AmCare Health Plans

http://www.amcarehealthplans.com

AMCARE HEALTH PLANS

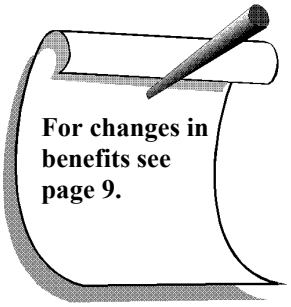
2002

A Health Maintenance Organization

Serving: TEXAS, LOUISIANA, AND OKLAHOMA

Enrollment in this Plan is limited. You must live in or work in our Geographic service area to enroll. See page 7 for requirements.

Enrollment codes for this Plan:



TEXAS (HOUSTON/EL PASO AREAS)
Enrollment Code:
2V1 Self Only
2V2 Self and Family

TEXAS (AUSTIN/SAN ANTONIO/DALLAS/FT. WORTH AREAS)
Enrollment Code:
ZG1 Self Only
ZG2 Self and Family

LOUISIANA (NEW ORLEANS AREA)
Enrollment Code:
ZH1 Self Only
ZH2 Self and Family

LOUISIANA (BATON ROUGE/ALEXANDRIA/SHREVEPORT AREAS)
Enrollment Code:
ZQ1 Self Only
ZQ2 Self and Family

OKLAHOMA (OKLAHOMA CITY/TULSA AREAS)
Enrollment Code:
ZX1 Self Only
ZX2 Self and Family

NCQA Accreditation

AmCare Health Plans of Oklahoma, Inc. has new health plan accreditation from October 31, 2000 through October 31, 2003. AmCare Health Plans of Texas, Inc. has new health plan accreditation from June 14, 2001 through June 14, 2004. AmCare Health Plans of Louisiana has new health plan accreditation from March 22, 2001 through March 22, 2004.

Authorized for distribution by the:

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

FEHB
Federal Employees Health Benefits Program

RI 73-805

Table of Contents

Introduction

AmCare Health Plans
3411 Richmond Ave. #500
Houston, TX 77046

This brochure describes the benefits of AmCare Health Plans under our contract (CS 2864) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

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

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 57. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plan's 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 AmCare 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 this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the 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 Texas: (800) 782-8373; Oklahoma: (800) 772-2993; Louisiana (800) 772-2995 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 require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments, 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.

How we pay providers

We contract with individual physicians, medical groups, IPA's and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. AmCare Health Plans offers members an extensive choice of primary care physicians.

Who provides my health care?

AmCare contracts with both direct physicians, Medical Groups and Independent Physician Associations (IPA). When choosing a physician from the provider directory for your primary care needs, you should expect to receive specialty care from providers affiliated with your primary care physician's medical group or IPA. Obstetricians/gynecologists must be selected from providers affiliated with your primary care physician's network. If the physician network cannot provide the services being requested, your primary care physician will make arrangements for you to receive the care from an appropriate provider. To find out if your primary care physician is affiliated with a medical group or IPA, check the provider directory or call the plan before you make your selection.

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. For Patient Bill of Rights information please go to our website at (www.amcarehealthplans.com) for a complete listing of information as required by the Patient's Bill of Rights.

If you want more information about us, call us at: Texas: (800) 782-8373; Oklahoma: (800) 772-2993; Louisiana (800) 772-2995., or write to AmCare Health Plans 3411 Richmond, #500, Houston, Texas 77046. You may also contact us by fax at (713) 864-9393 or visit our website at www.amcarehealthplans.com

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice.
Covered zip codes have been listed where we are licensed only in the part of a parish or county, with the following zip codes. Our service area is:

TEXAS (HOUSTON/EL PASO AREAS)

Enrollment Code:
2V1 Self Only
2V2 Self and Family

Full County

EL PASO
FORT BEND
GALVESTON
HARRIS
HUDSPETH
MONTGOMERY

Partial County by zip code

AUSTIN -BELLVILLE 77418, KENNEY 77452, SAN FELIPE 77473, SEALY 77474, WALLIS 77485
BRAZORIA - ALVIN 77511, 77512, ANGLETON 77515, 77516, CLUTE 77531, DAMON 77430, DANBURY 77534, DANCIGER 77431, FREEPORT 77541, 77542, LAKE JACKSON 77566, LIVERPOOL 77577, MANVEL 77578, OLD OCEAN 77463, PEARLAND 77581, 77584, ROSHARON 77583, WEST COLUMBIA 77486
CHAMBERS - BAYTOWN 77520
COLORADO - CAT SPRING 78933
LIBERTY -CLEVELAND 77327, DAYTON 77535

TEXAS (AUSTIN/SAN ANTONIO/DALLAS/FT. WORTH AREAS)

Enrollment Code:
ZG1 Self Only
ZG2 Self and Family

Full County

ATASCOSA	BURNET	GRAYSON	KERR	TRAVIS
BANDERA	CALDWELL	GUADALUPE	LEE	WALLER
BASTROP	COLLIN	HAYS	MEDINA	WILLIAMSON
BELL	COMAL	JOHNSON	MILAM	WILSON
BEXAR	DALLAS	KAUFMAN	PARKER	
BLANCO	DENTON	KENDALL	TARRANT	

OKLAHOMA (OKLAHOMA CITY/TULSA AREAS)

Enrollment Code:
ZX1 Self Only
ZX2 Self and Family

Full County

ALFALFA	COTTON	KINGFISHER	LOGAN	POTTAWATOMIE	WAGONER
CANADIAN	CREEK	KIOWA	OKFUSKE	ROGERS	WOODS
CHEROKEE	GARFIELD	MAYES	OKLAHOMA	SEMINOLE	
CLEVELAND	GRANT	MCCLAIN	OKMULGEE	TILLMAN	
COMANCHE	HUGHES	LINCOLN	PAWNEE	TULSA	

Partial County by zip code

BLAINE - HITCHCOCK 73744, OKEENE 73763, WATONGA 73772

CADDO - ALBERT 73001, CEMENT 73017, CYRIL 73029
GRADY - AMBER 73004, MINCO 73059, POCASSET 73079, TUTTLE 73089
MAJOR - AMES 73718, ISABELLA 73747, MENO 73760, RINGWOOD 73768
MUSKOGEE - BOYNTON 74422, HASKELL 74436, PORUM 74455, TAFT 74463, WARNER 74469
NOWATA - NOWATA 74048
OSAGE - AVANT 74001, BARNSDALL 74002, HOMINY 74035, OSAGE 74054, PAWHUSKA 74056, PRUE 74060, SKIATOOK 74070, WYNONA 74084
STEPHENS - DUNCAN 73533, 73534, MARLOW 73055
WASHINGTON - OCHELATA 74051, RAMONA 74061, VERA 74082
WASHITA - BESSIE 73622, BURNS FLAT 73624, CORDELL 73632, DILL CITY 73641, ROCKY 73661, SENTINEL 73664

LOUISIANA (BATON ROUGE/ALEXANDRIA/SHREVEPORT AREAS)

Enrollment Code:
ZQ1 Self Only
ZQ2 Self and Family

Full Parish

ASCENSION	CONCORDIA	LA SALLE	ST. HELENA
ASSUMPTION	DE SOTO	LIVINGSTON	WEBSTER
BIENVILLE	EAST BATON ROUGE	NATCHITOCHES	WEST BATON ROUGE
BOSSIER	EAST FELICIANA	POINTE COUPEE	WEST FELICIANA
CADDO	GRANT	RED RIVER	WINN
CLAIBORNE	IBERVILLE	SABINE	

LOUISIANA (NEW ORLEANS AREA)

Enrollment Code:
ZH1 Self Only
ZH2 Self and Family

Full Parish

JEFFERSON	ST. CHARLES	TANGIPAHOA
ORLEANS	ST. JAMES	WASHINGTON
PLAQUEMINES	ST. JOHN THE BAPTIST	
ST. BERNARD	ST. TAMMANY	

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 office or retirement office.

Section 2. How we change for 2002

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

Program-wide changes

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

Changes to this Plan

- CODE 2V - **TEXAS** (HOUSTON/EL PASO AREAS)
  Your share of the non-Postal premium will increase by 12.8% Self Only or 13.6% for Self and Family.

- CODE ZG - **TEXAS** (AUSTIN/SAN ANTONIO/DALLAS/ FORT WORTH AREAS)
  Your share of the non-Postal premium will increase by 21.1% Self Only or 21.9% for Self and Family.

- CODE ZH - **LOUISIANA** (NEW ORLEANS AREA)
  Your share of the non-Postal premium will increase by 8.3% Self Only or 9.1% for Self and Family.

- CODE ZQ - **LOUISIANA** (BATON ROUGE/ALEXANDRIA/SHREVEPORT AREAS)
  Your share of the non-Postal premium will increase by 16.2% Self Only or 17.1% for Self and Family.

- CODE ZX - **OKLAHOMA** (OKLAHOMA CITY/TULSA AREAS)
  Your share of the non-Postal premium will increase by 16.1% Self Only or 17.0% for Self and Family.

- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We now cover certain intestinal transplants. (Section 5(b))
- We changed the address for sending disputed claims to OPM. (Section 8)
- The following counties in the Dallas/Fort Worth Texas areas have been added to our Texas service area: Collin, Dallas, Denton, Grayson, Johnson, Kaufman, Parker and Tarrant.
- AmCare has changed mental health providers in Oklahoma from Magellan to Family Managed Care. (Section 5 (e))
- We now cover Intra uterine insemination (IUI) under Infertility Services. (Section 5 (a))
- We have added Chiropractic benefits for FEHB enrollees in Louisiana and Oklahoma.
- The following counties in Oklahoma have been dropped from our Oklahoma service area: Greer, Harmon and Jackson.

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 Texas: (800) 782-8373; Oklahoma: (800) 772-2993; Louisiana (800) 772-2995.

Where you get covered care

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

• Plan providers

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to NCQA 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. If you need assistance in choosing a primary care physician please call us at Texas: (800) 782-8373; Oklahoma: (800) 772-2993; Louisiana (800) 772-2995.

•Primary care

Your primary care physician can be a general practitioner, family practitioner, internist for members over age 16 or a pediatrician for children up to age 18. Your primary care physician will provide most of your health care, or give you a referral to see a specialist, when appropriate.

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

• Specialty care

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see an obstetrician/gynecologist 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 your specialist to develop a treatment plan that allows you to see your specialist for a certain number of visits, up to a 12 month referral for certain types of medical conditions which require on-going treatment of referring diagnosis, without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand). In certain situations with chronic, disabling or life threatening illnesses you may be eligible to have your specialist act as your primary care physician. This process requires the prior approval of the AmCare Health Plans Senior Medical Director and must meet certain criteria set forth by AmCare Health Plans.

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

  — terminate our contract with your specialist for other than cause; or

  — drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or

  — reduce our service area and you enroll in another FEHB Plan,

  you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us at Texas: (800) 782-8373; Oklahoma: (800) 772-2993; Louisiana (800) 772-2995 for more information; or, if we drop out of the Program, contact your new health plan.

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

• Hospital care

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at Texas: (800) 782-8373; Oklahoma: (800) 772-2993; Louisiana (800) 772-2995. 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 Referral Notification/Prior Authorization.

There are certain services which only require Referral Notification to AmCare by your physician: Specialist consultations; referrals to ER; Dialysis; Colonoscopy/Endoscopy; Cystoscopy; CT Scans; Home Uterine Monitoring; Hyperbaric treatment; Lithotripsy; Outpatient Chemotherapy; Outpatient Radiation; Outpatient Nuclear Imaging; ; Pre-natal care; and DME items such as: nebulizers, canes, crutches, walkers, commode chairs, and cervical traction units.

Your physician must obtain prior authorization for the following services: Inpatient admissions; Outpatient Surgery; Twenty-three hour observation (in a hospital); Angiography; CT Myelogram; MRA; MRI; DME, except as listed above; Home Health and Hospice services; Home IV therapy; Infertility Services; Nutritional Therapy and Dietician services; Occupational, speech, cardiac and physical therapy; Orthotics/Prosthetics/Braces; Psychological testing; Growth Hormones; Morbid Obesity Treatment; Requests for services by out-of-network providers; and Transplant Services.

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, physician, facility, pharmacy, etc., when you receive services.

Example: When you see your primary care physician or specialist , you pay a copayment of $10 per office visit and when you go in the hospital, you pay nothing per admission.

•Deductible

We do not have a deductible

•Coinsurance

Coinsurance is the percentage of our negotiated fee that you must pay for your care.

Example: In our Plan, you pay 50% of our allowance for infertility services and 50% of the cost of prescription drug medications not listed in the AmCare Preferred Plan Guide (see Prescription Drug benefits in section 5 for more information.)

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

After your copayments and/or coinsurance total $650 per person or $1500 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments and/or coinsurance for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments and/or coinsurance for these services:

- Durable Medical Equipment
- Prosthetic Devices
- Prescription Drugs
- Infertility Services

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

Section 5. Benefits – OVERVIEW

(See page 8 for how our benefits changed this year and page 57 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 the numbers below or at our website at www.amcarehealthplans.com.

Texas: (800) 782-8373 Oklahoma: (800) 772-2993 Louisiana: (800) 772-2995

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians	
• In physician's office	$10 per office visit
• After-hour physician visits in physician's office	$35 per office visit
Professional services of physicians	
• In an urgent care center	Nothing
• During a hospital stay	Nothing
• In a skilled nursing facility	Nothing
• Office medical consultations	$10 per office visit
• Second surgical opinion	Nothing
At home	$10 per office visit

Diagnostic and treatment services -- Continued on next page

Diagnostic and treatment services *(continued)*	**You pay**
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing
Preventive care, adult	
Routine screenings, such as: • Routine Physical Examinations • Total Blood Cholesterol – as clinically indicated • Colorectal Cancer Screening, including — Fecal occult blood test — Sigmoidoscopy, screening – every five years starting at age 50	Nothing
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	Nothing
Routine pap test Note: Included as part of the annual well-woman examination	Nothing
Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years • For those women with other risk factors	Nothing
Not covered: Physical exams or immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*

Preventive care, adult *(continued)*	**You pay**
Routine Adult Immunizations, such as: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, • Hepatitis A & B • Varicella (Prescribed as clinically indicated or in accordance with AmCare Preventive Care Guidelines for Adults)	Nothing
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well-child care charges for routine examinations, immunizations and care (under age 22) • Examinations, such as: — Eye exams through age 17 to determine the need for vision correction. — Ear exams through age 17 to determine the need for hearing correction — Examinations done on the day of immunizations (under age 22)	Nothing
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do need to precertify your normal delivery; see page 11 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). • Routine Obstetrical care includes medically necessary diagnostic procedures such as ultrasounds as determined by your Physician	$10 per office visit for initial visit only Nothing Nothing, after initial visit copayment noted above

Family planning	You pay
A broad range of voluntary family planning services, limited to:	
• Voluntary sterilization	$25 per office visit
• Counseling	$10 per office visit
• Surgically implanted contraceptives (Norplant)	50% of charges
• Injectable contraceptive drugs (Depo Provera)	$10 per office visit
• Intrauterine devices insertion/removal (IUD'S)	$25 per office visit
Not covered: reversal of voluntary surgical sterilization, subsequent resterilization; and genetic counseling,	*All charges.*
Infertility services	
Diagnosis and treatment of infertility, such as:	
• Diagnostic Testing	$10 per office visit
• Artificial insemination Services:	50% of charges per procedure
— *Intravaginal insemination (IVI)*	
— *Intracervical insemination (ICI)*	
__ *Intra-uterine insemination (IUI)*	
Not covered:	*All charges.*
• *Assisted reproductive technology (ART) procedures, such as:*	
— *in vitro fertilization*	
— *embryo transfer,gamete GIFT, and zygote ZIFT*	
— *Zygote transfer*	
• *Services and supplies related to excluded ART procedures*	
• *Cost of donor sperm*	
• *Cost of donor egg*	
• *Surrogate Parenting*	
• *Fertility drugs (We do not cover fertility drugs under either medical or prescription drug benefits.)*	

Allergy care	You Pay
Testing and treatment Allergy injection	$25 per office visit $10 per office visit
Allergy serum (Covered in full)	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 26. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: – We will only cover GHT when we prior authorize the treatment. Call Texas: (800) 585-7290; Oklahoma: (800) 977-1775; Louisiana (800) 772-2995 for prior authorization. We will ask you to submit information that establishes that the GHT is medically necessary and meets the plan's medical criteria. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you receive prior authorization. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	$10 per office visit

Physical and occupational therapies	You pay
Unlimited (Medically Necessary) Physical therapy, occupational therapy, and cardiac therapy provided inpatient or outpatient which meets the following requirements– • For a physically disabled person, is designed to restore maximum function, maintenance of functioning or prevention of or slowing of deterioration • Is authorized by your Primary Care Physician and approved by Us • Includes a written treatment plan with specific goals and objectives • Services can be expected to meet or exceed treatment goals and objectives in written treatment plan	$10 per office visit
Not covered: • *For cardiac rehabilitation, supervised exercise that is not EKG monitored*	*All charges.*
Speech therapy	
Unlimited (Medically Necessary) Speech therapy provided inpatient or outpatient which meets the following requirements. • Is authorized by your Primary Care Physician and approved by Us • Includes a written treatment plan with specific goals and objectives • Services can be expected to meet or exceed treatment goals and objectives in written treatment plan	$10 per office visit
Hearing services (testing, treatment, and supplies)	
• Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per office visit
• Hearing aids for children (up to 13 years of age)	$10 per office visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges.*

Vision services (testing, treatment, and supplies)	You pay
• Eye exam to determine the need for vision correction for children through age 17 (see preventive care) • Annual eye refractions for children through age 17 (see preventive care)	$10 per office visit
Not covered: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges.*
Foot care	
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 relating to the treatment of diabetes.	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Braces and splints*	*All charges.*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes • 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.	Nothing

Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges.*
Durable medical equipment (DME)	**You pay**
Rental or purchase, at our option, including replacement and adjustment of rented items, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Hospital beds-; • Standard wheelchairs-; • Crutches-; • Walkers-; • Orthopedic tractions • Bedside commodes--; • Suction machines • Blood glucose monitors; and • Insulin pumps. Note: If AmCare elects to purchase an item of DME for a Member, the member is the owner of the equipment and responsible for its repair, replacement, and maintenance.	Nothing
Not covered: • *Motorized and special lightweight wheel chairs and beds, comfort items, bedboards, bathtub lifts, overbed tables, air purifiers, disposable supplies, elastic stockings, sauna baths, exercise equipment, stethoscopes, sphygmomanometers, orthopedic shoes, arch supports, and dentures* • *Repair, replacement or maintenance of DME purchased by AmCare for a Member*	*All charges.*

Home health services	You pay
• 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, physical, speech and hearing, and occupational therapy.	$10 per office visit
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges.*
Chiropractic	
• manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application **NOTE: Chiropractic benefits are available only to FEHB enrollees in Louisiana and Oklahoma.**	$10 per office visit
Alternative treatments	
No benefit	*All charges*
Educational classes and programs	
Coverage is limited to: • Smoking Cessation – Up to $185 for one smoking cessation program per member per lifetime, including drugs, and office visits for educational programs.	$10 per office visit for any educational programs. Pharmacy co-payment would apply to any prescription drugs.
• Diabetes self-management	$10 per office visit

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5© for charges associated with the facility (i.e. hospital, surgical center, etc.) .
- YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION OF SOME SURGICAL PROCEDURES. Please refer to the prior authorization information shown in Section 3 to be sure which services require prior authorization and identify which surgeries require prior authorization.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- 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.	Nothing

Surgical procedures continued on next page.

Surgical procedures *(continued)*	**You pay**
• Voluntary sterilization • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*
Reconstructive surgery	
Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: — 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.	Nothing
• All stages of breast reconstruction surgery following a mastectomy, such as: — surgery to produce a symmetrical appearance on the other breast; — treatment of any physical complications, such as lymphedemas; — breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*

Oral and maxillofacial surgery	You pay
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • Surgical and non-surgical intervention for the treatment of TMJ, including corrective orthopedic appliances and physical therapy Note: Orthognathic surgery would be covered when the member's health is affected but not when the doctor determines it is to improve the appearance of a functioning structure.	Nothing
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*

Organ/tissue transplants	You pay
Limited to: • Kidney • Cornea • Liver • Heart • Lung/Heart-Lung • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols and medical criteria. Medical and hospital expenses of the donor are covered when we cover the recipient.	$10 per office visit Nothing for Inpatient services
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Donor's transportation and lodging costs* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*

Anesthesia	You pay
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as: • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, 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 bill by a hospital for use at home	Nothing *Inpatient hospital continued on next page.*

Inpatient hospital *(continued)*	**You pay**
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care, unless medically necessary*	*All charges.*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Not covered: blood and blood derivatives not replaced by the member	*All charges*
Skilled Nursing Care facility benefits	
The following services and supplies are covered on a short-term basis limited to sixty (60) consecutive days when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. • Use of a semi-private room • Meals and services of a dietician • General nursing care • Routine laboratory examinations and tests • Oxygen • Biologicals, drugs and medications furnished and administered by the SNF and • Services and supplies for the administration of blood, blood products, or blood plasma.	$25 per day not to exceed a total member copayment of $300.
Not covered: custodial care	*All charges*

Hospice care	You pay
The following services and supplies for a participating Hospice will be covered when medically necessary and appropriate including: • Dietary and nutritional guidance; • 24-hour home care for periods of crisis; • Bereavement counseling for family members; • Pain and symptom management; • Services of registered nurses, home health aides and medical and social workers. Note: Such services will continue only while the member is under the direct and active medial supervision of a participating physician for a condition necessitating hospice care. The member must be diagnosed with a terminal illness with a life expectancy of six months or less and all services must be requested by and authorized by member's Primary Care Physician	$25 per day
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
Local professional ambulance service when it is not medically appropriate to transport the member by ordinary public or private vehicle. Local professional ambulance service when medically necessary to transfer a member from a participating facility to another participating facility provided each trip is requested by the member's Primary Care Physician and receives prior authorization.	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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:

1. If time and circumstance permit, call your Primary Care Physician before seeking emergency care.
2. If possible, go to a participating emergency facility.
3. Call local emergency service or dial 911 and go to the emergency room
4. Show or have a family member show your AmCare ID card to the emergency room staff. It provides information they may need to verify your coverage.

Emergencies within our service area:

Member must obtain the services immediately after the emergency condition occurs, or as soon as possible afterward.

As soon as possible after the emergency occurs the member must contact his or her Primary Care Physician for advice and instruction. In any event, You or a family member must notify the Plan, unless it was not reasonably possible to do so.

The Member must be transferred to the care of health care providers that participate in the Plan as soon as this can be done without harming your condition .

Emergencies outside our service area: If a Member requires Emergency Care outside the service area when a Participating provider is not available all benefits as described in this brochure will be covered subject to the copayments and limitation set forth in this brochure. Such coverage is extended until such time as it is medically appropriate for the member to return to the care of a participating provider within the service area. Non-participating provider may require the member to make immediate and full payment for services rendered. AmCare will reimburse the member for any services and supplies covered under the Plan, less any copayments due for the services and supplies.

Benefit Description	You pay
Emergency within our service area	
• Emergency Care at an Urgent Care Center • Emergency Care at a hospital emergency room • Emergency Care as an outpatient at a hospital or urgent care center, includes doctors' services Note: Hospital emergency room copayments are waived if member is admitted	$35 per urgent care visit $75 per emergency visit
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
• Emergency Care at an Urgent Care Center • Emergency Care at a hospital emergency room • Emergency Care as an outpatient at a hospital or urgent care center, includes doctors' services Note: Hospital emergency room copayments are waived if member is admitted	$35 per urgent care visit $75 per emergency visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area.*	*All charges.*
Ambulance	
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	Nothing

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

IMPORTANT

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.
- We have no calendar year deductible
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the **Preauthorization** instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers	$10 per office visit
• Medication management	$10 per office visit

Mental health and substance abuse benefits - Continued on next page

Mental health and substance abuse benefits *(continued)*	You pay
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Preauthorization

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

In Texas AmCare Health Plans has contracted with Magellan Behavioral Health Services (Magellan) to provide mental health/substance abuse benefits. AmCare members may self-refer into the Magellan provider network. Case managers may also consult with the Primary Care Physician concerning hospitalization to ensure continuity of care. In the event of a crisis situation please contact Magellan at the numbers below to be directed to the appropriate provider or facility. Prior authorization for any mental health condition and/or crisis intervention must be obtained through Magellan.

Texas: (800) 324-8911

In Louisiana and Oklahoma AmCare Health Plans has contracted with Family Managed Care (FMC) to provide mental health/substance abuse benefits. AmCare members may self-refer into the FMC provider network. Case managers may also consult with the Primary Care Physician concerning hospitalization to ensure continuity of care. In the event of a crisis situation please contact FMC at the number below to be directed to the appropriate provider or facility. Prior authorization for any mental health condition and/or crisis intervention must be obtained through FMC.

Louisiana: (800) 219-6301
Oklahoma: (800) 219-6301

Limitation

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

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible
- Certain medications are eligible for coverage only after a patient-specific approval has been authorized. Physicians and pharmacists must contact MedImpact Healthcare Services, Inc. prior authorization requests are accepted by fax only from the physician. Please fax to (800) 578-9732.
- 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.

IMPORTANT

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

- **Who can write your prescription.** A licensed physician in the state where the services are rendered must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail through the Plan's mail order drug benefit for a maintenance medication.
- **We use a Preferred Plan Drug List.** The Preferred Plan Drug List is a listing of medications available at your generic, and preferred brand copay levels. As your plan is for a three tiered or open formulary, the medications not listed in the Generic or Preferred Brand categories are also available to you but at a higher copayment. There may also be medications not covered so see the Exclusions section for details. We administer a three tier formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a Preferred Plan Drug List. This list of generic and brand name 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 AmCare Customer Service.
- **These are the dispensing limitations.** The amount of covered medication will be limited to a 30-day supply. However, covered medications that are maintenance medications obtained through the mail under AmCare participating Mail Order program are limited to a 90-day supply. Prescription mail order and an explanation of how to use this program can be obtained from AmCare's Customer Service Department.
  A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the third (3^{rd}) tier copayment of 50%.
- **Why use generic drugs?** To reduce your out-of-pocket expenses! A generic drug is the chemical equivalent of a corresponding brand name drug. Generic drugs are less expensive than brand name drugs; therefore, you may reduce your out-of-pocket costs by choosing to use a generic drug.
- **When you have to file a claim.** If you have to pay for covered medications on a medical emergency basis when temporarily outside the service area, submit a copy of the paid bill to AmCare for reimbursement. All claims should be submitted to AmCare at: **AmCare Health Plans, Attention: Claims Department, 3411 Richmond, #500, Houston, Texas 77046** within 60 calendar days from the date expenses are incurred, beyond which no coverage is available. Please include the following information on a separate sheet of paper: a statement that you are an AmCare member; patient's name, address, and the id number and group number from the member's identification card; name , address, and phone number of the pharmacy (if not on the bill); name, address and phone number of the prescribing physician; detailed statement of the circumstances requiring the emergency care (i.e. describe "who, what, when, where, why, and how" it happened).

Benefit Description	You pay
Covered medications and supplies	
Retail Participating Pharmacy and Mail Order	**Retail Pharmacy**
Preferred Generic Prescription Drugs – A prescription drug which is therapeutically equivalent to a Brand name prescription drug, as published in the most current edition of the FDA "Orange Book". Those Preferred Generic medications on the AmCare Preferred Plan Drug List are included in the first tier of your prescription drug benefit.	$5 per prescription or refill
Preferred Brand Name Prescription Drugs – A prescription drug that has been given a brand or trade name by it's manufacturer and is advertised and sold under that name. Those Preferred Brand Name medications on the AmCare Preferred Plan Drug List are included in the second tier of your prescription drug benefit..	$15 per prescription or refill
Other Covered Prescription Drugs – A Brand Name prescription drug which is covered under the third tier .	50% of covered charges per prescription or refill Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
Mail Order Maintenance Drugs are covered for up to a 90-day supply per prescription unit or refill. Maintenance Medications prescription drugs intended for use in a chronic disease state or in the treatment of a disease or illness , the course of which is expected to continue for a period in excess of ninety (90) days. We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • AmCare Preferred Plan Drug List prescription drugs, which may be revised periodically, and Other prescription Drugs except as indicated under the exclusions section. • Compounded medications of which at least one ingredient is a prescription Drug and which is prescribed for an FDA approved indication • Prescription inhalers that are medically necessary • Prescription vitamins, including prenatal vitamins • Nutritional formulas necessary for the treatment of PKU or other inheritable diseases upon the written orders of a Participating Physician. • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as not covered. • Insulin • Disposable needles and syringes for the administration of covered medications • Contraceptive drugs and devices • Appetite suppressants as medically necessary in cases of morbid obesity	**Mail Order (Maintenance Drugs Only)** Preferred Generic - $10 per 90-day supply Preferred Brand - $30 per 90-day supply Other Covered Drugs – 50% of charges for a 90-day supply

Covered medications and supplies *(continued)*	**You pay**
• Drugs for sexual dysfunction (see **Note** below) • Prescription Drugs for smoking cessation up to $185, limited to one course of treatment in a lifetime. **Note**: Prescriptions drugs for the treatment of sexual dysfunction require prior authorization and may be limited to a specified number of pills per month. (i.e. Viagra is limited to 6 pills per 30 day period)	See Retail Pharmacy and Mail Order Maintenance Drugs copayments above.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Blood or urine testing devices* • *Medication that is not medically necessary for the treatment of the condition for which it is prescribed* • *Medical supplies such as dressing and antiseptics* • *Drugs to enhance athletic performance* • *Fertility Drugs* • *Appetite suppressants, except as used in the treatment of morbid obesity*	*All charges*

Section 5 (g). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
AmCare Arrivals A Program for Mothers To Be	Pregnant AmCare members are eligible to participate in AmCare's pre-natal care program "AmCare Arrival", a special program designed to assist the pregnant member with the various benefits related to her pregnancy. Features of the program include: • Early verification of coverage and benefits • Verification that the selected hospital for delivery is a participating AmCare facility • Assistance in selecting a Pediatrician for the newborn • Assistance in coordinating care and benefits for any special needs which may arise during a member's pregnancy • Resource support for any member pre-natal education • Discharge planning, including home nursing visits if needed to assist the member in transitioning from hospital to home
Services for deaf and hearing impaired	AmCare provides the hearing impaired with a Telephone Device for the Deaf (TDD) number to access for member information needs. TDD number (800) 772-4669
Travel benefit	When traveling in Louisiana, Texas or Oklahoma, you can receive non emergency care from our Plan in these respective States. For example, Louisiana members traveling in Texas or Oklahoma can receive services in these States. Member is required to contact our Customer Service Department prior to traveling to obtain access to this Travel benefit.

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- : We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *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.

IMPORTANT

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury..	$10 for professional services and nothing for hospitalization

Dental benefits

We have no other dental benefits.

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 elective 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 or coinsurance.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at Texas: (800) 782-8373; Oklahoma: (800) 772-2993; Louisiana (800) 772-2995.

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

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

Submit your claims to: **AmCare Health Plans**
3411 Richmond, #500
Houston, Texas 77046

Prescription drugs

If you have to pay for covered medications on an emergency basis when temporarily outside the service area, submit a copy of the paid bill to AmCare for reimbursement. Include all of the following on a separate sheet of paper:

- A statement that you are a member of AmCare Health Plans;
- The patient's name, address and the identification number and group number from the member's identification card;
- Name, address, and phone number of the pharmacy (if not on the bill);

- Name, address, and phone number of the physician; and
- A detailed statement of the circumstances or event requiring emergency care, the symptoms at the time of emergency, and the type of emergency care received (i.e. in general describe "who, what, where, when and how" it happened).

Submit your claims to: **AmCare Health Plans**
3411 Richmond, #5 00
Houston, Texas 77046

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	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: AmCare Health Plans, 3411 Richmond #500, Houston, TX 77046. (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, DC 20415-3630.

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 Texas: (800) 782-8373; Oklahoma: (800) 772-2993; Louisiana (800) 772-2995 and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage You must tell us if you 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. Your care must continue to be authorized by your Plan PCP, or precertified as required.
We will not waive any of our copayments, coinsurance, and deductibles.

(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 re-employed 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 Texas: (800) 782-8373; Oklahoma: (800) 772-2993; Louisiana (800) 772-2995., or write to AmCare Health Plans 2707 N. Loop West, Suite 300, Houston, Texas 77008. You may also visit our website at www.amcarehealthplans.com
- **We do not waive some costs when you have the Original Medicare Plan --** When Original Medicare is the primary payer, we do not waive any out-of-pocket costs.

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a 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 if you reside in Harris or Tarrant county, Texas and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments, or coinsurance 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, or coinsurance. In this case we do not waive any out-of-pocket costs. 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.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 12.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 12.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Care provided primarily for the maintenance of a patient in meeting his or her activities of daily living and, which is not primarily provided for its therapeutic value in the treatment of a sickness or injury. Activities of daily living include bathing, feeding, dressing, walking, and taking oral medicine.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12.

Experimental or investigational services

A drug, biological product, device, medical treatment, or procedure is determined to be experimental or investigational if reliable evidence shows it meets one of the following criteria:

- When applied to the circumstances of a particular patient is the subject of ongoing phase I,II, or III clinical trials, or
- When applied to the circumstances of a particular patient is under study with written protocol to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy in comparison to conventional alternatives, or
- Is being delivered or should be delivered subject to the approval and supervision of an Institutional review Board as required and defined by the USFDA or Department of Health and Human Services; and
- Is not generally accepted by the medical community.

Reliable evidence means, but is not limited to, published reports and articles in authoritative medical scientific literature or regulations and other official actions and publications issued by the USFDA or the Department of Health and Human Services.

Group health coverage

An employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care including items and services paid for as medical care to employees or their dependents, as defined under the terms of the Plan, directly or through insurance, reimbursement, or otherwise.

Medical necessity

Means covered health care services which meet the following criteria:

- it is required for the diagnosis, treatment or prevention of an illness or injury, or a medical condition such as pregnancy,

- it could not be omitted without adversely affecting the Member's condition;
- it is not primarily for the convenience of the Member or the treating provider;
- it is generally accepted as safe and effective treatment under standard medical practice in the community where the service is rendered and;
- it is provided in the most cost-efficient manner that is consistent with an appropriate level of care.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: For a capitated provider the discounted fee for service equivalent of the provider's capitated rate is used to determine the allowable. For a provider reimbursed on a fee for service basis the allowable is the fee for service rate the provider would be entitled to under his contract with AmCare Health Plans.

Us/We

Us and we refer to AmCare 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 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. It can supplement care provided by family members, reducing the burden you place on them. *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 planing. *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.

Index

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

Summary of benefits for the AmCare 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.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office.....	Office visit copay: $10 primary care; $10 specialist	14-22
Services provided by a hospital: • Inpatient..... • Outpatient.....	Nothing Nothing	28-29 29
Emergency benefits: • In-area/Out-of-area..... • Urgent Care……..	$75 per emergency room visit $35 per urgent care visit	31-32 31-32
Mental health and substance abuse treatment	Regular cost sharing.	33-34
Prescription drugs.....	*Retail Pharmacy - $5 Preferred Generic; $15 Preferred Brand; 50% Other Covered Prescription Drugs Mail Order Maintenance Drugs - $10 Preferred Generic: $30 Preferred Brand: 50% Other Covered Prescription Drugs*	35-38
Dental Care (Accidental Injury Only)……..	$10 for professional services Nothing for hospitalization	40
Vision Care.....	No benefit	
Special features: Flexible Benefits Option; AmCare Arrivals A Program for Mothers To Be; Services for deaf and hearing impaired; Travel Benefit for OK, TX, and LA		39
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $650/Self Only or $1,500/Family enrollment per year Some costs do not count toward this protection (See page 13).	13

2002 Rate Information for
AmCare 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, 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 who are not career postal employees. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
TEXAS (HOUSTON/EL PASO AREAS)							
Self Only	2V1	$77.17	$25.72	$167.20	$55.73	$91.31	$11.58
Self and Family	2V2	$202.10	$67.36	$437.87	$145.96	$239.15	$30.31
TEXAS (AUSTIN/SAN ANTONIO/DALLAS/FORT WORTH AREAS)							
Self Only	ZG1	$76.32	$25.44	$165.36	$55.12	$90.31	$11.45
Self and Family	ZG2	$199.89	$66.63	$433.10	$144.36	$236.54	$29.98
LOUISIANA (NEW ORLEANS AREA)							
Self Only	ZH1	$68.27	$22.76	$147.92	$49.31	$80.79	$10.24
Self and Family	ZH2	$178.79	$59.60	$387.38	$129.13	$211.57	$26.82
LOUISIANA (BATON ROUGE/ALEXANDRIA/SHREVEPORT AREAS)							
Self Only	ZQ1	$82.88	$27.62	$179.57	$59.85	$98.07	$12.43
Self and Family	ZQ2	$217.04	$72.35	$470.26	$156.75	$256.83	$32.56
OKLAHOMA (OKLAHOMA CITY/TULSA AREAS)							
Self Only	ZX1	$77.37	$25.79	$167.63	$55.88	$91.55	$11.61
Self and Family	ZX2	$202.61	$67.54	$439.00	$146.33	$239.76	$30.39