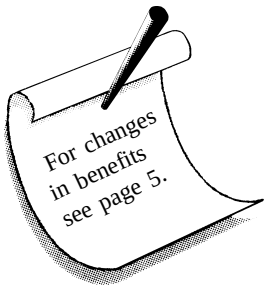
AvMed™
Health Plan

AvMed Health Plan 2000

A Health Maintenance Organization

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

Enrollment in this Plan is limited; see page 6 for requirements.



Gainesville area:
Enrollment Code:
JF1 Self Only
JF2 Self and Family

Jacksonville area:
Enrollment Code:
HW1 Self Only
HW2 Self and Family

Orlando area:
Enrollment Code:
GP1 Self Only
GP2 Self and Family

South Florida area:
Enrollment Code:
EM1 Self Only
EM2 Self and Family

Tampa area:
Enrollment Code:
H51 Self Only
H52 Self and Family

This Plan has full accreditation from the NCQA. See the *2000 Guide* for more information on NCQA.

Joint Commission
on Accreditation of Healthcare Organizations

This Plan has accreditation with commendation from the JCAHO. See the *2000 Guide* for more information on JCAHO.

Visit the OPM website at http://www.opm.gov/insure
and
AvMed Health Plan's website at http://www.avmed.com

Authorized for distribution by the:

United States Office of
Personnel Management
Retirement and Insurance Service

Federal Employees
Health Benefits Program

Table of Contents

Introduction

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

This brochure describes the benefits you can receive from AvMed Health Plan HMO under its contract (CS 1955) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is 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.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on page 5. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to AvMed Health Plan HMO as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not re-written the Benefits section of this brochure. You will find new benefits language next year.

How to use this brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. Health Maintenance Organizations (HMO). This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.

2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.

3. How to get benefits. Make sure you read this section; it tells you how to get services and how we operate.

4. What to do if we deny your claim or request for service. This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.

5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.

6. General exclusions – Things we don't cover. Look here to see benefits that we will not provide.

7. Limitations – Rules that affect your benefits. This section describes limits that can affect your benefits.

8. FEHB facts. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organizations

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventative care such as routine office visits, physical exams, well-baby care and immunizations, as well as treatment for illness and injury.

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay copayments listed in this brochure. When you receive emergency services 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. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How we change for 2000

Program-wide changes

To keep your premium as low as possible OPM has set a minimum copay of $10 for all primary care office visits.

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program. (See Section 3, How to get benefits, for more information.)

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

Enrollment code **JF**: Your share of the non-postal premium will increase by 17.4% for Self Only or 33.9% for Self and Family.

Enrollment code **HW**: Your share of the non-postal premium will increase by 24.6% for Self Only or 66.1% for Self and Family.

Enrollment code **GP**: Your share of the non-postal premium will increase by 16.1% for Self Only or 33.7% for Self and Family.

Enrollment code **EM**: Your share of the non-postal premium will increase by 12.2% for Self Only or 19.1% for Self and Family.

Enrollment code **H5**: Your share of the non-postal premium will increase by 24.6% for Self Only or 67.7% for Self and Family.

- Office visit copay has increased to $10.

Benefit Changes

- A member under eight (8) years of age may have general anesthesia and hospitalization services related to dental procedures in certain circumstances. (See pg. 12)
- Coverage of durable medical equipment is no longer limited to a list of items. Coverage continues to be limited to $50 per episode of illness subject to a maximum Plan benefit of $500 per contract year.
- Obesity control is covered subject to a $10 copay per visit.

Clarifications

- The benefit description for coverage of prosthetic devices has been clarified.
- The allergy testing and treatment benefit description has been clarified.
- The brochure has been clarified to show the Plan's orthotic appliance benefit.
- **SPECIAL NOTICE**: Brevard and Volusia Counties have been dropped from the Plan's service area. Members living or working in these counties should select another health plan. Members who do not choose another health plan will have to travel to our Plan's remaining service area to obtain medical care in order to receive full benefits from the Plan.

Section 3. How to get benefits

What is this Plan's service Area?

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

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

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

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

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

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

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care. We will not pay for any other health care services.

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

You must share the cost of some services. This is called a copayment (a set dollar amount). Please remember you must pay this amount when you receive services.

How much do I pay for services?

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

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

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us. If you file a claim, please send us all of the documents (remember to keep copies) for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Who provides my health care?

AvMed Health Plan is an Individual Practice Association organization in Florida. Members' medical services are provided by a wide array of primary care doctors and specialists with whom AvMed contracts. AvMed contracts with approximately nine thousand one hundred fifty (9,150) doctors and ninety seven (97) major hospitals in the area to provide medical care to members.

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

The Plan's provider directory lists primary care doctors (generally family practitioners, pediatricians, and internists) with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon your request by calling the Member/Provider Services Department at 1-800-882-8633. You can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important note: When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider cannot be guaranteed.

Should you decide to enroll, you will be asked to complete a primary care doctor selection form and send it directly to the Plan, indicating the name of the primary care doctor (s) selected for you and each member of your family. Members may change their doctor selection by notifying the Plan 30 days in advance.

Call us. We will help you select a new one.

What do I do if my primary care physician leaves the Plan?

Talk to your Plan physician. If you need to be hospitalized, your primary care physician or specialist will make the necessary arrangements and continue to supervise your care.

What do I do if I need to go into the hospital?

First, call our customer service department at 1-800-882-8633. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program

What do I do if I'm in the hospital when I join this Plan?

and are switching 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 became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

How do I get specialty care?

Your primary care physician will arrange your referral to a specialist. Except in a medical emergency, or when a primary care doctor has designated another doctor to see patients when he or she is unavailable, you must receive a referral from your primary care doctor before seeing any other doctor or obtaining special services. Referral to a participating specialist is given at the primary care doctor's discretion; if specialists or consultants are required beyond those participating in the Plan, the primary care doctor will make arrangements for the appropriate referrals. Services of other providers are covered only when there has been a referral by the member's primary care doctor with the following exceptions: a member may obtain covered services from a chiropractor without a referral; a woman may see her Plan gynecologist directly once a year for an annual check-up, with no need to be referred by her primary care doctor; a member may obtain up to five (5) office visits per calendar year to a Plan dermatologist for covered services.

When you receive a referral from your primary care doctor, you must return to the primary care doctor after the consultation. All follow-up care must be provided or arranged by the primary care doctor. On referrals, the primary care doctor will give specific instructions to the consultant as to what services are authorized. If additional services or visits are suggested by the consultant, you must first check with your primary care doctor. Do not go to the specialist unless your primary care doctor has arranged for the visit and the Plan has issued an authorization for the referral in advance.

If you have a chronic, complex, or serious medical condition that causes you to see a Plan specialist frequently, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct access visits with that specialist. The treatment plan will permit you to visit your specialist without the need to obtain further referrals. Requests by primary care doctors for referrals to specialists are evaluated based upon medical information given by the provider. The authorization for the referral includes the initial visit as well as the follow up visits as determined by the medical condition. The authorization is good for 90 days. At the end of the 90 days, additional visits can be authorized based upon the medical condition of the patient.

What do I do if I am seeing a specialist when I enroll?

Your primary care physician will decide what treatment you need. If they decide 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.

What do I do if my 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.

But, what if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you

have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

How do you authorize medical services?

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

How do you decide if a service is experimental or investigational?

The Plan's experimental/investigational determination process is based on authorative information from medical literature, medical consensus bodies, FDA approval, clinical trials, and health care professionals with specialty expertise in the subject.

Section 4. What to do if we deny your claim or request for service

If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing,
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Arrange for a health care provider to give you the service; or
4. Ask for more information

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

Call us at 1-800-882-8633 and we will expedite our review.

What if I have a serious or life threatening condition and you haven't responded to my request for service?

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's health benefits Contract Division IV at (202)-606-0737 between 8 a.m. and 5 p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

Are there other time limits?

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.

2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

Your request must be complete, or OPM will return it to you. You must send the following information:

What do I send to OPM?

1. A statement about why you believe our decision is wrong, based on specific benefit provisions in this brochure;
2. Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
3. Copies of all letters you sent us about the claim;
4. Copies of all letters we sent you about the claim; and
5. Your daytime phone number and the best time to call.

If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Those who have a legal right to file a disputed claim with OPM are:

Who can make the request?

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contract Division IV, P.O. Box 436, Washington, D.C. 20044

Where should I mail my disputed claim to OPM?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our decision, your only recourse is to sue.

What if OPM upholds the Plan's denial?

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 or supplies.

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 made its decision on your claim. You may recover only the amount of benefits in dispute.

What laws apply if I file a lawsuit?

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. Benefits

Medical and Surgical Benefits

What is covered?

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; you pay a $10 office visit copay, but no additional copay for laboratory tests and X-rays. Within the Service Area, house calls will be provided if in the judgment of the Plan doctor such care is necessary and appropriate. You pay nothing for a doctor's house call or for home visits by nurses and health aides.

The following services are included:

- Preventive care, including well-baby care and periodic check-ups
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters
- Hearing tests for children through age 17
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. Copays are waived for maternity care. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary family planning services and sterilization (you pay a sterilization copay of $100). Covered abortion will require a copay of $100.
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including test and treatment materials (such as allergy serum). (You pay $50 per course of testing.)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.
- Cornea, heart, kidney, and liver transplants; 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, testicular, mediastinal, retroperitoneal and ovarian germ cell tumors; breast cancer; multiple myeloma; and epithelial ovarian cancer. Treatment for these conditions may be limited to non-randomized clinical trials, as determined by the Plan's medical Director. Related medical and hospital expenses of the donor are covered when the recipient is covered by the Plan.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis
  Chemotherapy, radiation therapy, and inhalation therapy
- Surgical treatment of morbid obesity
- Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you.

Limited Benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

General anesthesia and hospitalization services are covered for a member who is under 8 years of age and is determined by a licensed dentist and the member's physician to require necessary dental treatment in a hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or if the member has one or more medical conditions that would create significant or undue medical risk for the member in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical center. Pre-authorization by AvMed is required. There is no coverage for diagnosis or treatment of dental disease.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery. A patient and her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.

Short-term rehabilitative therapy (physical, speech, and occupational) is provided on an outpatient or inpatient basis for up to 60 days calendar per condition if significant improvement can be expected within two months. You pay a $10 copay per outpatient session.

Diagnosis and treatment of infertility including artificial insemination is covered. The following types of artificial insemination are covered: intravaginal insemination (IVI); intracervical insemination (ICI) and intrauterine insemination (IUI); you pay a $20 copay per visit. Surgery for the enhancement of fertility is provided. You pay $100 to the surgeon and $500 to the hospital or surgicenter. Cost of donor sperm is not covered. Other assisted reproductive technology (ART) procedures that enable a woman with otherwise untreatable infertility to become pregnant through other artificial conception procedures such as in vitro fertilization and embryo transfer are not covered. Fertility drugs are not covered.

Transitional care services provided in any licensed facility, including sub-acute care units or centers, ventilator dependent units and alternative care units, are covered for up to a maximum of 150 days per calendar year when confinement in a hospital or extended care facility is not medically necessary. You pay nothing.

Chiropractic services are limited to spinal manipulations. You pay a $10 copay per visit.

Durable medical equipment such as hospital beds, crutches, and wheel chairs, is covered. Medical supplies and devices, such as corsets which do not require a prescription are not covered. The option of purchasing or renting will be determined by cost. AvMed will require that the most economical option be selected.

Coverage for orthotic appliances is limited to leg, arm, back, and neck custom-made braces when related to a surgical procedure or when used in an attempt to avoid surgery and are

necessary to carry out normal activities of daily living, excluding sports activities. Coverage is limited to the first such item; repair and/or replacement is not covered. All other orthotic appliances are not covered.

For Durable medical equipment and orthotic appliances, you pay a $50 copay per episode of illness. Benefits are limited to a maximum of $500 per contract year.

Prosthetic devices are covered, limited to surgically implanted devices (excluding penile prothesis), artificial limbs, artificial joints, breast prostheses, surgical bras and ocular protheses. Coverage is limited to the initial purchase, fitting, or adjustment. Replacement is covered only when medically necessary due to a change in bodily configuration. Replacement of cataract lenses is covered only if there is a change in prescription which cannot be accommodated by eyeglasses. You pay nothing.

What is not covered?

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- Transplants not listed as covered
- Hearing tests for members over age 17
- Blood and blood derivatives (no charge if replacement is arranged by member)
- Hearing aids
- Foot orthotics and other external prostheses not listed above
- Long-term rehabilitative therapy
- Homemaker services
- External lenses following cataract surgery
- Cardiac rehabilitation
- Medical equipment not listed above

Hospital/Extended Care Benefits

What is covered?

Hospital Care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. You pay nothing. All necessary services are covered, including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care

- Specialized care units, such as intensive care or cardiac care units

Extended Care

The Plan provides a comprehensive range of benefits for up to 30 post-hospital days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor, and approved by the Plan. You pay nothing. All necessary services are covered, including:

- Bed, board and general nursing care

- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.

Hospice Care

Supportive and palliative care for a terminally ill member is covered in the home or hospice

facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance Service
Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor.

Limited Benefits

Inpatient Dental Procedures
Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

General anesthesia and hospitalization services related to dental procedures for children under eight (8) years of age are covered for the following circumstances:

a) Member requires dental treatment in a hospital or ambulatory surgical center due to a significantly complex dental condition; or
b) Member has a developmental disability in which patient management in the dental office has proven to be ineffective; or
c) member has one or more medical conditions that would create significant or undue medical risk for the member in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical center.

Diagnosis or treatment of dental disease is not covered.

Acute Inpatient Detoxification
Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 16 for nonmedical substance abuse benefits.

What is not covered?

- Personal comfort items, such as telephone and television
- Blood and blood derivatives (no charge if replacement is arranged by member)
- Custodial care, rest cures, domiciliary or convalescent care

Emergency Benefits

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 the Plan may determine are medical emergencies — what they all have in common is the need for quick action.

Emergencies within the Service Area.

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 48 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the

Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full. Benefits are available for care for non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

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

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

Plan pays . . .

You pay . . .

$30 per hospital emergency room visit at participating hospitals and per visit at Plan urgent care centers, or $50 per emergency room visit at non-participating hospitals and visits to non-participating urgent care centers for emergency services that are covered benefits of this Plan.

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

Emergencies outside the Service Area.

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

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

Reasonable charges for emergency care services to the extent the services would have been covered if received from Plan providers.

Plan pays . . .

$50 per hospital emergency room visit or urgent care center visit for emergency services that are covered benefits of this Plan.

You pay . . .

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service approved by the Plan

What is 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

What is not covered?

Filing claims for non-Plan providers.

With your authorization the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts (remember to keep copies) to the Plan along with an explanation of the services and the identification information from your ID card. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 9.

Mental Conditions/Substance Abuse Benefits

The medical management of mental conditions will be covered under this Plan's Medical and

Mental Conditions

Surgical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits. Office visits for the medical aspects of treatment do not count toward the 40 outpatient Mental Conditions visit limit.

To the extent shown below, this Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

What is covered?

Up to 40 visits to Plan doctors, consultants, or other psychiatric personnel each calendar year, you pay a $20 copay for each covered visit — all charges thereafter.

Outpatient Care

Up to 30 days of hospitalization each calendar year; you pay $100 per day to the hospital and $20 per inpatient visit by a doctor for the first 30 days — all charges thereafter.

Inpatient Care

- Care for psychiatric conditions which in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment.
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.

What is not covered?

- Psychological testing that is not medically necessary to determine the appropriate treatment of a short-term psychiatric condition.

Substance Abuse

What is covered?

This Plan provides medical and hospital services such as acute detoxification services for the medical, nonpsychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition. Services for the psychiatric aspects are provided in conjunction with the Mental conditions benefits shown above. Outpatient visits to Plan providers for treatment are covered, as well as inpatient services necessary for diagnosis and treatment. The Mental conditions benefits visit/day limitations and copayments apply to any covered substance abuse care.

What is not covered?

- Treatment not authorized by a Plan doctor.

Prescription Drug Benefits

What is covered?

Prescriptions drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply (or 100 unit dosage, whichever is less); 240 milliliters of liquid (8 oz.); 60 grams of ointment, creams or topical preparation; or one commercially prepared unit (e.g. one inhaler, one vial ophthalmic medication or insulin). You pay a $5 copay per prescription unit or refill for generic drugs or for name brand drugs when no generic equivalent is available. Members who request name brand drugs when a generic is available must pay the $5 copay plus the difference in cost between the name brand and generic drugs.

Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's Drug Formulary. The Drug Formulary is a list of commonly prescribed medications that have been chosen by the Pharmacy and Therapeutic Committee based on a drug's effectiveness and cost. The Pharmacy and Therapeutic Committee will evaluate any needed additions or deletions to

the formulary. Upon a participating provider's request, specific medications can be evaluated on a case by case basis to be added to the formulary. Non-formulary drugs will be covered when prescribed by a Plan doctor. It is the prescribing doctor's responsibility to obtain authorization for non-formulary drugs before they are dispensed.

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Insulin
- Disposable needles and syringes needed to inject covered prescribed medication, including insulin
- Full range of FDA-approved drugs, prescriptions, and devices for birth control
- Intravenous fluids and medication for home use, implantable drugs and some injectable drugs are covered under Medical and Surgical Benefits.

Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits. You pay the drug copayment up to the dosage limit and all charges above that.

Limited Benefit

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies
- Vitamins and nutritional substances that can be purchased without a prescription

What is not covered?

- Medical supplies such as dressings and antiseptics
- Diabetic supplies except for needles and syringes
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Drugs to aid in smoking cessation, including nicotine patches
- Fertility drugs

Other Benefits

Dental Care

What is covered?

The following dental services are covered when provided by participating Plan dentists to children through age 11.

Preventive and diagnostic	You Pay
Oral examinations	Nothing
X-rays as necessary	Nothing
Prophylaxis (cleaning)	Nothing
Topical application of fluoride	$10 for each application

Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth are covered. The need for these services must result from an accidental injury occurring while the member is covered under the FEHB Program. You pay nothing.

Accidental Injury Benefit

- Other dental services not shown as covered.

What is not covered?

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refractions (which include the written lens prescription) may be obtained from Plan providers for children through age 17. You pay a $10 copay per visit.

Vision Care

What is covered?

- Eye exercises
- Replacement for any lenses provided during the same calendar year
- Eye glasses
- External lenses following cataract surgery

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all enrollees and family members who are members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium; any charges for these services do not count toward any FEHB deductibles, out-of-pocket maximum copay charges, etc. These benefits are not subject to the FEHB disputed claims procedure.

Expanded dental benefits

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

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

- Topical fluoride
- Oral exams
- X-rays
- Cleanings (semi-annual)
- Local anesthesia

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

Expanded vision care

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

- Eye exams
- Eye glasses
- Contact lenses
- Designer glasses, sun glasses, etc.

For details on specific services and discounts in your Service Area, please call your Plan's Membership Services Office listed on page 7 of the brochure.

Additional value added services include:

- 24 hours/7 days a week Member Service line
- 24 hours/7 days a week AvMed nurse help line
- Weight Watchers

Medicare prepaid plan enrollment — This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated in Section 7, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later re-enroll in the FEHB program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on changing your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 1-800-535-9355 for information on the Medicare prepaid plan and the cost of that enrollment.

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

Section 6. General exclusions — Things we don't cover

The exclusions in this section apply to all benefits. Although we may list a specific service as a benefit, we will not cover it unless

your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness or condition.

We do not cover the following:

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

Section 7. Limitations – Rules that affect your benefits

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

Medicare

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Enrollment Season.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800-638-6833. For information on the Medicare+Choice plan offered by this Plan, see above.

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

Other group insurance coverage

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

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

Circumstances beyond our control

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. We will cover the cost of treatment that exceeds the amount you received in the settlement. If you do not seek damages, you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

When others are responsible for injuries

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

TRICARE

We do not cover services that:

- You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide;
- 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.

Workers' compensation

Once the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

We pay first if both Medicaid and this Plan cover you.

Medicaid

We do not cover services and supplies that a local, State, or Federal Government agency directly or indirectly pays for.

Other Government Agencies

Section 8. FEHB FACTS

You have a right to information about your HMO.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website **(www.opm.gov)** lists the specific types of information that we must make available to you.

If you want specific information about us, call 1-800-882-8633, or write to 9400 South Dadeland Blvd., Suite 200, Miami, FL 33156. You may also contact us by fax at (305) 671-4710, or visit our website at www.avmed.com.

Where do I get information about enrolling in the FEHB Program?

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
- The next Open Enrollment Season.

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.

When are my benefits and premiums effective?

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin January 1.

What happens when I 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, which is described later in this section.

What types of coverage are available for my family and me?

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 or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get 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 you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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.

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

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,

Are my medical and claims records confidential?

- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payment 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.

Information for new members

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

Identification cards

Your old plan's deductible continues until our coverage begins.

What if I paid a deductible under my old plan?

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

Pre-existing conditions

When you lose benefits

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.

What happens if my enrollment in this Plan ends?

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

What is former spouse 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 more information about your coverage choices.

What is TCC?

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 TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct. 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.

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;

Key points about TCC:

- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

How do I enroll in TCC?

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an 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 if individual coverage is available. 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.

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. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the

How can I get a Certificate of Group Health Plan Coverage?

certificate.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may request a certificate from them, as well.

Inspector General Advisory: Stop Health Care Fraud!

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-800-882-8633 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 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 they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Summary of Benefits for AvMed Health Plan - 2000

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated, subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or

change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.**

Benefits		Plan pays/provides	Page
Inpatient Care		Comprehensive range of medical and surgical services with no dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private care nursing if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** nothing	
	Hospital	All necessary services, up to 30 days per calendar year. **You pay** nothing	**13**
		Up to 30 days of inpatient care per year for diagnosis and treatment of acute psychiatric conditions. **You pay** $100 per day to the hospital and $20 per inpatient visit by doctor for covered days - all charges thereafter	
	Extended Care	Covered under Mental conditions benefits	**13**
	Mental Conditions	Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and x-rays; complete maternity care (copays are waived for maternity care.). **You pay** a $10 copay per office visit; nothing per home visit by doctor	**16**
	Substance Abuse		**16**
Outpatient Care		All necessary visits by nurses and health aides. **You pay** nothing	**11**
		Up to 40 outpatient visits per year. **You pay** a $20 copay per covered visit - all charges thereafter	
	Home Health Care	Covered under Mental conditions benefits	**11**
	Mental Conditions	Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $30 copay at a participating hospitals or $50 at non-participating hospitals	**16**
	Substance Abuse		**16**
Emergency Care		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** a $5 copay per prescription unit or refill for generic drugs unless no generic equivalent is available. Members who request a name brand drug when a generic is available must pay the $5 copay plus the difference between the generic and name brand drug	**14**
Prescription Drugs			**16**
		Accidental injury benefit. You pay nothing. Preventive dental care for children through age 11. **You pay** a $10 copay for each topical application of fluoride; nothing for other covered services	
Dental Care		Refractions, including lens prescriptions, limited to children through age 17. **You pay** a $10 copay per visit	**17**
Vision Care		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $1,500 per Self Only or $2,500 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include copays for prescription drugs, dental services, inpatient treatment of mental conditions and substance abuse, and voluntary family planning services	**17**
Out-of-pocket limit			**7**

2000 Rate Information for AvMed Health Plan

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

Postal rates apply to most career U.S. Postal Service employees. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee but not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees," RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium				**Postal Premium A**		**Postal Premium B**	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS	Your
Broward/Dade/Palm Beach Counties									
Self Only	EM1	$66.80	$22.26	$144.72	$48.24	$79.04	$10.02	$79.04	$10.02
Self and Family	EM2	$175.97	$68.95	$381.27	$149.39	$207.74	$37.18	$201.02	$43.90
Gainesville Area									
Self Only	JF1	$75.04	$25.01	$162.59	$54.19	$88.79	$11.26	$88.79	$11.26
Self and Family	JF2	$175.97	$99.13	$381.27	$214.78	$207.74	$67.36	$201.02	$74.08
Jacksonville Area									
Self Only	HW1	$74.07	$24.69	$160.49	$53.49	$87.65	$11.11	$87.65	$11.11
Self and Family	HW2	$175.97	$95.63	$381.27	$207.20	$207.74	$63.86	$201.02	$70.58
Orlando Area									
Self Only	GP1	$67.41	$22.47	$146.06	$48.68	$79.77	$10.11	$79.77	$10.11
Self and Family	GP2	$175.97	$71.20	$381.27	$154.27	$207.74	$39.43	$201.02	$46.15
Tampa Area									
Self Only	H51	$72.33	$24.11	$156.71	$52.24	$85.59	$10.85	$85.59	$10.85
Self and Family	H52	$175.97	$89.21	$381.27	$193.29	$207.74	$57.44	$201.02	$64.16