medical and surgical services, hospitals are paid per diem rates, which are specific amounts paid for each day a member is in the hospital. These rates usually vary according to the intensity of services provided. Some hospitals are also paid case rates, which are set dollar amounts paid for a complete hospital stay related to a specific procedure or diagnosis, e.g., transplants. For most outpatient and emergency services and procedures, most hospitals are paid specific rates based on the type of service performed. Hospitals may also be paid a global rate for certain outpatient services (e.g., lab and radiology) that includes both the facility and physician payment. For a few services, hospitals are paid based on a percentage of billed charges. Most hospitals are paid through a combination of the above payment mechanisms for various services. There are provisions in contracts with some hospitals that contain quality and/or utilization incentives.

Skilled Nursing Homes, Rehabilitation Hospitals, and other care facilities: Most skilled nursing and other special care facilities are paid per diem rates, which are specific amounts paid for each day a member is in the facility. These amounts may vary according to the intensity of services provided.

Ambulatory surgical centers (ASCs)

Most ASCs are paid specific rates based on the type of service performed. For a few services, some ASCs are paid based on a percentage of billed charges.

Physician group practices and physician associations

Certain physician group practices and independent physician associations (IPAs) employ or contract with individual physicians to provide medical services. These groups are paid as outlined above. These groups may pay their affiliated physicians a salary and/or provide incentives based on production, quality, service, or other performance standards.

Ancillary service providers

Some ancillary service providers, such as durable medical equipment and home health care providers, are paid fee-for-service payments according to our HMO fee schedule for the specific medical services performed. Other ancillary service providers, such as those providing laboratory services, are paid a set dollar amount per member, per month (capitation) for each member. Capitated ancillary service vendors are responsible for paying their contracted providers and do so on a fee-for-service basis.

Radiology services

We contract with a radiology service company, which provides a network of participating radiology providers in New Jersey, and is paid a set amount per member, per month (capitation) for each member. The radiology service company pays its affiliated providers on a fee-for-service and/or capitated basis. AmeriHealth also contracts with some radiology sites that are affiliated with participating hospitals. These radiology sites are reimbursed on a fee-for-service and/or capitated basis.

Mental health/substance abuse

A mental health/substance abuse (“behavioral health”) management company administers most of our behavioral health benefits, provides a network of participating behavioral health care providers and processes the related claims. The behavioral health management company is paid a set dollar amount per member, per month (capitation) for each member and is responsible for paying its contracted providers on a fee-for-service basis. Currently, particular behavioral health outpatient sites are assigned to PCP practices as their primary behavioral health care provider; however, this designation of behavioral health provider sites is expected to change in 2004. AmeriHealth New Jersey HMO members may choose any participating behavioral health outpatient site, but are encouraged to use the site assigned to their PCP. The contract with the behavioral health management company includes performance-based payments related to quality, provider access, service, and other such parameters. One of our affiliate companies has a less than one percent ownership interest in this behavioral health management company.

Pharmacy

A pharmacy benefits management company (PBM), which is affiliated with AmeriHealth administers, our prescription drug benefits, and is responsible for providing a network of participating pharmacies and processing pharmacy claims. The PBM also negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. AmeriHealth anticipates that it will pass on a high percentage of the expected rebates it receives from its PBM through reductions in the overall cost of pharmacy benefits. Under most benefit plans, prescription drugs are subject to a member copayment.

If you desire additional information about how our Primary Care Physicians or any other Providers in our Service Area are compensated, you may do either of the following. You may call Member Services at the number on the back of your ID card. Or, you may write to AmeriHealth HMO, Inc., AmeriHealth Service Center, P.O. Box 41574, Philadelphia, PA 19101-1574. The laws of the State of New Jersey, at N.J.S.A. 45:9-22.4 et seq., mandate disclosure of the following. If a physician, chiropractor or podiatrist who is permitted to make referrals to other health care providers the following must be disclosed, if applicable. The physician, chiropractor or podiatrist must inform his or her patients of any significant financial interest he or she may have in a health care provider or facility when making a referral to that health care provider or facility. If you want more information about this, contact your physician, chiropractor or podiatrist. If you believe that you are not receiving the information to which you are entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504-6200 OR (800) 242-5846.

Who provides my health care?

AmeriHealth HMO is an individual practice plan (IPP) HMO. The Plan is comprised of over 29,000 private practice doctor sites who practice from their own private offices. Over 7,900 of these doctors are participating primary care doctors. A wide range of specialty care is represented throughout the Plan. Inpatient services are available and can be provided at 185 hospitals conveniently located throughout the Plan's service area. 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. Services of other providers are covered only when there has been a referral by the member's primary care doctor except for eye exams, dental care, and visits to the OB/GYN for preventive care, routine maternity or for problems related to gynecological conditions when medically necessary. Non-routine care provided by Reproductive Endocrinologists/Infertility Specialists, and Gynecologic Oncologists continue to require a referral from the primary care physician. Treatment for mental conditions and substance abuse may be obtained directly from Magellan Behavioral Health at 1-800-809-9954. Magellan Behavioral Health, or any other mental health administrator for AmeriHealth HMO, manages all care related to mental health and substance abuse services. Magellan Behavioral Health will determine what specialty care is appropriate and which specialists will be utilized.

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, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. If you want more information about us, call 1-800-877-9829, or write to AmeriHealth HMO, Inc., P.O. Box 41574, Philadelphia, PA 19103. You may also visit our website at www.amerihealth.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll with us, you must live in or work in our service area. This is where our providers practice. Our service area is the state of New Jersey. Contract holders must select a Primary Care Physician (PCP) within the state of New Jersey.

Outside Service Area

Ordinarily, you must get your care from providers who contract with us. However, emergency (described in section 5(d)) and urgent care provided outside the service area will be covered. Urgent care includes covered services provided in order to treat an unexpected medical or psychiatric illness or injury that is not life threatening and requires care by a provider within 24 hours. The service must be required in order to prevent a serious deterioration in your or your covered family member's health, if treatment were delayed.

If you become ill or injured while traveling outside the service area, AmeriHealth will provide coverage for urgent care services. Members who are away from home for at least 90 days may temporarily enroll in the AmeriHealth Guest Advantage Program. Members are eligible for Guest Advantage for up to six months if, for example, they are assigned out-of-area temporarily. Guest Advantage enables members to receive the same full range of HMO benefits and services without the need for a referral. To enroll, members simply contact their Guest Advantage Coordinator in advance by using the phone number on the back of the ID card. Guest Advantage members will be required to obtain pre-authorization for some services. For more information on how to access these services, please contact us by calling the phone number on the back of your ID card.

Section 2. How we change for 2008

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 High Option only

- Your share of the non-postal premium will increase for Self and Self and Family
- Decrease the primary care physician visit copayment from \$30 to \$25
- Increase the physician specialist visit copayment from \$35 to \$40
- Increase the emergency room visit copayment from \$75 to \$100, waived if admitted to hospital
- Decrease the inpatient hospital copay from \$200 per day to \$150 and increase the day maximum from 3 days to 5 days
- Decrease the copayment for generic prescription drugs from \$10 to \$5

For 2008, we have added a second plan option (our Standard Plan) in addition to our High Option Plan.

Section 3. How you get care

Identification cards	<p>We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.</p> <p>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 1-800/877-9829. You may also request replacement cards through our Web site</p>
Where you get covered care	<p>You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductible and/or coinsurance.</p>
<ul style="list-style-type: none">• Plan providers	<p>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.</p> <p>We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.</p>
<ul style="list-style-type: none">• Plan facilities	<p>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.</p>
What you must do to get covered care	<p>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. Contract holders must select a PCP within the state of New Jersey.</p>
<ul style="list-style-type: none">• Primary care	<p>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.</p> <p>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</p>
<ul style="list-style-type: none">• Specialty care	<p>Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see a participating physician for eye exams, dental care, and visits to the OB/GYN for preventive care, routine maternity or for problems related to gynecological conditions when medically necessary. You may also visit a participating facility for all mammograms. Non-routine care provided by Reproductive Endocrinologists/ Infertility Specialists, and Gynecologic Oncologists continues to require a referral from the primary care physician. Treatment for mental conditions and substance abuse may be obtained directly from Magellan Behavioral Health at 1-800-809-9954. .</p> <p>Here are some other things you should know about specialty care:</p>

- 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 4 months 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.

• 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 1-800/444-6282. 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.

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.

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.

Services requiring our prior approval

We call this review and approval process preauthorization. Your physician must obtain preauthorization for the following services such as:

- All Non-Emergency Hospital Admissions
- Organ Tissue Transplants
- All Same Day Surgery/Short Procedure Unit Admissions
- Morbid Obesity (Bariatric Surgery)
- Outpatient Therapies: Speech, Cardiac, Pulmonary, Respiratory, Home Infusion
- Other Facility Services: Skilled Nursing, Home Health, Hospice, Birthing Center
- Rental/Purchase of Durable Medical Equipment and Prostheses (purchases over \$500.00 and all rentals)
- Non-Emergency Ambulance Services
- Inpatient Psychiatric Care
- Inpatient Alcohol and Substance Abuse Treatment
- Some Medications that have specific uses and are administered in Outpatient Settings or Physicians Offices
- Your physician must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Before giving approval we determine if the service is medically necessary, and if it follows generally accepted medical practices. members are not responsible for payment of services if the provider does not obtain preauthorization for services rendered.

Section 4. Your costs for covered services

You must share the costs of some services. You are responsible for:

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 \$25 per office visit or a copayment of \$40 per office visit to a specialist.

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.

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 towards any deductible.

- There is no calendar year deductible for the High Option.
- The calendar year deductible is \$1,000 per person for the 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 \$2,000 under Standard 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 under the Standard Option.

Example: In our plan, you pay 80% for hospitalization after the deductible is met for the Standard Option.

Your Catastrophic protection out-of-pocket maximum

After your copayments of \$1,500 per person or \$3,000 per family for the High Option has been reached in a calendar year, you will be reimbursed for any copayment amounts paid thereafter, following submission of paid receipts. After your copayment or coinsurance of \$3,000 per person or \$6,000 per family for the Standard Option has been reached in a calendar year, you will be reimbursed for any copayment amounts paid thereafter, following submission of paid receipts. However, copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription drugs
- Dental services

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

When Government facilities bill us

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

Section 5. High and Standard Option Benefits Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read the *Important things you should keep in mind* at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800-877-9829 or at our website at www.amerihealth.com.

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**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.
- 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	
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>		
Diagnostic and treatment services	High Option	Standard Option
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • Office medical consultations • Second surgical opinion 	\$25 per visit to your primary care physician \$40 per visit to a specialist	\$30 per visit to your primary care physician \$50 per visit to a specialist
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility 	Nothing	Nothing
At home	\$40 copayment per visit	\$50 copayment per visit
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Charges for missed appointments</i> • <i>Charges for completion of insurance forms</i> 	<i>All charges</i>	<i>All charges</i>
Lab, X-ray and other diagnostic tests	High Option	Standard Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Pathology • Urinalysis • Non-routine Pap tests • Mammograms 	Nothing	Nothing
X-rays Ultrasound Electrocardiogram and EEG	\$40 copayment	\$50 copayment

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Lab, X-ray and other diagnostic tests (cont.)		
MRI/MRA, CT, PET Scans	\$40 copayment	\$100 copayment
Preventive care, adult	High Option	Standard Option
Routine screenings, based on medical necessity and risk such as: <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 	\$25 per office visit to your primary care physician \$40 copayment per office visit to your specialist	\$30 per office visit to your primary care physician \$50 copayment per office visit to your specialist
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	\$25 copayment per office visit to your primary care physician \$40 copayment per office visit to a specialist	\$30 copayment per office visit to your primary care physician \$50 copayment per office visit to a specialist
Routine Pap test Note: You do not pay a separate copay for a Pap test performed during your routine annual physical; see <i>Diagnostic and treatment services</i> .	\$40 copayment per office visit	\$30 copayment per office visit
Routine mammogram	Nothing	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	\$25 copayment per office visit	\$30 copayment per office visit
<i>Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges</i>	<i>All charges</i>
Preventive care, children	High Option	Standard Option
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	\$25 copayment per office visit, nothing for immunization	\$30 copayment per office visit, nothing for immunization
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: <ul style="list-style-type: none"> - Eye exams through age 17 to determine the need for vision correction - Ear exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22) 	\$25 copayment per office visit	\$30 copayment per office visit

Benefit Description	You pay	
	High Option	Standard Option
Infertility services		
Diagnosis and treatment of infertility such as: <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> • intravaginal insemination (IVI) • intracervical insemination (ICI) • intrauterine insemination (IUI) • Services and supplies related to ART • In vitro fertilization • GIFT (Gamete intra-fallopian transfer) • ZIFT (Zygote intra-fallopian transfer) • Embryo transfer, • Fertility Injections administered in a physician's office • Oral Fertility drugs-covered under the prescription drug benefit 	\$40 copayment per office visit	\$50 copayment per office visit
Not covered: <ul style="list-style-type: none"> • Services and supplies related to excluded ART procedures • Cost of donor sperm • Cost of donor egg. 	All charges	All charges
Allergy care	High Option	Standard Option
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	If treated at PCP office, \$25 copayment per office visit. At specialist office, \$40 copayment per office visit.	If treated at PCP office, \$30 copayment per office visit. At specialist office, \$50 copayment per office visit.
Not covered: <ul style="list-style-type: none"> • Provocative food testing • Sublingual allergy desensitization 	All charges	All charges
Maternity care	High Option	Standard Option
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: <ul style="list-style-type: none"> • You do not need to precertify your normal delivery • 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. 	\$40 copayment applies to the first visit only	\$30 copayment applies to the first visit only

Maternity care - continued on next page

Benefit Description	You pay	
Maternity care (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. 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). 	\$40 copayment applies to the first visit only	\$30 copayment applies to the first visit only
<i>Not covered: Routine sonograms to determine fetal age, size or sex.</i>	<i>All charges</i>	<i>All charges</i>
Family planning	High Option	Standard Option
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> Voluntary sterilization (See Surgical procedures Section 5 (b)) Surgically implanted contraceptives. Insertion and removal covered under Medical-Drug covered under the prescription drug benefit Injectable contraceptive drugs (such as Depo provera) covered under the prescription drug benefit Intrauterine devices (IUDs) and Diaphragms - Device covered under the prescription drug benefit <p>Note: We cover oral contraceptives under the prescription drug benefit (see Prescription Drug Benefit Section 5(f) and cover contraceptive devices through the medical benefit).</p>	\$40 copayment per office visit	\$50 copayment per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Reversal of voluntary surgical sterilization</i> <i>Genetic counseling</i> <i>Removal of surgically implanted time-release medications before the end of the expected life, unless medically necessary and approved by the Plan.</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
	High Option	Standard Option
<p>Treatment therapies</p> <ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 31.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We will only cover GHT when we preauthorize the treatment. If we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	Nothing	80%, after deductible
<i>Not covered: See Section 6 General Exclusions</i>	<i>All charges</i>	<i>All charges</i>
<p>Physical and occupational therapies</p> <ul style="list-style-type: none"> • 60 consecutive days per condition if significant improvement can be expected for the services of each of the following: <ul style="list-style-type: none"> - qualified physical therapists; - occupational therapists; and - hand therapy <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <ul style="list-style-type: none"> • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 12 weeks. 	\$40 copayment per visit	\$50 copayment per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
	High Option	Standard Option
Speech therapy	High Option	Standard Option
<ul style="list-style-type: none"> 60 consecutive days per condition 	\$40 copayment per visit.	\$50 copayment per visit.
Hearing services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> Hearing testing for children through age 17, which include; (see <i>Preventive care, children</i>) 	\$25 copayment per office visit	\$30 copayment per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> All other hearing testing Hearing aids, testing and examinations for them 	<i>All charges</i>	<i>All charges</i>
Vision services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> One eye exam and refraction every two calendar years. 	\$40 copayment per office visit	\$50 copayment per office visit
<ul style="list-style-type: none"> One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) 	Nothing	Nothing
<ul style="list-style-type: none"> Eye screening by PCP to determine the need for vision correction for children through age 17 (see preventive care) 	\$25 copayment per office visit	\$30 copayment per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Eyeglasses or contact lenses and, after age 17, examinations for them but see non-FEHB page Eye exercises and orthoptics Radial keratotomy and other refractive surgery 	<i>All charges</i>	<i>All charges</i>
Foot care	High Option	Standard Option
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts</p>	\$40 copayment per office visit	\$50 copayment per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> 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) 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
	High Option	Standard Option
Orthopedic and prosthetic devices	High Option	Standard Option
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Artificial lenses following cataract surgery • Externally worn breast prostheses- initial device only • Surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices and their replacements, such as artificial joints, pacemakers, and surgically implanted breast implant, external and shown above, following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	Nothing	80%, after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Dental Prosthetics</i> • <i>Cost of cochlear implanted device</i> • <i>Cranial prosthesis, including wigs and other devices intended to replace hair</i> 	<i>All charges</i>	<i>All charges</i>
Durable medical equipment (DME)	High Option	Standard Option
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment when cost to repair is less than the cost to replace it. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen; • Dialysis equipment; • Standard hospital beds • Standard wheelchairs • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. • Motorized wheelchairs 	Nothing	80%, after deductible
<p><i>Not covered:</i></p>	<i>All charges</i>	<i>All charges</i>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Durable medical equipment (DME) (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Customized durable medical equipment 	<i>All charges</i>	<i>All charges</i>
Home health services	High Option	Standard Option
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. 	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Nursing care requested by, or for the convenience of, the patient or the patient's family; • Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative. 	<i>All charges</i>	<i>All charges</i>
Chiropractic	High Option	Standard Option
Spinal manipulation will be provided for up to 60 consecutive days per condition if significant improvement can be expected in the two month period.	\$40 copayment per office visit	\$50 copayment per office visit
Alternative treatments	High Option	Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Acupuncture - see Section 5(i) non-FEHB benefits available to Plan members • Naturopathic services • Hypnotherapy • Biofeedback 	<i>All charges</i>	<i>All charges</i>
Educational classes and programs	High Option	Standard Option
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Diabetes self management training and education through community-based programs certified by the American Diabetes Association or Department of Health. Covered services may also be provided by these contracted providers; a licensed health care professional; or at a hospital on an outpatient basis 	Nothing	Nothing

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.
- 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 FOR 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	
Note:		
Surgical procedures	High Option	Standard Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see <i>Reconstructive surgery</i>) • Surgical treatment of morbid obesity - a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over <p>Note: If you need additional information on the criteria that must be met for the surgical treatment of morbid obesity, you can reach our Website at http://www.amerhealth.com/providers/policies_guidelines_pubs/medical_policy.htm</p> <ul style="list-style-type: none"> • Insertion of internal prosthetic devices . See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) 	Nothing*	80%, after deductible

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	Nothing*	80%, after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Reversal of voluntary sterilization</i> <i>Routine treatment of conditions of the foot; see Foot care</i> 	<i>All charges</i>	<i>All charges</i>
Reconstructive surgery	High Option	Standard Option
<p>Your physician must obtain approval from us before providing services.</p> <ul style="list-style-type: none"> Surgery to correct a functional defect Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> the condition produced a major effect on the member's appearance and the condition can reasonably be expected to be corrected by such surgery Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> surgery to produce a symmetrical appearance of breasts; treatment of any physical complications, such as lymphedemas; breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	Nothing*	80%, after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>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</i> <i>Surgeries related to sex transformation</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
	High Option	Standard Option
Oral and maxillofacial surgery	High Option	Standard Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	Nothing*	80%, after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<i>All charges</i>	<i>All charges</i>
Organ/tissue transplants	High Option	Standard Option
<p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	Nothing*	80%, after deductible
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses. The medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia 	Nothing*	80%, after deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Autologous transplant for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) <p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - <u>Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)</u> 	Nothing*	80%, after deductible
<ul style="list-style-type: none"> • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Note: We cover related medical and hospital expenses of the donor when we cover the recipient. 	Nothing*	80%, after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<i>All charges</i>	<i>All charges</i>
Anesthesia	High Option	Standard Option
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) 	Nothing*	80%, after deductible
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	Nothing*	80%, after deductible

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.
- 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 FOR HOSPITAL STAYS. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay	
<i>Note:</i>		
Inpatient hospital	High Option	Standard Option
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	\$150 copayment per day, up to a 5 day maximum per admission	80%, after deductible
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood and blood plasma • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	\$150 copayment per day, up to a 5 day maximum per admission	80%, after deductible
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Custodial care</i> 	<i>All charges</i>	<i>All charges</i>

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> 	<i>All charges</i>	<i>All charges</i>
Outpatient hospital or ambulatory surgical center	High Option	Standard Option
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma , if not donated or replaced • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	\$100 facility copayment	80%, after deductible
Extended care benefits/Skilled nursing care facility benefits	High Option	Standard Option
<p>Skilled nursing facility (SNF): Up to 180 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.</p>	\$150 copayment per day per admission, up to a 5 day maximum unless admitted directly from an inpatient hospitalization	80%, after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Rest cures</i> • <i>Domiciliary or convalescent care</i> • <i>Personal comfort items, such as telephones and television</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
Hospice care	High Option	Standard Option
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	\$150 copayment per day per admission, up to a 5 day maximum unless admitted directly from an inpatient hospitalization	80%, after deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Independent nursing</i> • <i>Homemaker services</i> • <i>Custodial care</i> • <i>Rest cures</i> • <i>Domiciliary or convalescent care</i> • <i>Personal comfort items, such as telephones and television</i> 	<i>All charges</i>	<i>All charges</i>
Ambulance	High Option	Standard Option
Local professional ambulance service when medically appropriate. Preapproval is required, unless for emergency.	Nothing	80%, after deductible

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.
- 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, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. 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:

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

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

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	
	High Option	Standard Option
Emergency within our service area		
• Emergency care at a doctor’s office	\$25 copayment per office visit	\$30 copayment per office visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors’ services (copayment waived if admitted or you are referred to the emergency room by your PCP and services could not have been provided by your doctor)	\$100 copayment per visit	\$150 copayment per visit
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>
• <i>Elective care or non-emergency care</i>		

Emergency within our service area - continued on next page

Benefit Description	You pay	
Emergency within our service area (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges</i>	<i>All charges</i>
Emergency outside our service area	High Option	Standard Option
<ul style="list-style-type: none"> • Emergency care at a doctor's office 	\$25 copayment per office visit	\$30 copayment per office visit
<ul style="list-style-type: none"> • Emergency care as an outpatient or inpatient at a hospital, including doctors' services (copayment waived if admitted or you are referred to the emergency room by your PCP and services could not have been provided by your doctor) 	\$100 copayment per visit	\$150 copayment per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges</i>	<i>All charges</i>
Ambulance	High Option	Standard Option
Professional or air ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	Nothing	80%, after deductible

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.
- 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 FOR THESE SERVICES. See the instructions after the benefits description below.

Benefit Description	You pay	
<i>Note:</i>		
Mental health and substance abuse benefits	High Option	Standard Option
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p><i>Note:</i> Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$40 per visit</p>	<p>\$50 per visit</p>
<p>Diagnostic tests</p> <ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, full-day hospitalization, facility based intensive outpatient treatment 	<p>\$40 copayment per office visit; nothing for diagnostic test</p> <p>Copayment of \$150 per day, up to a 5 day maximum per admission</p>	<p>\$50 copayment per office visit, nothing for diagnostic test</p> <p>80%, after deductible</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Network out-of-pocket maximums	After your copayment total, \$1,500 per person or \$3,000 per family enrolled in a calendar year, has been reached, you will be reimbursed for any copayment amounts paid thereafter, following submission of paid receipts.
Preauthorization	<p>To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:</p> <p>Treatment for mental conditions and substance abuse is coordinated directly by Magellan Behavioral Health or other behavioral health administrator designated by the Plan. Magellan Behavioral Health, acting as behavioral health administrator for AmeriHealth HMO, Inc., manages all care related to mental health and substance abuse services. Questions about related benefits and pre-certification should be addressed to Magellan Behavioral Health at 1-800-809-9954.</p>
Limitation	We may limit your benefits if you do not follow your 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.
- We do not have a deductible
- 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 or licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan retail pharmacy, or by mail at the Plan mail order pharmacy for maintenance medications.
- **We use a formulary.** Drugs are prescribed by licensed doctors and dispensed in accordance with the Plan's formulary.
- The Plan formulary includes all generic drugs and a list of selected brand drugs that have been evaluated for their medical effectiveness, safety and value. The Plan formulary is designed to include all therapeutic categories, provide coverage for all types of drugs and provide physicians with prescribing options.
- **Prior Authorization.** Your pharmacy benefits plan requires prior authorization of certain covered drugs to ensure that the drug prescribed is medically necessary and appropriate and is being prescribed according to the Food and Drug Administration (FDA) guidelines. The approval criteria were developed and endorsed by the Pharmacy and Therapeutics Committee, which is an established group of Medical Directors and independent area physicians and pharmacists.
- **These are the dispensing limitations.** Prescription drugs prescribed by a licensed doctor or dentist and obtained at a Plan retail pharmacy will be dispensed in the following quantities:

1-30 days: One Formulary Copayment or Non-Formulary Coinsurance

31-60 days: Two Formulary Copayments; or Non-Formulary Coinsurance

61-90 days: Three Formulary Copayments; or Non-Formulary Coinsurance

Maintenance drugs obtained through the Plan mail order pharmacy will be dispensed in the following quantities:

1-30 days: One Formulary Copayment or Non-Formulary Coinsurance

31-90 days: Two Formulary Copayments; or Non-Formulary Coinsurance

Prescription refills will be dispensed only if 75% of the previously dispensed quantity has been consumed based on the dosage prescribed. If you are in the military and called to active duty due to an emergency, please contact us if you need assistance in filling a prescription before your departure.

- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand product. Generics typically cost less than the equivalent brand product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand drugs. You can save money by using generic drugs. However, you and your physician have the option to request a brand if a generic option is available. Using the most cost-effective medication saves money.

When you have to file a claim. Prescription drugs obtained from a non-Plan retail pharmacy are eligible with a higher out-of-pocket expense except for an out-of-area emergency which will be reimbursed after your copayment. You must submit acceptable proof-of-payment with a direct reimbursement form. All claims for payment must be received within ninety (90) days of the date of proof-of-purchase. **Direct reimbursement forms may be obtained by calling 1-888-678-7012.**

Benefit Description	You pay	
Covered medications and supplies (cont.)	High Option	Standard Option
<p>Here are some things to keep in mind about our prescription drug program:</p> <ul style="list-style-type: none"> • We have a formulary. You will receive increased benefits by using formulary drugs. 	<p>\$40 copayment per covered brand formulary prescription/refill (up to a 30 day supply)</p> <p>\$80 copayment per covered brand formulary prescription/refill (31-90 day supply)</p> <p>50% coinsurance per covered non-formulary prescription/refill (up to a 90 day supply)</p>	<p>\$40 copayment per covered brand formulary prescription/refill (up to a 30 day supply)</p> <p>\$80 copayment per covered brand formulary prescription/refill (31-90 day supply)</p> <p>50% coinsurance per covered non-formulary prescription/refill (up to a 90 day supply)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs available without a prescription or for which there is a nonprescription equivalent available</i> • <i>Vitamins and nutritional substances that can be purchased without a prescription</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Drugs for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs to aid in smoking cessation</i> • <i>The cost of a prescription drug when the usual and customary charge is less than the member's prescription drug copayment</i> • <i>Non-formulary injectable drugs</i> 	<i>All charges</i>	<i>All charges</i>

Section 5(g). 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.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
Accidental injury benefit	High Option	Standard Option
<p>We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth when provided by Plan dentists. The need for these services must result from an accidental injury and be treated within six (6) months or as other medical conditions permit after the accident.</p>	\$35 copayment per office visit	\$35 copayment per office visit
Dental benefits	High Option	Standard Option
<p>The following dental services are covered when provided by participating Plan general dentists:</p> <p>Preventive services:</p> <ul style="list-style-type: none"> • Oral examination and diagnosis (limited to once in 6 months) • Prophylaxis/teeth cleaning to include scaling and polishing (limited to once in 6 months) • Topical fluoride (include child and adult) • Oral hygiene instruction <p>Diagnosis services</p> <ul style="list-style-type: none"> • Complete series X-rays • Intraoral occlusal film • Bitewings (limited to once in 6 months) • Panoramic film • Cephalometric film <p>Restorative services</p> <ul style="list-style-type: none"> • Amalgam (silver) restoration to primary and permanent teeth • Anterior and posterior composite restoration to primary and permanent teeth • Pin retention 	\$5 copayment per office visit	\$5 copayment per office visit

Dental benefits - continued on next page

Benefit Description	You Pay	
Dental benefits (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Sedative filling (per tooth) 	\$5 copayment per office visit	\$5 copayment per office visit
<p>Other services</p> <ol style="list-style-type: none"> 1. Endodontic 2. Orthodontic 3. Oral surgery 4. Single unconnected crowns 5. Prosthodontic 	A discounted amount; what you pay may change periodically, so call us for the amounts you pay for these dental services.	A discounted amount; what you pay may change periodically, so call us for the amounts you pay for these dental services.
<p>Emergency dental services provided by participating and non-participating providers.</p>	\$5 copayment per office visit	\$5 copayment per office visit
<p>We will provide coverage for covered dental services in connection with dental emergencies for palliative treatment (to relieve pain). To receive payment for these services from a non-participating dental provider, you must submit a receipt to AmeriHealth Member Services. The receipt must be itemized and show the dental services performed and the charge for each service.</p>	\$48 copayment per occurrence	\$48 copayment per occurrence
<ol style="list-style-type: none"> 1. Emergency exam 2. Palliative treatment of dental pain 		
<p><i>Not covered: Other dental services not shown as covered</i></p>	<i>All Charges</i>	<i>All Charges</i>

Section 5(h). Special features

Feature	Description	
Feature	High Option	Standard Option
<p>Flexible benefits option</p>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. 	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
<p>Services for deaf and hearing impaired</p>	<p><i>TDD 1-888-857-4816</i></p>	<p><i>TDD 1-888-857-4816</i></p>
<p>Reciprocity benefit</p>	<p>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.</p>	<p>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.</p>

Feature - continued on next page

Feature	Description	
Feature (cont.)	High Option	Standard Option
<p>Travel benefit</p>	<p>Ordinarily, you must get your care from providers who contract with us. However, emergency (described in Section 5(d)) and urgent care provided outside the service area will be covered. Urgent care includes covered services provided in order to treat an unexpected medical or psychiatric illness or injury that is not life-threatening and requires care by a provider within 24 hours. The services must be required in order to prevent a serious deterioration in your or your covered family member's health, if treatment were delayed.</p> <p>If you become ill or are injured while traveling outside the service area, AmeriHealth will provide coverage for urgent care services. For more information on how to access these services, please contact us by calling the phone number found on the back of your I.D. card.</p> <p>Your prescription drug card works in more than 98% of retail pharmacies locally and 95% of retail pharmacies nationwide.</p> <p>No coverage will be provided for urgent care or for routine or elective services rendered outside the service area.</p>	<p>Ordinarily, you must get your care from providers who contract with us. However, emergency (described in Section 5(d)) and urgent care provided outside the service area will be covered. Urgent care includes covered services provided in order to treat an unexpected medical or psychiatric illness or injury that is not life-threatening and requires care by a provider within 24 hours. The services must be required in order to prevent a serious deterioration in your or your covered family member's health, if treatment were delayed.</p> <p>If you become ill or are injured while traveling outside the service area, AmeriHealth will provide coverage for urgent care services. For more information on how to access these services, please contact us by calling the phone number found on the back of your I.D. card.</p> <p>Your prescription drug card works in more than 98% of retail pharmacies locally and 95% of retail pharmacies nationwide.</p> <p>No coverage will be provided for urgent care or for routine or elective services rendered outside the service area.</p>

Feature - continued on next page

Feature	Description	
Feature (cont.)	High Option	Standard Option
	<p>Members who are away from home for at least 90 days may temporarily enroll in the AmeriHealth Guest Advantage Program. Members are eligible for Guest Advantage for up to six months if, for example, they are assigned out-of-area temporarily. Guest Advantage enables members to receive the full range of HMO benefits and services offered by the hosting HMOs. To enroll, members simply contact their Guest Advantage Coordinator in advance. The phone number is on the back of the ID card. Guest Advantage members will be required to obtain pre-authorization for some services.</p>	<p>Members who are away from home for at least 90 days may temporarily enroll in the AmeriHealth Guest Advantage Program. Members are eligible for Guest Advantage for up to six months if, for example, they are assigned out-of-area temporarily. Guest Advantage enables members to receive the full range of HMO benefits and services offered by the hosting HMOs. To enroll, members simply contact their Guest Advantage Coordinator in advance. The phone number is on the back of the ID card. Guest Advantage members will be required to obtain pre-authorization for some services.</p>

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 1-800-877-9829 or visit their website at www.amerihhealth.com.

Weight Management Program – AmeriHealth HMO’s Weight Management Reimbursement program gives you the option of participating in any weight management program offered by an AmeriHealth network hospital or Weight Watchers. 100% reimbursement of all program fees (up to \$200).

Fitness Program – To give members added incentive to maintain an active lifestyle, we will reimburse members up to \$150 of their annual fitness club fees. Members can now enjoy the flexibility of joining any approved fitness club and working out at multiple fitness clubs.

Visits can be recorded by swipe-card, computer printout, telephone or logbook. Members must complete 120 visits per 365-day enrollment period and maintain active coverage to receive reimbursement.

Smoking Cessation – If you smoke, quitting is one of the best things you can do for your health. Better yet, when you kick the habit, we’ll help foot the bill! You can get up to \$200 back when you complete your choice of a variety of proven smoking cessation programs. And to give you even more incentive, we now will reimburse you the costs of nicotine replacement products and smoking cessation aides. If you choose a smoking cessation program that costs less than \$200, you can use the difference toward the purchase of nicotine replacement products, such as “the patch” or chewing gum.

Vision Care – Up to a \$35 allowance for eyeglasses or contact lenses once every two (2) calendar years, members maximize their benefit by using participating providers.

BabyFootSteps Program – AmeriHealth HMO members can receive educational materials and free gifts for you and your baby in our maternity program. Plus, you can receive a 100% reimbursement (up to \$50) of the cost of a parenting or childbirth class, and \$50 back toward the purchase of a breast pump.

Mother’s Option – AmeriHealth HMO pregnant mothers have the option of a 24 or 48 hour length of stay for a normal delivery and a 3 or 4 day length of stay for a caesarean delivery. If member opts for a 24 hour stay for a normal delivery, the mother will receive two (2) home care visits. If member opts for a 3 day stay for a caesarean delivery, the mother will receive one (1) home care visit.

Safety Program – Offers tips on how to reduce children’s risk for household accidents such as burns, injuries from firearms, choking, and accidental poisonings, tips for safe bicycling and more. Reimbursement up to \$25 for bike helmet. AmeriHealth HMO members can receive up to \$25 reimbursement on any course offered by the American Red Cross or American Heart Association.

Alternative Health Discounted Services – Take advantage of up to a 25% discount from a national network or practitioners of acupuncture, massage therapy and dietetics. Also receive preferred discounts of up to 40% on more than 2,400 health & wellness products.

Preventive Health Reminders – Receive periodic reminders about important health screenings such as mammography, colorectal, Pap and osteoporosis.

ConnectionsSM Health Management Program – Access a Health Coach 24 hours, 7 days a week, 365 days per year. Receive educational materials and health reminders mailed to your home and utilize our on-line Healthwise[®] Knowledgebase with thousands of articles on various health topics.

Medicare Prepaid Plan Enrollment – This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 54, annuitants and former spouses with FEHB coverage and Medicare 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. Those without Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. 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. Contact us at 1-800-898-3492 for information on Plan benefits under the Medicare 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 1-800-898-3492 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 (see specifics regarding transplants).**

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- 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 1-800/877-9829.

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: AmeriHealth HMO, Inc.

P.O. Box 41574
Philadelphia, PA 19101

Prescription drugs

Submit your claims to: FutureScripts™
Dept. #0382
P.O. Box 419019
Kansas City, MO 64141

Other supplies or services

Submit your claims to: AmeriHealth HMO, Inc.
P.O. Box 41574
Philadelphia, PA 19101

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. Disagreements between you and the CDHP or HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

- 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: ; and
 - c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
 - d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

- 2** We have 30 days from the date we receive your request to:
- a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
 - b) Write to you and maintain our denial - go to step 4; or
 - c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

- 3** You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

- 4** If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group x, 1900 E Street, NW, Washington, DC 20415-xxxx.

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.

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

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

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

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

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 1-800/227-3114 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group x at 202/606-0755 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 1-800-877-9829 or see our Web site at www.amerihhealth.com.

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.

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 or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) 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 #1 above	✓	
4) 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	✓	
5) 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 #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓ *	
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	✓	
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 the program.

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any 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 costs.

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.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services.
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	Care provided primarily for maintenance of the patient or care which is designed essentially to assist the patient in meeting his/her activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision of self-administration of medications which do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively. Custodial care that lasts 90 days or more is sometimes known as Long term care.
Experimental or investigational service	To establish if a biological, medical device, drug or procedure is experimental/ investigational or not, a technology assessment is performed. The results of the assessment provide the basis for the determination of the service's status (e.g., medically effective, experimental, etc.). Technology assessment is the review and evaluation of available data from multiple sources using industry standard criteria to assess the medical effectiveness of the service. Sources of data used in technology assessment include, but are not limited to, clinical trials, position papers, articles published by local and/or nationally accepted medical organizations or peer-reviewed journals, information supplied by government agencies, as well as regional and national experts and/or panels and, if applicable, literature supplied by the manufacturer.
Us/We	Us and We refer to AmeriHealth HMO, Inc.
You	You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

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 Benefits*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

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

- **Types of coverage available for you and your family**

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

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

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

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

- **Children's Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

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

• **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2008 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 2007 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.

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 Benefits 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 Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

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

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

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

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

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

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

Section 12. Three Federal Programs complement FEHB benefits

Important information

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

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

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

Third, the **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 qualified dependents.

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 severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). 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.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. **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)** – Pays 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 coverage or 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 other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses for your child(ren) under age 13 or for dependents unable to care for themselves that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

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.

What expenses can I pay with an FSAFEDS account?

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

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

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

AND MUCH MORE! Visit www.FSAFEDS.com

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

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

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

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

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

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

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 has 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. 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 sealing, 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 computer, call 1-877-888-3337 (TTY number, 1-877-889-5680).

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Summary of Benefits for High and Standard Options - 2008

- **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: \$25 primary care; \$40 specialist	16-32
Services provided by a hospital:		
• Inpatient	\$150 copayment per day, up to a 5 day max/admission	33-35
• Outpatient	\$100 facility copayment	33-35
Emergency benefits:		
• In-area	\$100 copayment for emergency room visit and any charges for services that are not covered by this Plan, waived if admitted.	36-37
• Out-of-area	\$100 copayment for emergency room visit and any charges for services that are not covered by this Plan, waived if admitted.	37
Mental health and substance abuse treatment:	Regular cost sharing	38-39
Prescription drugs:		
• Drugs prescribed by <i>any</i> doctor and obtained at a Plan retail pharmacy. Retail dispensing available for up to a 90 day supply.	Copayments (per 30 day supply)	40-42
• Formulary Generic Drugs	\$5 copayment per prescription or refill	40-42
• Formulary Brand Drugs	\$40 copayment per prescription or refill	40-42
• Covered Non-formulary Drugs	50% coinsurance per prescription or refill	40-42
A Mail Order program is available for maintenance medications	2 copayments per 90 day supply	40-42
• Formulary Generic Drugs	\$10 copayment per prescription or refill	40-42
• Formulary Brand Drugs	\$80 copayment per prescription or refill	40-42

High Option Benefits	You pay	Page
• Covered Non-formulary Drugs	50% coinsurance per prescription	40-42
• Non-Plan retail pharmacy		
• Non-Emergency	50% of the total cost of the drug	40-42
• Emergency	The appropriate copayment indicated above	40-42
Dental care:		44-45
• Accidental injury benefit	\$35 copayment per visit	
• Preventive, Diagnostic, and Restorative dental care	\$5 copayment per visit	
Vision care:		
• Eye exam and refraction once every two calendar years	\$40 copayment per visit	23
Special features: Services for deaf and hearing impaired; and Urgent care/travel benefit.		43
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	\$1,500 per person or \$3,000 per family per calendar year. This copayment maximum does not include prescription drugs or dental services. Some costs do not count toward this protection	13
Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$30 primary care; \$50 specialist	16-32
Services provided by a hospital		
• Inpatient	80% after deductible	33-35
• Outpatient	80% after deductible	33-35
Emergency benefits		
• In-area	\$150 copayment for emergency room visit and any charges for services that are not covered by this Plan, waived if admitted	36-37
Out-of-area	\$150 copayment for emergency room visit and any charges for services that are not covered by this Plan, waived if admitted	37
Mental health and substance abuse treatment	Regular cost sharing	38-39
Prescription drugs:		

Standard Option Benefits	You Pay	Page
<ul style="list-style-type: none"> • Drugs prescribed by any doctor and obtained at a Plan retail pharmacy. Retail dispensing available for up to a 90 day supply. 	Copayments (per 30 day supply)	40-42
Formulary Generic Drugs	\$5 copayment per prescription or refill	40-42
Formulary Brand Drugs	\$40 copayment per prescription or refill	40-42
Covered Non-formulary Drugs	50% coinsurance per prescription or refill	40-42
A Mail Order program is available for maintenance medications	2 copayments per 90 day supply	40-42
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<ul style="list-style-type: none"> • Formulary Brand Drugs 	\$80 copayment per prescription or refill	40-42
<ul style="list-style-type: none"> • Covered Non-formulary Drugs 	50% coinsurance per prescription or refill	40-42
<ul style="list-style-type: none"> • Non-Plan retail pharmacy 		
<ul style="list-style-type: none"> • Non-emergency 	50% of the total cost of the drug	40-42
<ul style="list-style-type: none"> • Emergency 	The appropriate copayment indicated above	40-42
Dental care:		
<ul style="list-style-type: none"> • Accidental injury benefit 	\$35 copayment per visit	44-45
<ul style="list-style-type: none"> • Preventive, Diagnostic, and Restorative dental care 	\$5 copayment per visit	44-45
Vision care:		
<ul style="list-style-type: none"> • Eye exam and refraction once every two calendar years 	\$50 copayment per visit	23
Special features: Services for deaf and hearing impaired; and Urgent care/travel benefit		43
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	<p>\$3,000 per person or \$6,000 per family per calendar year. This copayment maximum does not include prescription drugs or dental services.</p> <p>Some costs do not count toward this protection</p>	13

2008 Rate Information for AmeriHealth HMO

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 Category 1 rates apply to certain career non-law enforcement Postal Service employees. **Postal Category 2 rates** apply to other career non-law enforcement Postal Service employees. *PostalEASE*, the employee self-service system used for FEHB enrollment, automatically provides the applicable premium to individual employees. Career non-law enforcement employees may also refer to the *Guide to Federal Benefits for the United States Postal Service Employees*, RI 70-2, to determine their rates.

Different rates apply and a special Guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

For further assistance, Postal Service employees should call.

Human Resources Shared Service Center

1-877-3273, Option 5

TTY: 1-866-260-7507

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	Category 1 Your Share	Category 2 Your Share

All of New Jersey

High Option Self Only	FK1	\$145.04	\$91.52	\$314.25	\$198.30	\$67.34	\$65.33
High Option Self and Family	FK2	\$329.30	\$230.31	\$713.48	\$499.01	\$175.43	\$170.85
Standard Option Self Only	FK4	\$145.04	\$64.50	\$314.25	\$139.75	\$40.32	\$38.31
Standard Option Self and Family	FK5	\$329.30	\$166.59	\$713.48	\$360.95	\$111.71	\$107.13