

A Health Maintenance Organization

Serving: *Gainesville, Jacksonville, Orlando, South Florida, and Tampa areas*

Enrollment in this Plan is limited. You must live or work in our Geographic service area; see page 5 for requirements.



This Plan has commendable accreditation from the NCQA. See the *2002 Guide* for more information on NCQA.



Joint Commission

on Accreditation of Healthcare Organizations

This Plan has accreditation with commendation from the JCAHO. See the *2002 Guide* for more information on JCAHO.

Enrollment Codes for this Plan:

Florida Service Area Code:

EM1 Self Only

EM2 Self and Family

This plan has consolidated the rating areas of Gainesville, code JF; Jacksonville, code HW; Orlando, code FP; South Fl, code EM; and Tampa, code H5 into one rating area. AvMed enrollees that choose not to change enrollment to another participating plan during Open Enrollment Season will automatically be transferred to the enrollment code EM.

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RETIREMENT AND INSURANCE SERVICE
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Introduction

AvMed, Inc.
9400 South Dadeland Boulevard
Miami, FL 33156

This brochure describes the benefits of AvMed Health Plan under our contract (CS 1955) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2002 unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

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

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

Inspector General Advisory

Stop health care fraud!

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 800/882-8633 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE--202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

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.

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 only pay the copayments 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.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments.

Your Rights

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

AvMed Health Plan is an Individual Practice Association organization in Florida. Member's medical services are provided by a wide array of primary care doctors and specialists with whom AvMed contracts. AvMed contracts with approximately nine thousand four hundred forty-three (9,443) doctors and eighty-five (85) major hospitals in the area to provide medical care to members.

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. See Specialty Care below for services that you can receive without a referral from your primary doctor.

If you want more information about us, call 800/882-8633, or write to 9400 South Dadeland Blvd., Suite 200, Miami, FL 33156. You may also contact us by fax at 305/671-4710 or visit our website at www.avmed.com.

Service Area

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

Gainesville area:

Service from Plan providers are available in the following area: Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Levy, Marion, Putnam, Suwannee, and Union Counties.

Jacksonville area:

Services from Plan providers are available in the following area: Baker, Clay, Duval, Nassau, and St. Johns Counties.

Orlando area:

Services from Plan providers are available in the following area: Orange, Osceola, and Seminole Counties.

South Florida area:

Services from Plan providers are available in the following area: Dade, Broward, and Palm Beach Counties.

Tampa area:

Services from Plan providers are available in the following area: Hernando, Hillsborough, Lee, Pasco, Pinellas, Polk, and Sarasota Counties.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

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

Section 2. How we change for 2002

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

Program-wide changes

- We increased speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5 (a))

Changes to this Plan

- Your share of the non-Postal premium will increase by 6.6% for Self Only and decrease by 5.6% for Self and Family.
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5 (a))
- We have included a \$100 copay for hospital admission/surgical procedure. (Section 5 (c))
- We have included a \$100 copay for Outpatient hospital or ambulatory surgical centers (Section 5 (c))
- We now have a 3-tier prescription copay; \$5 for generic drugs, \$10 for preferred brand-name drugs and \$25 for non-preferred brand-name drugs. (Section 5 (f))
- We have included a Mail order benefit for maintenance medications (Section 5 (f))
- We have included a \$75 copay for injectable drug coverage (Section 5 (f))
- This plan has consolidated the rating areas of Gainesville, code JF; Jacksonville, code HW; Orlando, code GP; South Fl, code EM; and Tampa, code H5 into one rating area. AvMed enrollees that choose not to change enrollment to another participating plan during Open Enrollment Season will automatically be transferred to the enrollment code EM.
- We changed the address for sending disputed claims to OPM. (Section 8)
- We now cover certain intestinal transplants. (Section 5 (b))

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-882-8633.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments and you will not have to file claims.

- Plan providers

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards. All AvMed physicians are reviewed at the time of initial application and every two years following. The vast majority of AvMed physicians are board certified or board eligible in their specialty.

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

- Plan facilities

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

What you must do to get covered care

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

You can select your primary care physician by using AvMed’s provider directory. This directory is available at the time of enrollment or upon your request by calling the Member Services Department at 1-800-882-8633. You can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to make sure that he or she still participates with the Plan and is accepting new patients. Important note: When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan’s delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider cannot be guaranteed.

If you decide to enroll, you will be asked to complete a primary care doctor selection form and send it directly to the Plan, indicating the name of the primary care doctor(s) selected for you and each member.

- Primary care

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

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

- Specialty care

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care

physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. On referrals, the primary care physician will give specific instructions to the consultant about what services are authorized. If additional services or visits are suggested by the consultant, you must first check with your primary care physician. However, you may see certain specialists without a referral. Except in a medical emergency, or when a primary care physician has designated another doctor to see patients when he or she is unavailable, you must receive a referral from your primary care physician before seeing any other doctor or obtaining special services. Referral to a participating specialist is given at the primary care physician's discretion; if specialists or consultants are required beyond those participating in the Plan, the primary care physician will make arrangements for the appropriate referral. A member may obtain covered services from a chiropractor or a podiatrist without a referral; a woman may see her Plan gynecologist directly once a year for an annual check-up, with no need to be referred by her primary care physician; a member may obtain up to 5 office visits per calendar year to a Plan dermatologist for covered services.

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

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will work with you and AvMed to 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 or 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 Plan; or
 - reduce our service area and you enroll in another FEHB Plan,

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

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

- Hospital care

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

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

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

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

These provisions apply only to the benefits of the hospitalized person.

Circumstances beyond our control

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

Services requiring our prior approval

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

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

AvMed will provide benefits for covered services only when the services are medically necessary to prevent, diagnose or treat your illness or condition. Your plan doctor must obtain the Plan's determination of medical necessity before you may be hospitalized, referred for specialty care or obtain follow-up care from a specialist.

Section 4. Your costs for covered services

You must share the cost 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 services.

Example: When you see your primary care physician you pay a copayment of \$10 per office visit and when you go in the hospital, you pay \$100 per admission.

- **Deductible**

We do not have a deductible.

- **Coinsurance**

We do not usually charge coinsurance; however, if you choose a non-Plan Physician for a second medical opinion, you will be responsible for 40% of the reasonable and customary charges.

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

After you pay \$1,500 in copayments for Self Only enrollment, or \$2,500 for Self and Family enrollment, you do not have to make any further payments for certain services for the rest of the year. This is called an out-of-pocket limit. However, copayments for your prescription drugs, dental services, and voluntary family planning services do not count toward these limits, and you must continue to make these payments.

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

Section 5. Benefits -- OVERVIEW

(See page 7 for how our benefits changed this year and page 51 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800-882-8633 or at our website at www.avmed.com

(a) Medical services and supplies provided by physicians and other health care professionals	13-20
• Diagnostic and treatment services	
• Lab, X-ray, and other diagnostic tests	
• Preventive care, adult	
• Preventive care, children	
• Maternity care	
• Family planning	
• Infertility services	
• Allergy care	
• Treatment therapies	
• Physical and occupational therapies	
• Speech therapy	
• Hearing services (testing, treatment, and supplies)	
• Vision services (testing, treatment, and supplies)	
• Foot care	
• Orthopedic and prosthetic devices	
• Durable medical equipment (DME)	
• Home health services	
• Chiropractic	
• Alternative treatments	
• Educational classes and programs	
(b) Surgical and anesthesia services provided by physicians and other health care professionals	21-23
• Surgical procedures	
• Reconstructive surgery	
• Oral and maxillofacial surgery	
• Organ/tissue transplants	
• Anesthesia	
(c) Services provided by a hospital or other facility, and ambulance services	24-25
• Inpatient hospital	
• Outpatient hospital or ambulatory surgical center	
• Extended care benefits/skilled nursing care facility benefits	
• Hospice care	
• Ambulance	
(d) Emergency services/accidents	26-27
• Medical emergency	
• Ambulance	
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Section 5 (a). Medical services and supplies provided by physicians and other health care professionals

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year 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.

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Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician's office 	\$10 per visit to your primary care physician or participating specialist
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations 	No separate physician charge in addition to the applicable facility charge
Second surgical opinion	\$10 per office visit – Plan physician If the Member chooses a non-Plan Physician, the Member will be responsible for 40% of the amount of reasonable and customary charges for the second medical opinion
At home	Nothing
<i>Not covered:</i> <i>Injuries received in connection with the commission of a felony</i>	<i>All charges.</i>

Lab, X-ray and other diagnostic tests	You pay
<p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms 	<p>Nothing if you receive these services during your office visit; otherwise, \$10 per office visit</p>
<p>Prior authorization is required for the following:</p> <ul style="list-style-type: none"> • CAT Scans/MRI • Ultrasound • Electrocardiogram • EEG 	<p>Nothing if you receive these services during your office visit; otherwise, \$10 per office visit</p>
Preventive care, adult	
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 	<p>Nothing if you receive these services during your office visit; otherwise, \$10 per visit</p>
<p>Prostate Specific Antigen (PSA test) – one annually for men age 40 and older</p>	<p>Nothing if you receive these services during your office visit; otherwise \$10 per visit</p>
<p>Cervical pap smear test</p> <p>Note: The office visit is covered if pap test is received on the same day; see <i>Diagnosis and Treatment</i>, above.</p>	<p>\$10 per office visit</p>
<p>Routine mammogram –covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	<p>\$10 per office visit</p>
<p><i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i></p>	<p><i>All charges.</i></p>

Preventive care, adult – Continued on next page

Preventive care, adult <i>(continued)</i>	You pay
Routine immunizations limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over 	\$10 per office visit
Preventive care, children	
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	\$10 per office visit
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (under 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 (under age 22) 	\$10 per office visit
Maternity care	
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> • Prenatal care • Postnatal care 	Copayments are waived for maternity care.
<ul style="list-style-type: none"> • Delivery Note: Here are some things to keep in mind: <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 10 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	\$100 per admission
<i>Not covered: No more than one routine sonogram during pregnancy</i>	<i>All charges.</i>

Family planning	You pay
<p>A broad range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization 	\$100 per hospital admission
<ul style="list-style-type: none"> • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms <p>NOTE: We cover oral contraceptives under the prescription drug benefit. See page 30.</p>	\$10 per office visit
<p><i>Not covered: reversal of voluntary surgical sterilization, genetic counseling</i></p>	<i>All charges.</i>
Infertility services	
<p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - <i>intra</i>vaginal insemination (IVI) - <i>intra</i>cervical insemination (ICI) - <i>intra</i>uterine insemination (IUI) 	\$20 per office visit
<p>Surgery for the enhancement of fertility</p>	<p>\$100 for physician \$500 for facility</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>in vitro</i> fertilization - <i>embryo transfer, gamete GIFT and zygote ZIFT</i> - <i>Zygote transfer</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> • <i>Fertility drugs</i> 	<i>All charges.</i>
Allergy care	
<p>Testing and treatment</p>	\$50 per course of testing
<p>Allergy injection</p>	\$10 per office visit
<p>Allergy serum</p>	Nothing
<p><i>Not covered: provocative food testing and sublingual allergy desensitization</i></p>	<i>All charges.</i>

Treatment therapies	You pay
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 23.</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. Call 1-800-816-5465 for preauthorization. We will ask your AvMed physician to submit information that establishes that the GHT is medically necessary. Be sure your AvMed physician obtains approval before you begin treatment; otherwise, we will only cover GHT services from the date you get approval. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	\$10 per office visit
Physical and occupational therapies	
<ul style="list-style-type: none"> • 60 visits per condition for the services of each of the following: <ul style="list-style-type: none"> – qualified physical therapists and – occupational therapists. 	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>exercise programs</i> • <i>Cardiac rehabilitation</i> 	<i>All charges.</i>
Speech therapy	
60 visits per condition	\$10 per office visit
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>all other hearing testing</i> • <i>hearing aids, testing and examinations for them</i> 	<i>All charges.</i>

Vision services (testing, treatment, and supplies)	You pay
<ul style="list-style-type: none"> Annual eye refractions to determine the need for vision correction for children through age 17 (see preventive care) Diagnosis and treatment of diseases of the eye 	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> All other vision testing (eye examinations and refractions) Eyeglasses or contact lenses (including replacement of lenses provided during the same calendar year) External lenses following cataract surgery Eye exercises and orthoptics Radial keratotomy and other refractive surgery 	<i>All charges.</i>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	\$10 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) Podiatric shoe inserts or foot orthotics 	<i>All charges.</i>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> Artificial limbs and eyes; stump hose Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. 	\$10 per office visit

Orthopedic and prosthetic devices- Continued on next page

Orthopedic and prosthetic devices (Continued)	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>orthopedic and corrective shoes</i> • <i>arch supports</i> • <i>cochlear implants</i> • <i>foot orthotics</i> • <i>non orthopedic brace</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>penile implants</i> • <i>prosthetic replacements provided less than 3 years after the last one we covered</i> 	<p><i>All charges.</i></p>
Durable medical equipment (DME)	
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • hospital beds; • standard wheelchairs; and • crutches; • infusion pumps <p>Coverage for orthotic appliances is limited to leg, arm, back, and neck custom-made braces when related to a surgical procedure or when used in an attempt to avoid surgery and are necessary to carry out normal activities of daily living, excluding sports activities. Coverage is limited to the first such item; repair and replacement is not covered.</p> <p>Note: In the treatment of diabetes, coverage for an infusion pump will apply towards the annual maximum limitation but shall not be subject to the DME benefit limitation.</p>	<p>\$50 per episode of illness</p> <p>Benefits are limited to a maximum of \$500 per contract year. You pay anything above that amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Medical supplies such as corsets which do not require a prescription</i> • <i>Motorized wheelchairs</i> • <i>Non-standard wheelchairs</i> • <i>All other orthotic appliances</i> 	<p><i>All charges.</i></p>

Home health services	You pay
<ul style="list-style-type: none"> Home health services of nurses and health aides when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need. Services include oxygen therapy, intravenous therapy and medications. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>nursing care requested by, or for the convenience of, the patient or the patient's family;</i> <i>home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative.</i> 	<i>All charges.</i>
Chiropractic	
<ul style="list-style-type: none"> Manipulation of the spine and extremities Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	\$10 per office visit
<i>Not covered: As alternative treatment</i>	<i>All charges.</i>
Alternative treatments	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>naturopathic services</i> <i>hypnotherapy</i> <i>biofeedback</i> <i>Acupuncture</i> <i>Homeopath services</i> 	<i>All charges.</i>
Educational classes and programs	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> Smoking Cessation – Up to \$100 for one smoking cessation program per member per lifetime, including all related expenses such as prescription drugs. Diabetes self-management 	\$10 per office visit
<i>Not Covered: Over the counter products</i>	<i>All charges</i>

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year 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.
- 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 PREAUTHORIZATION OF SOME SURGICAL PROCEDURES.** Please refer to the preauthorization information shown in Section 3 to be sure which services require preauthorization and identify which surgeries require preauthorization.

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Benefit Description	You pay
Surgical procedures	
<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 reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. 	\$10 per office visit
<ul style="list-style-type: none"> • Voluntary sterilization • 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>	\$100 per procedure
<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>

Reconstructive surgery	You pay
<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; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> – surgery to produce a symmetrical appearance on the other breast; – treatment of any physical complications, such as lymphedemas; – breast prostheses and surgical bras and replacements (see Prosthetic devices) • Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. 	<p>\$10 per office visit</p>
<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> 	<p><i>All charges.</i></p>
Oral and maxillofacial surgery	
<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. 	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral/ dental implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> • <i>Impacted wisdom teeth</i> 	<p><i>All charges.</i></p>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Kidney • Liver • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas <p>Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>Nothing</p>
<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> 	<p><i>All charges.</i></p>
Anesthesia	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) 	<p>Covered under Hospital admission copay</p>

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

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Here are some important things to remember 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.
- We have no calendar year 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.
- 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 covered in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require preauthorization.

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Benefit Description	You pay
Inpatient hospital	
<p>Room and board, such as</p> <ul style="list-style-type: none"> • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. <p>NOTE: If you want a private room when it is not medically necessary, you pay the additional per day charge above the semiprivate room rate, in addition to the admission charge.</p>	\$100 per admission
<p>Other hospital services and supplies, such as:</p> <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 or blood plasma, only if donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <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>Blood and blood derivatives not replaced by the member</i> 	<i>All charges.</i>

Outpatient hospital or ambulatory surgical center	You pay
<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, only if 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 per procedure
<i>Not covered: blood and blood derivatives not replaced by the member</i>	<i>All charges.</i>
Extended care benefits/skilled nursing care facility benefits	
<p>Extended care benefit: We provide a comprehensive range of benefits for up to 30 post-hospital days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor, and approved by the Plan. All necessary services are covered, including:</p> <ul style="list-style-type: none"> • Bed, board, and general nursing care; • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Residential treatment facilities</i> 	<i>All charges.</i>
Hospice care	
<p>We provide supportive and palliative care for a terminally ill member in the home or hospice facility. Services included:</p> <ul style="list-style-type: none"> • Inpatient and outpatient care; • Family counseling <p>These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Independent nursing</i> • <i>Homemaker services</i> 	<i>All charges.</i>
Ambulance	
<ul style="list-style-type: none"> • Local professional ambulance service when medically appropriate and ordered or authorized by a Plan doctor. 	Nothing

Section 5 (d). Emergency services/accidents

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year 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.

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What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area:

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

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

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

Emergencies outside our service area:

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

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

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> Emergency care at a participating doctor's office 	\$10 per visit
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$30 per visit
<ul style="list-style-type: none"> Emergency care at a non-participating urgent care center or non-participating hospital emergency room 	\$50 per visit
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>
Emergency outside our service area	
<ul style="list-style-type: none"> Emergency care at a doctor's office Emergency care at an urgent care center Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	\$50 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Elective care or non-emergency care</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>
Ambulance	
<p>Professional ambulance service when medically appropriate.</p> <p>Air ambulance, when medically necessary and preauthorization by Medical Director or Chief Medical Officer</p> <p>See 5(c) for non-emergency service.</p>	Nothing

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

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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.

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

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Benefit Description	You pay
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	Your cost sharing responsibilities are no greater than for other illness or conditions.
<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 	\$10 per visit
<ul style="list-style-type: none"> • Diagnostic tests 	\$10 per visit
<ul style="list-style-type: none"> • Services provided by a hospital or other facility 	\$100 per admission
<ul style="list-style-type: none"> • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	\$10 per visit
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All charges.</i>

Preauthorization

To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes:

Pre-Authorization is required for most scheduled diagnostic tests/procedures and all scheduled inpatient/outpatient surgical procedures. It is the responsibility of the requesting physician to obtain authorization prior to scheduling services. In order to check on a referral, call AvMed Link Line at 1-800-806-3623.

Limitation

We may limit your benefits if you do not obtain a treatment plan.

Section 5 (f). Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year 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.

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication.
- **We use a formulary.** Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's Drug Formulary. The Drug Formulary is a list of commonly prescribed medications that have been chosen by the Pharmacy and Therapeutic Committee based on a drug's effectiveness and cost. The Pharmacy and Therapeutic Committee will evaluate any needed additions or deletions to the formulary. Upon a participating provider's request, specific medications can be evaluated on a case by case basis to be added to the formulary. Non-formulary drugs will be covered when prescribed by a Plan doctor. It is the prescribing doctor's responsibility to obtain authorization for on-formulary drugs before they are dispensed.
- **These are the dispensing limitations.** Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply (or 100 unit dosage, whichever is less); 240 milliliters of liquid (8 oz.); 60 grams of ointment, creams or topical preparation; or one commercially prepared unit (e.g. one inhaler, one vial ophthalmic medication or insulin).

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- **Why use generic drugs?** The active ingredient that makes a drug work is the medicine. All drugs, Brand and Generic, have this same active ingredient inside. Brand drugs have a patent for the name, shape and color. Generic drugs used by AvMed have the same ingredients as the Brand drug, they just look different on the outside.
 - **When you have to file a claim.** If you need a prescription before you receive your Membership card, you can fill the prescription at a participating pharmacy and submit the receipt and a copy of the prescription to AvMed for reimbursement. The copayment amount will be subtracted from the reimbursement. Please indicate your Social Security Number on the receipt. See Section 7 for specific information.

Prescription drug benefits begin on the next page.

Benefit Description	You pay
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see Prior authorization below) Coverage is limited; contact AvMed for dose limits. You pay the drug copayment up to the dosage limit and all charges above that. • Contraceptive drugs and devices 	<p>Retail Drugs</p> <p>\$ 5 Generic Drugs</p> <p>\$ 10 Preferred Brand Name Drug</p> <p>\$ 25 Non-Preferred Brand Name Drugs</p>
<p>Mail service is a benefit option for maintenance medications needed for chronic or long-term health conditions. It’s best to get an initial prescription filled at your retail pharmacy. Ask your physician for an additional prescription for up to a 90-day supply of your medication to be ordered through mail service. Up to 3 refills are allowed per prescription. Pay the following copayment (as well as the Brand Additional Charge if you or your physician choose a Brand name product when a Generic is available).</p>	<p>Mail Order Drugs</p> <p>\$ 10 Generic Drugs</p> <p>\$ 20 Preferred Brand Name Drugs</p> <p>\$ 50 Non-Preferred Brand Name Drugs</p>
<p>Your injectable drug prescription coverage includes the quantity sufficient to treat the acute phase of an illness or established by the manufacturers packaging guidelines but not more than a 30 day supply per copayment or actual cost, whichever is less.</p>	<p>\$75 Generic Drugs</p>
<p>Here are some things to keep in mind about our prescription drug program:</p> <ul style="list-style-type: none"> • A Generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic. • We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. 	

Covered medications and supplies - continued on next page

Covered medications and supplies	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines or medicines for which there is a nonprescription equivalent</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Medical supplies such as dressing and antiseptics</i> • <i>Drugs to enhance athletic performance</i> • <i>Fertility drugs</i> 	<p><i>All charges.</i></p>

Section 5 (g). Special features

Feature	Description
Flexible benefits option	<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.
24 hour nurse line	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-888-866-5432 and talk with a registered nurse who will discuss treatment options and answer your health questions.</p>
Centers of Excellence for transplants/heart surgery/etc.	<p>Consult Member Services at 1-800-882-8633 to obtain a complete list of centers.</p>
Disease Management	<p>Call 1-800-972-8633 for information and help with the following:</p> <ul style="list-style-type: none"> • Healthy Hearts – congestive heart failure • E-Z Breath'n – asthma • Healthy Expectations – high risk pregnancy

Section 5 (h). Dental benefits

I M P O R T A N T	<p>Here are some important things to keep in mind about these benefits:</p> <ul style="list-style-type: none"> 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 have no calendar year deductible. 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, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. 	I M P O R T A N T
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Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Nothing

Dental benefits

We cover the following dental services when provided by participating Plan dentists to children through age 11.

Service	You pay
<u>Preventive and Diagnostic</u> <ul style="list-style-type: none"> Oral examinations X-rays as necessary Prophylaxis (cleaning) 	Nothing
<ul style="list-style-type: none"> Topical application of fluoride 	\$10 per application

Section 5 (i). 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 out-of-pocket maximums.

Expanded dental benefits

AvMed is making available dental services through American Dental Plan (ADP) to Federal employees for an additional premium.

ADP's benefits include NO CHARGE services for the following:

- Topical fluoride
- Oral examinations
- X-rays
- Cleaning (semi-annual)
- Local anesthesia

For more information on how to enroll in the Dental Plan, please call ADP at (352) 371-2811 or 1-800-342-5209.

Expanded vision care

Discounts on vision services are available to AvMed members. Services include:

- Eye exams
- Eyeglasses
- Contact lenses
- Designer glasses, sunglasses, etc.

For details on specific services and discounts in your Service Area, please call your Plan's Membership Services Office listed on page 8 of the brochure.

Additional value added services include Weight Watchers and Smokenders.

Medicare prepaid plan enrollment – This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated in Section 9, annuitants and former spouses with FEHB coverage and Medicare Part 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 and changing to Medicare prepaid plan. Contact us at 1-800-535-9355 for information on the Medicare prepaid plan and the cost of that enrollment.

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

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

The exclusions in this section apply to all benefits. **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 and we agree, as discussed under *What Services Require Our Prior Approval* on page 10.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

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.

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. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-800-882-8633.

When you must file a claim -- such as for out-of-area care -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Submit your claims to: 9400 South Dadeland Blvd., Suite 200, Miami, FL 33156

Prescription drugs

Submit your claims to: 9400 South Dadeland Blvd., Suite 200, Miami, FL 33156

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible (remember to keep copies). 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 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:

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">(a) Write to us within 6 months from the date of our decision; and(b) Send your request to us at: AvMed Member Relations, P.O. Box 749, Gainesville, FL 32602-0749; and(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and(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	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none">(a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); 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	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">• 90 days after the date of our letter upholding our initial decision; or• 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or• 120 days after we asked for additional information. <p>Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, DC 20415-3630.</p>

The Disputed Claims process (*Continued*)

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 different claims, you must clearly identify which documents apply to which claim.

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

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

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

6 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 preauthorization. This is the only deadline that may not be extended.

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

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

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

- (a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-882-8633 and we will expedite our review; or
- (b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You can call OPM's Health Benefits Contracts Division 3 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 are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other 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. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

- What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are 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.

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

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

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

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

(Primary payer chart begins on next page.)

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

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

- Medicare managed care plan

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

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments for your FEHB coverage.

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

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

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

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

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related 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. You must use our providers.

Medicaid

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

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.

Section 10. Definitions of terms we use in this brochure

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

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

- 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 enrollment season begins.

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

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

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

When you retire

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

When you lose benefits

- When FEHB coverage ends

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

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

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

- Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

- 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 job, if you are a covered dependent child and you turn 22 or marry, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage*

and Former Spouse Enrollees, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

You may be entitled to continued coverage through the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Federal law 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.

Get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. It highlights 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 it has information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG!*
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. LTC insurance can supplement care provided by family members, reducing the burden you place on them.

I'm healthy. I won't need long term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. Many people now consider long term care insurance to be vital to their financial and retirement planning.

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed \$50,000. Home care for only three 8-hour shifts a week can exceed \$20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

Department of Defense/FEHB Demonstration Project

What is it?

The Department of Defense/FEHB Demonstration Project allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years and began with the 1999 open enrollment season for the year 2000. Open enrollment season will be for an effective date of January 1, 2002. DoD and OPM have set up some special procedures to implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible

DoD determines who is eligible to enroll in the FEHB Program. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare;
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare;
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried; or
- You are a survivor dependent of a deceased active or retired uniformed service member; and
- You live in one of the geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

The demonstration areas

- Dover AFB, DE
- Fort Knox, KY
- Dallas, TX
- New Orleans, LA
- Adair County, IA area
- Commonwealth of Puerto Rico
- Greensboro/Winston Salem/High Point, NC
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA
- Coffee County, GA area

When you can join

You may enroll under the FEHB/DoD Demonstration Project during the 2001 open enrollment season, November 12, 2001, through December 10, 2001. Your coverage will begin January 1, 2002. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877/DOD-FEHB (1-877/363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during open enrollment season. Your coverage will begin January 1, 2002. If you become eligible for the DoD/FEHB Demonstration Project outside of open enrollment season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2002 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM web site at www.opm.gov.

Temporary Continuation Of Coverage (TCC)

See Section 11, FEHB Facts; it explains temporary continuation of coverage (TCC). Under this DoD/FEHB Demonstration Project the **only** individual eligible for TCC is one who ceases to be eligible as a "member of family" under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHB Demonstration Project ends. TCC enrollment

terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child, or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHB Demonstration Project.

TCC is not available if you move out of a DoD/FEHB Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

Other features

The 31-day extension of coverage and right to convert do not apply to the DoD/FEHB Demonstration Project.

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

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Summary of benefits for the AvMed Health Plan - 2002

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copay: \$10 primary care; \$10 specialist	13
Services provided by a hospital: • Inpatient • Outpatient	\$100 per admission copay \$100 copay	24 25
Emergency benefits: • In-area • Out-of-area	\$30 per visit \$50 per visit	27 27
Mental health and substance abuse treatment.....	Regular cost sharing.	28
Prescription drugs.....	Retail - Generic \$5, Preferred Brand \$10, Non Preferred Brand \$25 Mail Order – Generic \$10, Preferred Brand \$20, Non Preferred Brand \$50	30
Dental Care	Preventive dental care for children through age 11. \$10 per topical application.	33
Vision Care	Refractions, including lens prescriptions, limited to children through age 17. \$10 copay per visit.	18
Special features: Flexible benefit option, 24-hour nurse line, Disease Management, Centers of Excellence		32
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after \$1,500/Self Only or \$2,500/Family enrollment per year Some costs do not count toward this protection	11

2002 Rate Information for AvMed Health Plan

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

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

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

Type of Enrollment	Code	<i>Non-Postal Premium</i>				<i>Postal Premium</i>	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

Location Information

High Option Self Only	EM1	\$92.17	\$30.72	\$199.70	\$66.56	\$109.06	\$13.83
High Option Self & Family	EM2	\$223.41	\$114.51	\$484.06	\$248.10	\$263.75	\$74.17