

Avera Health Plans

<http://www.averahealthplans.com>

2002

A Health Maintenance Organization with a point of service product

Serving: *Eastern and Central South Dakota and Northwestern Iowa.*

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

Enrollment codes for this Plan:

AV1 Self Only
AV2 Self and Family

Special notice: This Plan is offered for the first time under the Federal Employees Health Benefits Program during the 2001 Open Season.

Authorized for distribution by the:



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



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Introduction

Avera Health Plans, Inc.
3900 West Avera Drive
Sioux Falls, South Dakota 57108 5721

This brochure describes the benefits of Avera Health Plans, Inc. under our contract (CS 2863) 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. 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 Avera Health Plans.
- 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 e-mail us at fehbwcomments@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 1- 888-322-2115 and explain the situation.
- If we do not resolve the issue, call or write

**THE HEALTH CARE FRAUD HOTLINE
202/418-3300**

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 encourage you to see the 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, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

We also have Point-of-Service (POS) benefits:

Our HMO offers Point-of-Service (POS) benefits. This means you can receive covered services from a participating provider without a required referral, or from a non-participating provider. These out-of-network benefits have higher out-of-pocket costs than our in-network benefits.

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 deductible, copayment and coinsurance. Participating physicians and other health care professionals submit claims to us for services provided to you and they are reimbursed on a fee for service basis. The fee is an amount negotiated by the participating provider and Avera Health Plans. Participating hospitals that provide services to Avera Health Plans members are reimbursed on a fee for service basis or on an amount that is calculated by multiplying the number of days you are hospitalized by a specified dollar amount. There are no contractual arrangements in place between Avera Health Plans and participating providers that would create an incentive for providers to withhold care.

Your Rights

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

- Avera Health Plans is a for profit division of Avera Health that was established to provide health care financing and delivery services.
- Avera Health Plans operates under a Certificate of Authority issued by the South Dakota Division of Insurance and the Iowa Division of Insurance.
- Avera Health Plans began operations in October of 1999 and provides health care coverage and services to over 10,000 individuals in South Dakota, Iowa, Minnesota, and Nebraska.
- If you want more information about us, call 605-322-4545 or 888-322-2115, or write to Avera Health Plans, 3900 W. Avera Drive, Suite 200, Sioux Falls, SD 57108-5721.
- You may also contact us by fax at 605/322-4535 or visit our website at www.averahealthplans.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area in South Dakota is the following counties in Central and Eastern South Dakota: Aurora, Beadle, Bon Homme, Brookings, Brown, Brule, Buffalo, Charles Mix, Clark, Clay, Codington, Davison, Deuel, Douglas, Edmonds, Faulk, Grant, Gregory, Hamlin, Hand, Hanson, Hutchinson, Jerauld, McPherson, Kingsbury, Lake, Lincoln, Marshall, McCook, Miner, Minnehaha, Moody, Roberts, Sanborn, Tripp, Turner, Union, Walworth, and Yankton.

In Iowa our Service Area is: Dickinson, Emmet, Lyon, O'Brien, Plymouth, Osceola, and Sioux.

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

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

Section 2. We are a new plan

This Plan is new to the FEHB Program. We are being offered for the first time during the 2001 open season.

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 605-322-4545 or 888-322-2115.

Where you get covered care

When you get care from “Plan providers” and “Plan facilities” you will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims. If you use our point-of-service program, you can also get care from non-Plan providers, or from participating providers without a required referral, but it will cost you more.

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our 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. The name of the selected primary care physician will appear on your identification card. You do have the right to change your primary care physician. Primary care physicians are listed in a primary care physician section of our provider directory.

- **Primary care**

Your primary care physician can be a Family Practitioner, Internist, General Practitioner, Obstetrician/Gynecologist, or Pediatrician. Your primary care physician will provide most of your health care, or may 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 may refer you to a specialist for needed care. However, you may see a specialist without a referral.

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 the specialist and with us to develop a treatment plan that allows you to access specialty care. 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 may continue to receive services under point-of-service (POS) benefits, but it will cost you more.
- 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.
- 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 approved by us. Contact us, 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 may obtain approval 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 605-322-4545 or 888-322-2115. 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 precertification. Your physician must obtain precertification for the following services:

- Chemotherapy
- Consideration of In Network Benefits for Out of Network Care (except emergency and urgent care)
- Coronary Angiography/Catheterization
- Dialysis
- Durable Medical Equipment (Purchase or Total Rental), over \$200
- Home Health Services
- Hospice Care
- Hyperbaric Chamber Treatment
- Infertility Studies
- Inpatient Hospital Admissions
- Inpatient and Outpatient Alcoholism & Chemical Dependency Treatment
- Inpatient and Outpatient Mental Health Services
- Lithotripsy
- MRI/MRA
- Non-Emergency Ambulance Transport
- Occupational Therapy
- Organ Transplants
- Outpatient Surgeries/Procedures not performed in the Physician's Office
- Penile Implant
- PET scans
- Physical Therapy
- Prosthetic or Orthotic Devices, over \$300
- Radiation Therapy
- Skilled Nursing Facility Admissions
- Sleep Studies
- Speech Therapy
- Video EEGs

The following services do not require precertification : CT Scans, Cystoscopy, Doppler studies, ECG's/Cardiac Stress tests/Event Monitors, EEG's, EMG's/NVC's, Flexible Sigmoidoscopy, Mammography, Nuclear Medicine Scans, Pulmonary Function tests, Routine Lab and Xrays, and Ultrasounds.

Injections of the following drugs when given in a Physician's Office must be precertified before administration of the drug:

- Botulin
- Growth Hormone
- Interferon
- Lupron
- Betaserons

Under your point-of-service (POS) benefit these services need to be precertified. The ultimate responsibility for requesting precertification remains with you, however, information provided by your provider's office will also satisfy this requirement. If you require any of the services listed above, you must contact Medical Management at **1-888-605-1331** as soon as possible after the indication of need for the services.

The AHP Medical Management Department will review the Member profile information against standard criteria. A determination will be made by the Medical Management Department within forty-eight (48) hours of the initial request or the next business day if the request is made on a weekend or holiday. The determination shall either be an authorization for the requested service or additional review by the AHP Medical Director.

If the determination is to authorize the requested service, you, the attending provider, and those providers involved in the provision of the service shall be notified of the decision in writing. When the service is approved, the Medical Management Department will assign an authorization number.

When the request requires a need for further review, an intensified review will be performed by the AHP Medical Director. If additional documentation is required, you, your representative, and/or the Provider shall be responsible for submitting any necessary information. A determination either authorizing or denying the request for services will be made in writing. The attending practitioner, those providers involved in the provision of the service and you shall be notified of the decision.

If the decision is to deny the service, you and those providers who are involved in the provision of the service shall be informed of the reasons for the denial and AHP's appeal procedures.

AHP will not deny coverage for the health care services listed in this section which you have already received solely on the basis of lack of precertification to the extent that the health care services would otherwise have been covered had precertification been obtained.

Service listed in this section that you obtain under the point-of-service (out of network) are subject to precertification.

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 \$250 per admission.

- **Deductible**

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

- The calendar year deductible is \$350 per person under our Plan. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$700 under our Plan.

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

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

- **Coinsurance**

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

Example: In our Plan, you pay 20% of our allowance for infertility services and durable medical equipment for services received in network.

Your catastrophic protection out-of-pocket maximum for coinsurance

After your coinsurance totals \$1,500 per person or \$3,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments for these services:

- Physician office visits
- Preventive care examinations
- Chiropractic office visits
- Hospital services
- Skilled nursing facility services
- Outpatient mental health services
- Inpatient chemical dependency treatment
- Partial day chemical dependency treatment
- Prescription drugs

Section 5. Benefits – OVERVIEW

(See page 59 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 (888) 322-2115 or at our website at www.averahealthplans.com.

(a) Medical services and supplies provided by physicians and other health care professionals.....	14-23
•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.....	24-27
•Surgical procedures	
•Reconstructive surgery	
•Oral and maxillofacial surgery	
•Organ/tissue transplants	
•Anesthesia	
(c) Services provided by a hospital or other facility, and ambulance services.....	28-31
•Inpatient hospital	
•Outpatient hospital or ambulatory surgical center	
•Extended care benefits/skilled nursing care facility benefits	
•Hospice care	
•Ambulance	
(d) Emergency services/accidents.....	32-33
•Medical emergency	
•Ambulance	
(e) Mental health and substance abuse benefits	34-35
(f) Prescription drug benefits	36-38
(g) Special features	39
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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.
- The calendar year deductible is \$350 per person and \$700 per family for In Network Services. For Out of Network Services the calendar year deductible is \$1,500 per person and \$3,000 per family. The calendar year deductible applies to almost all benefits in this Section.
- 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 Medicare.

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Benefit Description	You pay After the calendar year deductible...
NOTE: The calendar year deductible applies to almost all benefits in this Section.	
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician's office 	In Network : \$10 per visit to your primary care physician \$35 per visit to a specialist Out of Network: 40% after deductible plus any difference between our allowable charge and the provider's actual charge.
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 • Second surgical opinion 	In Network: 20% after deductible Out of Network 40% after deductible plus any difference between our allowable charge and the provider's actual charge.

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 • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG 	<p>In Network: 20% after deductible</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider's actual charge.</p>
Preventive care, adult	You Pay
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including: <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening—every 5 years starting at age 50 <p>Prostate Specific Antigen (PSA test) – one annually for men age 50 and older; age 45-49 annual if history of prostate cancer.</p> <p>Routine Pap 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>In Network: \$10 Copay with PCP</p> <p>Out of Network: All charges.</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>In Network: Nothing</p> <p>Out of Network: All Charges</p>

Preventive care, adult (<i>continued</i>)	You Pay
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All Charges</i>
Preventive care, children	You Pay
<ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics 	In Network: Nothing Out of Network: All charges
<ul style="list-style-type: none"> Well-child care charges for routine examinations, immunizations and care (through age 18) Examinations, such as: <ul style="list-style-type: none"> Eye exams to determine the need for vision correction. Ear exams to determine the need for hearing correction (through age 17) Examinations done on the day of immunizations (through age 18) 	In Network: Nothing with PCP to age 6 \$10 with PCP age 7 to 18 \$35 with a Specialist Out of Network: All Charges For Lab and X-ray: In Network: 20% after deductible Out of Network: All Charges
Maternity care	You pay
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> Prenatal care Delivery Postnatal care <p>Note: Here are some things to keep in mind:</p> <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). 	In Network: Nothing Out of Network: 40% after deductible plus any difference between our allowable charge and the provider's actual charge.

Family planning	You Pay
<p>A broad range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization • 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.</p>	<p>In Network : \$10 per visit to your primary care physician \$35 per visit to a specialist</p> <p>Out of Network: 40% after deductible plus any difference between our allowable charge and the provider's actual charge.</p>
Infertility services	You pay
<p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> — intravaginal insemination (IVI) — intracervical insemination (ICI) 	<p>In Network : 20% after deductible</p> <p>Out of Network: 40% after deductible plus any difference between our allowable charge and the provider's actual charge.</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 fertilization</i> — <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>Infertility services after voluntary sterilization</i> 	<p><i>All charges</i></p>

Allergy care	You Pay
<p>Testing and treatment</p> <p>Allergy Injection</p>	<p>In Network: 20% after deductible</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider's actual charge.</p>
<p>Allergy serum</p>	<p>In Network: Nothing</p> <p>Out of Network: 40% after deductible plus any difference between our allowable charge and the provider's actual charge.</p>
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 18</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.</p>	<p>In Network: 20% after deductible</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider's actual charge.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Chelation Therapy</i> 	<p><i>All Charges</i></p>

Physical and occupational therapies	You pay
<ul style="list-style-type: none"> • Up to 2 consecutive months per condition for physical and occupational therapy • Phase II. <p>Note: These services all require precertification</p>	<p>In Network: 20% after deductible</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider's actual charge.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long term rehabilitative therapy</i> • <i>Lifestyle improvement services such as physical fitness programs, health or weight loss clubs or clinics.</i> 	<p><i>All charges</i></p>
Speech Therapy	You Pay
<p>Up to 2 consecutive months per condition.</p>	<p>In Network: 20% after deductible</p> <p>Out of Network : 40% after deductible plus any difference between our allowable charge and the provider's actual charge.</p>

Hearing services (testing, treatment, and supplies)	You pay
<ul style="list-style-type: none"> Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	In Network: \$35 Copay Out of Network: All charges
<i>Not covered:</i> <ul style="list-style-type: none"> All other hearing tests Hearing aids, testing and examination for them 	<i>All charges</i>
Vision services (testing, treatment, and supplies)	You pay
One complete exam per Calendar Year for eyeglasses (spectacles) or up to the spectacle exam amount for a contact lens exam.	In Network Nothing Out of Network All Charges
Vision Services for aphakia patients and for treatment of a disease or injury, limited to services for the prescribing and fitting of eyeglasses or contact lenses for aphakia patients or soft contact lenses or scleral shells intended for use in the treatment of a eye disease or injury (one pair per calendar year).	In Network: 20% after deductible Out of Network 40% after deductible plus any difference between our allowable charge and the provider's actual charge
<i>Not Covered:</i> <ul style="list-style-type: none"> Examination, purchase, or fitting of Eyeglasses or Contact Lenses, except as specifically covered elsewhere. Radial Keratotomy and other refractive surgery. Eye exercises and orthoptics 	<i>All Charges</i>
Foot care	You pay
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	In Network: \$35 copay Out of Network 40% after deductible plus any difference between our allowable charge and the provider's actual charge.
Podiatry Services	In Network: 20% after deductible Out of Network 40% after deductible plus any difference between our allowable charge and the provider's actual charge.

Foot care <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<p><i>All Charges</i></p>
Orthopedic and prosthetic devices	You pay
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	<p>In Network: 20% after deductible</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider's actual charge.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>orthopedic and corrective shoes</i> • <i>arch supports</i> • <i>foot orthotics</i> • <i>heel pads and heel cups</i> • <i>lumbosacral supports</i> • <i>corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>prosthetic replacements provided more frequently than the product's useful life as stated by the manufacturer</i> 	<p><i>All charges</i></p>

Durable medical equipment (DME)	You pay
<p>Durable Medical Equipment includes, but is not limited to:</p> <ul style="list-style-type: none"> • crutches • walkers • wheelchairs • nebulizers <p>Note: AHP reserves the option to rent or purchase Durable Medical Equipment, and the option to select appropriate new, used or refurbished Durable Medical Equipment. Rental costs shall not exceed the allowable charge for Durable Medical Equipment purchase. Covered services include replacement and repairs when medically necessary and appropriate, but does not include replacement due to damage or loss. Coverage for wheelchairs are limited to the cost of one standard, manual wheelchair. Coverage for oxygen units are limited to one stationary and one portable unit depending on medical necessity.</p>	<p>In Network: 20% after deductible</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider's actual charge.</p>
<p><i>Not covered: benefits for motorized equipment or standard, commonly available batteries for durable medical equipment.</i></p>	<p><i>All charges</i></p>
Home health services	You Pay
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications 	<p>In Network: 20% after deductible</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider's actual charge.</p> <p>Out of Network services are limited to 60 visits per calendar year.</p>
<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 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> 	<p><i>All charges</i></p>

Chiropractic	You Pay
<p>Chiropractic Services from a doctor of chiropractic who deals with the relationship of the nervous system and the spinal column in the restoration and maintenance of health.</p> <p>Note: Services are limited to 20 visits per calendar year.</p>	<p>In Network: \$35 Copay</p> <p>Out of Network: All charges</p>
Alternative treatments	You Pay
<p>No benefit.</p>	<p>All charges</p>
Educational classes and programs	You Pay
<p>Diabetic Education, Supplies and Equipment</p> <ul style="list-style-type: none"> • Equipment, supplies, and self-management training and education, including medical nutrition therapy, for treatment of persons diagnosed with diabetes if prescribed by a physician or other licensed health care provider legally authorized to prescribe such treatment. • Diabetes self-management training and education shall be covered if the service is provided by a physician, nurse, dietitian, pharmacist, or other licensed health care provider who satisfies the current academic eligibility requirements of the National Certification Board for Diabetic Educators and has completed a course in diabetes education and training or has been certified as a diabetes educator. • Coverage of diabetes self-management training is limited to (a) persons who are newly diagnosed with diabetes or have received no prior diabetes education; (b) persons who require a change in current therapy; (c) persons who have a co-morbid condition such as heart disease or renal failure; or (d) persons whose diabetes condition is unstable. Under these circumstances, no more than two comprehensive education programs per lifetime and up to eight follow-up visits per year need be covered. 	<p>In Network: 20% after deductible</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider's actual charge.</p>
<p>Smoking Cessation</p> <ul style="list-style-type: none"> • Prescription drugs including oral and topical medications Note: Smoking cessation drug products are limited to \$300 per lifetime. • Smoking Cessation Programs Note: One smoking cessation program approved by AHP will be covered per lifetime of the contract, and limited to \$200. 	<p>In Network: 20% after deductible</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider's actual charge.</p>

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.
- The calendar year deductible is \$350 per person and \$700 per family for In Network Services. For Out of Network Services the calendar year deductible is \$1,500 per person and \$3,000 per family. The calendar year deductible applies to almost all benefits in this Section.
- 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 Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.)
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

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Benefit Description	You pay After the calendar year deductible...
NOTE: The calendar year deductible applies to almost all benefits in this Section.	
Surgical procedures	You Pay
<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. 	<p>In Network: 20% after deductible</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider's actual charge.</p>
<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>	<p>In Network: 20% after deductible</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider's actual charge.</p>

Surgical procedures	You Pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery and other supplies and services for conditions that are not the result of disease, injury, trauma, congenital, or developmental abnormalities, which are meant to improve appearances, including but not limited to breast augmentation or reduction, rhinoplasty, liposuction, and cosmetic dental services.</i> • <i>Sexual reassignment.</i> • <i>Elective Termination of pregnancy.</i> 	<p><i>All charges</i></p>
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) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>In Network: 20% after deductible</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider’s actual charge.</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	You Pay
<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>In Network: 20% after deductible</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider's actual charge.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Mouth conditions due to periodontal or periapical disease, or the teeth, their surrounding tissue or structure, the alveolar process, or the gingival tissue unless the service is for the treatment or removal of tumors not incidental to the fitting or continued use of dentures</i> • <i>Services and Supplies related to Ridge Augmentation, Implantology, and Preventive Vestibuloplasty</i> • <i>Dental Services, not specifically listed as Covered Services, including dental x-rays, shortening of the mandible or maxillae for cosmetic purposes</i> 	<p><i>All charges</i></p>
Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogenic (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>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>In Network: 20% after deductible</p> <p>Out of Network All charges</p>

Organ/tissue transplants (continued)	You pay
<p>Medical expenses for the testing to identify a suitable donor, surgical extraction, storage and transportation costs incurred that are directly related to the donation of the organ used in an organ transplant procedure. The maximum benefit payable for organ procurement shall not exceed \$20,000 for each covered organ transplant procedure that is not covered by any other group health plan or coverage arrangement.</p>	<p>In Network: 20% after deductible</p> <p>Out of Network All charges</p>
<p>Necessary and reasonable transportation, lodging and meal expenses are covered benefits subject to <u>all</u> of the following conditions:</p> <ul style="list-style-type: none"> • Expenses will be a covered benefit if incurred for the confinement period during which the transplant occurs and the immediate inpatient post operative care period, including expenses incurred for travel to the site of the covered transplant procedure. • Meal and Lodging expenses will be a covered benefit during the transplant confinement period and immediate post-operative care period up to a combined daily maximum of \$150 for the recipient, attendant, and if a bone marrow transplant procedure, the bone marrow transplant donor. • In no event shall the total of the necessary and reasonable expenses exceed \$10,000 for each transplant procedure. • Coverage for transportation, lodging and meal expenses are per transplant procedure and are not an annual benefit. • Expense reimbursement is available only while the Organ Transplant Recipient is covered by AHP. 	<p>All charges in excess of \$150 per day and in excess of \$10,000 transplant limit.</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> • <i>Expenses related to transplants of animal organs.</i> 	<p><i>All charges</i></p>
Anesthesia	You pay
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) 	<p>In Network: 20% after deductible</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider’s actual charge.</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>In Network: 20% after deductible</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider’s actual charge.</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.
- Unlike Sections (a) and (b), in this section the calendar year deductible applies to only a few benefits. In that case we added “calendar year deductible applies?”. The calendar year deductible is \$350 per person and \$700 per family for In Network Services. For Out of Network Services the calendar year deductible is \$1,500 per person and \$3,000 per Family. The calendar year deductible applies to almost all benefits in this Section.
- 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 PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

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Benefit Description	You pay
NOTE: The calendar year deductible applies to some benefits in this Section.	
Inpatient hospital	You Pay
<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 charge above the semiprivate room rate.</p>	<p>In Network \$250 Copay</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider’s actual charge.</p>

Inpatient hospital (<i>continued</i>)	You Pay
<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, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care 	<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, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	<p>Calendar year deductible applies</p> <p>In Network 20% after deductible</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider’s actual charge.</p>
<p>Blood and Blood Products. The administration of whole blood and blood plasma is a Covered Service. The purchase of whole blood and blood components is not covered unless such blood components are classified as drugs in the <i>United States Pharmacopoeia</i>.</p>	Nothing

Extended care benefits/skilled nursing care facility benefits	You Pay
<p>Must be approved by AHP in lieu of continued or anticipated hospitalization. The following services are covered:</p> <ul style="list-style-type: none"> • Skilled nursing care, whether provided in an inpatient skilled nursing unit, a skilled nursing facility, or in a home health care program. • Room and board in a skilled nursing facility. • Special diets in a skilled nursing facility, if specifically ordered. • 100 days per calendar year. 	<p>In Network \$250 copay</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider's actual charge.</p>
<p><i>Not covered: Confinement in a nursing home for custodial, convalescent, intermediate level, or domiciliary care, rest cures or care, or services to assist in activities of daily living.</i></p>	<p><i>All Charges</i></p>
Hospice care	You Pay
<p>Coverage is provided when:</p> <ul style="list-style-type: none"> • the member elects hospice care instead of traditional covered services; • the member has been diagnosed with a terminal disease and a life expectancy of six months or less; and • hospice has been approved by AHP. <p>The following services are covered:</p> <ul style="list-style-type: none"> • Admission to a hospice facility, hospital, skilled nursing care facility for room and board, supplies and services for pain management and other acute/chronic symptom management. • Part-time or intermittent nursing care by a Registered Nurse (RN), Licensed Practical Nurse/Licensed Vocational Nurse (LPN/LVN), or home health aide for patient care up to 8 hours per day. • Social services under the direction of a participating provider. • Psychological and dietary counseling. <p>Note: Hospice care may be provided as inpatient or outpatient services with a combined benefit limit of 185 days.</p>	<p>Calendar year deductible applies</p> <p>In Network: 20% after deductible</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider's actual charge.</p>

Ambulance	You Pay
<ul style="list-style-type: none"> Local professional ambulance service when medically appropriate 	Calendar year deductible applies In Network: 20% after deductible Out of Network 20% after deductible
<i>Not covered:</i> <ul style="list-style-type: none"> <i>Non-Emergency Travel, unless approved and arranged by AHP</i> 	<i>All charges</i>

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.
- The calendar year deductible is \$350 per person and \$700 per family for In Network Services. For Out of Network Services the calendar year deductible is \$1,500 per person and \$3,000 per family. The calendar year deductible applies to almost all benefits in this Section.
- 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 an emergency condition arises, members should proceed to the nearest emergency facility. If the emergency condition is such that a member cannot go safely to the nearest participating emergency facility, then the member should seek care at the nearest emergency facility. An urgent care situation is a degree of illness or injury which is less severe than an emergency condition, but requires prompt medical attention within twenty-four (24) hours. If an urgent care situation occurs, members should contact their primary care provider immediately and follow the primary care provider's instructions.

Emergencies outside our service area: If an emergency occurs when traveling outside of AHP's service area, members should go to the nearest emergency facility to receive care. The member or a designated relative or friend must notify AHP and the member's primary care provider as soon as reasonably possible, and no later than 48 hours after physically or mentally able to do so. In-Network coverage will be provided for emergency conditions outside of the service area unless the member has traveled outside the service area for the purpose of receiving such treatment.

Benefit Description	You pay
Emergency within our service area	You pay
<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 	20% after deductible

Emergency outside our service area	You Pay
<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 	20% after deductible
<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>All charges.</i>
Ambulance	You Pay
<p>Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.</p>	<p>In Network: 20% after deductible</p> <p>Out of Network 20% after deductible</p>
<i>Not covered: non-emergency travel, unless approved and arranged by AHP</i>	<i>All charges</i>

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.
- The calendar year deductible or, for facility care, the inpatient deductible apply to almost all benefits in this Section. We added “No Deductible” to show when a deductible does not apply.
- The calendar year deductible is \$350 per person and \$700 per family for In Network Services. For Out of Network Services the calendar year deductible is \$1,500 per person and \$3,000 per family. The calendar year deductible applies to almost all benefits in this Section.
- 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 After the calendar year deductible...
Mental health and substance abuse benefits	You Pay
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illness or conditions.</p>
<ul style="list-style-type: none"> • Inpatient Mental Health Services from a licensed or certified provider are provided as described under Inpatient Hospital Benefits in Section C. 	<p>In Network: \$250 copay, No deductible</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider’s actual charge.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers. • Medication management 	<p>In Network: \$35 copay. No deductible</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider’s actual charge.</p>

Mental health and substance abuse benefits (<i>continued</i>)	You Pay
<ul style="list-style-type: none"> Diagnostic tests 	<p>In Network: \$20% after deductible</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider's actual charge.</p>
<ul style="list-style-type: none"> Services provided by a hospital or other facility Services in approved alternative care setting such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment. 	<p>In Network: \$250 Copay, No deductible</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider's actual charge.</p>
<p>Chemical Dependency Outpatient Treatment from a licensed or certified provider.</p>	<p>In Network: 20% after deductible</p> <p>Out of Network 40% after deductible plus any difference between our allowable charge and the provider's actual charge.</p>

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all the authorization processes found on pages 10 and 11.

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 charge beginning on the next page.
- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible does not apply to benefits in this section.
- 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 can you obtain prescribed drugs?** You must fill the prescription at a plan pharmacy or by mail for a maintenance medication.
 - **We use a formulary.** We cover nonformulary drugs prescribed by a Plan doctor. 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. To order a prescription drug brochure, call (888) 322-2115.
 - **These are the dispensing limitations.** Prescription drugs are dispensed in a 30-day supply, or less, if less is needed. A 90-day supply of maintenance drugs may be obtained through mail order. 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, you have to pay the higher copay for the brand name drug.
 - **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you – and us – less than a name brand prescription.
 - **When you have to file a claim.** Read section 7 regarding the procedure for filing a pharmacy claim.
-

Covered medications and supplies	You Pay
<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>. • Drugs for sexual dysfunction <p>Note: Quantity limitations may apply.</p> <ul style="list-style-type: none"> • Contraceptive drugs and devices (IUDs and implantable birth control devices, e.g., Norplant and Depro-Provera) 	<p>In Network: (30 day supply) Generic \$10 Copay Formulary/Preferred \$20 Copay Non-Formulary \$35 Copay</p> <p>In Network: (90 day supply- mail order) Generic \$20 Copay Formulary/Preferred \$40 Copay Non-Formulary \$70 Copay</p> <p>Out of Network All Charges</p>
<p>Diabetic supplies and insulin</p> <ul style="list-style-type: none"> • A 30-day supply of diabetic needles, syringes, wipes, strips, and pump supplies; and • Either a 30-day supply or one 10-ml bottle, whichever is greater, of injectable insulin. <p>Note: Each of the following shall constitute a separate prescription “supply” for copay purposes, and together they constitute the maximum amount of diabetic treatment that may be dispensed at any one time:</p>	<p>In Network: (30 day supply) Generic \$10 Copay Formulary/Preferred \$20 Copay Non-Formulary \$35 Copay</p> <p>In Network: (90 day supply- mail order) Generic \$20 Copay Formulary/Preferred \$40 Copay Non-Formulary \$70 Copay</p> <p>Out of Network All Charges</p>

Covered medications and supplies (<i>continued</i>)	You Pay
Birth Control Drugs and Devices including, but not limited to: <ul style="list-style-type: none"> • IUDS • Implantable birth control devices, e.g., Norplant and Depo-Provera 	In Network: (30 day supply) Generic \$10 Copay Formulary/Preferred \$20 Copay Non-Formulary \$35 Copay In Network: (90 day supply- mail order) Generic \$20 Copay Formulary/Preferred \$40 Copay Non-Formulary \$70 Copay Out of Network All Charges
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Fertility drugs</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> 	<i>All charges</i>

Section 5 (g) Special Features

Feature	Description
Employee Assistance Program	Employee Assistance Program for individual and family problems that have a negative impact upon personal or work life. Benefits include up to three counseling sessions with a behavioral health professional per contract year, access to behavioral health professionals with a wide range of expertise in family, couples, individual, and substance abuse related services, and access to toll-free Referral Service line 24 hours/7days a week.

Section 5 (h). Dental benefits

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is \$350 per person and \$700 per family for In Network Services. For Out of Network Services the calendar year deductible is \$1,500 per person and \$3,000 per family. The calendar year deductible applies to almost all benefits in this Section.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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Accidental injury benefit	You pay
<p>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.</p>	<p>In Network: \$35 per visit to a specialist 20% after deductible for other covered services</p> <p>Out of Network: 40% after deductible plus any difference between our allowable charge and the provider's actual charge.</p>

Dental benefits

We have no other dental benefits.

Section 5 (i). Point of service benefits

Point of Service (POS) Benefits

Facts about this Plan's POS option

At your option you may choose to obtain benefits covered by this Plan from non-Plan doctors and hospitals whenever you need care, except for the benefits listed below under “What is not covered.” Benefits not covered under Point of Service must either be received from or arranged by Plan doctors to be covered. When you obtain covered non-emergency medical treatment from a non-Plan doctor without a referral from a Plan doctor, you are subject to the deductibles, coinsurance and maximum benefit stated below.

What is covered

Most of the covered services described in Section 5 allow you to choose a non-participating provider, except those listed in “What is not covered”. When you choose non-participating providers, covered services provided by those providers are covered at the “out of network” level as described in Section 5. All covered services provided by participating or in-network providers are covered at the in-network benefit level.

Services do not need to be obtained within the Plan service area to be eligible for coverage under POS.

Precertification

Services received out-of-network are subject to the same precertification or prior approval requirements as described in Section 3. You do not need to obtain a referral from a Plan doctor prior to seeking a non-Plan doctor, but you or the non-plan doctor must obtain prior approval before receiving any of the procedures listed in Section 3 as requiring prior approval. Failure to obtain prior approval may result in benefits being denied, however, we will not deny coverage solely on the basis of lack of precertification to the extent that the health care services would have been covered had precertification been obtained.

Deductible

The Plan deductible for Point of Service benefits is \$1,500 for an individual and \$3,000 for a family.

Coinsurance

The coinsurance requirement for covered Point of Service benefits is 40% of the Plan’s allowable charge to be paid by you, and 60% to be paid by the Plan, after the deductible. You will also be responsible for any difference between our allowable charge and the non-participating provider’s actual charge.

Maximum benefit

The catastrophic maximums you will have to pay for Point of Service care is \$10,000 for an individual or a family. Out of pocket expenses under POS do not qualify for the Plan’s in-network catastrophic maximum.

Hospital/extended care

When you use a non-participating hospital it is an out of network service, however, if you use a participating hospital you will receive in network benefits even if non-plan doctors are being used.

Emergency benefits

True emergency care is always payable as an in-Plan benefit.

What is not covered

The following covered services do not have Point of Service coverage:

- Adult Preventive Care
- Children Preventive Care
- Vision Examination for eyeglasses or contact lenses
- Chiropractic Services
- Organ/Tissue Transplants
- Prescription Drugs

How to obtain benefits

You may access covered Point of Service benefits directly. You may also contact us and ask us to consider In-Network benefits for out of network services that are medically necessary and not available within the Plan's network by calling Medical Management at 1-888-605-1331.

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

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

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency 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, coinsurance, or deductible.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance and also to get a copy of the claim form, call us at (888) 322-2115.

When you must file a claim -- such as for out-of-area care -- submit it on a HCFA-1500 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: Avera Health Plans
3900 West Avera Drive, Suite 200
Sioux Falls, SD 57108-5721**

Prescription drugs

Network pharmacies will usually submit your claims electronically for you. If you need to submit a claim on your own, contact Customer Service at (888) 322- 2115 to obtain a claim form.

When you file a claim form, you must include a receipt from the pharmacy showing the following:

- Name of the drug;
- Amount Dispensed;
- Price you paid for the drug.

**Submit your claims to: Avera Health Plans
3900 West Avera Drive, Suite 200
Sioux Falls, SD 57108-5721**

Deadline for filing your claim

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

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny 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: Avera Health Plans Attn: Appeals Coordinator 3900 West Avera Drive, Suite 200 Sioux Falls, SD 57108-5721(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 2, 1900 E Street, NW, Washington, DC 20415-3620.</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 precertification or prior approval. This is the only deadline that may not be extended.

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

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

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

- (a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at (888) 605-1331 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 2 at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage You must tell us if you 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.

•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 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. This includes following procedures for precertifying procedures and treatments.

(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		✓

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

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at (888) 322-2115.

We do not waive any costs when you have Medicare

- **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, coinsurance, or deductibles 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, coinsurance, or deductibles. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

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

- **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	Coinsurance is the percentage of our allowance that you must pay for your care. See pg. 12.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See pg. 12.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Patient care that is not medically required but is necessary when the patient is unable to perform self-care. Custodial care may involve medical or non-medical services that do not seek to cure, but are provided during periods when the patient's medical condition is not changing. Custodial care services such as assistance in the activities of daily living, normally do not require ongoing administration by medical personnel.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See pg. 12.
Durable Medical Equipment	Equipment prescribed by an attending physician which is medically necessary, not primarily and customarily used for non-medical purposes, designed for prolonged use, and for a specific therapeutic purpose in the treatment of an illness or injury.
Experimental or Investigational services	Any health care service which: <ul style="list-style-type: none">• is not recognized in accordance with generally accepted medical standards as being safe and effective for treatment of the condition in question, regardless of whether the service is authorized by law or used in testing or other studies; or• requires approval by any governmental authority and such approval has not been granted prior to the service being performed.
Medical necessity	Covered health care services required to preserve and maintain your health status in accordance with the accepted standards of medical practice in the medical community in the area where services are rendered. Services or treatments are considered Medically Necessary and appropriate if they could not have been omitted without adversely affecting the patient's condition or the quality of medical care provided. Medically necessary care must: <ul style="list-style-type: none">• be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and• help restore or maintain the patient's health; or• prevent deterioration of the patient's condition; or• prevent the reasonably likely onset of a health problem or detect a problem in the beginning stages.
Plan allowance	Plan Allowance means the amount that we use to determine our payment and your coinsurance (if applicable) for covered services. All covered services are subject to this Plan Allowance definition. An expense or service or a portion of an expense or service that is not covered by us is not an allowable charge. Our participating providers accept the plan allowance as payment in full for covered services.

Us/We

Us and we refer to Avera Health Plans.

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 season for enrollment begins.

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

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

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

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

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

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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 Avera Health Plans – 2002

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Below, an asterisk (*) means the item is subject to the 2002 calendar year deductible.

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: \$10 primary care; \$35 specialist	14
Services provided by a hospital:		
• Inpatient.....	\$250 per admission copay	28
• Outpatient*	20% of allowed charge after deductible	29
Emergency benefits:		
• In-area*	20% of allowed charge after deductible	32
• Out-of-area*	20% of allowed charge after deductible	33
Mental health and substance abuse treatment*	Regular cost sharing.	34
Prescription drugs	\$10 for a 30 day supply of generic drugs \$20 for a 30 day supply of formulary drugs \$35 for a 30 day supply of non-formulary drugs \$20 for a 60 day mail order supply of generics \$40 for a 60 day mail order supply of formulary drugs \$60 for a 60 day mail order supply of non-formulary drugs	37
Vision Care	One routine vision exam per year with a participating provider (eyeglass exam only)	20
Special features:	Employee Assistance Program	39
Protection against catastrophic costs (your out-of-pocket maximum).....	Nothing after \$1,500/Self Only or \$3,000/Family enrollment per year Some costs do not count toward this protection	12

2002 Rate Information for Avera Health Plans

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 (see 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

Self Only	AV1	\$78.90	\$26.30	\$170.95	\$56.98	\$93.37	\$11.83
Self & Family	AV2	\$181.08	\$60.36	\$392.34	\$130.78	\$214.28	\$27.16