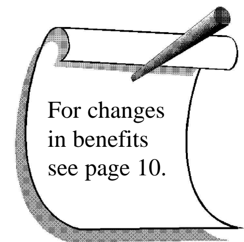
AmeriHealth

AmeriHealth HMO

http://www.amerihealth.com

2003

A Health Maintenance Organization



Serving: All of New Jersey

Enrollment in this Plan is limited. See page 9 for requirements.
You must live or work in our geographic service area to enroll.

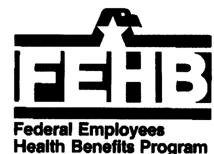
This Plan has received "Excellent" accreditation from the NCQA. See the 2003 Guide for more information on NCQA.

Enrollment codes for this Plan:

FK1 Self Only
FK2 Self and Family

Authorized for distribution by the:

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



RI 73-065

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

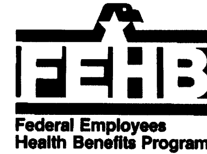
In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

Kay Coles James
Director



Notice of the Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

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

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

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Introduction

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

AmeriHealth HMO, Inc.
1901 Market Street
Philadelphia, PA 19103

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and are summarized on page 61. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area 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.

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 1-800-444-6282 and explain the situation.
  - If we do not resolve the issue:

CALL – THE HEALTH CARE FRAUD HOTLINE
202-418-3300

OR WRITE TO:

The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

- Do not maintain as a family member on your policy:
  - your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed or with OPM if you are retired.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Section 1. Facts about this HMO plan

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

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

Our HMO reimbursement programs for health care providers are intended to encourage the provision of quality, cost-effective care for our Members. Set forth below is a general description of our HMO reimbursement programs, by type of Participating Provider. These programs vary by state, and the reimbursement programs outlined below apply to services rendered in New Jersey.

Please note that these programs may change from time to time, and the arrangements with particular Participating Providers may be modified as new contracts are negotiated. If after reading this material you have any questions about how your Participating Provider is compensated, or desire information on reimbursement programs in another state, please speak with your Participating Provider directly or contact Member Services.

Professional Providers

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

Referred Specialists: Most Referred Specialists are paid on a fee-for-service basis. This means that payment is made according to our HMO fee schedule for the specific medical services that the Referred Specialist performs. Some Referred Specialists are paid a global fee covering all of the related services delivered during an encounter and therefore may be at risk for the cost of these services. Obstetricians are paid global fees that cover most of their professional services for prenatal care and delivery.

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

Institutional Providers

Hospitals: For most inpatient medical and surgical Covered Services, Hospitals are paid per diem rates, which are specific amounts paid for each day a Member is in the hospital. These rates usually vary according to the intensity of services provided. Some Hospitals are also paid case rates, which are set dollar amounts paid for a complete Hospital stay related to a specific procedure or diagnosis, e.g., transplants. For most outpatient and Emergency Covered Services and procedures, most Hospitals are paid specific rates based on the type of service performed. For a few Covered Services, Hospitals are paid based on a percentage of billed charges. Most Hospitals are paid through a combination of the above payment mechanisms for various Covered Services.

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

Ambulatory Surgical Centers (ASCs): Most ASCs are paid specific rates bsed on the type of service performed. For a few Covered Services, some ASCs are paid based on a percentage of billed charges.

Ancillary Service Providers

Some ancillary service Providers, such as Durable Medical Equipment and Home Health Care Providers, are paid fee-for-service payments according to our HMO fee schedule for the specific medical services performed. Other ancillary service Providers, such as those providing laboratory, dental and vision Covered Services, are paid a per Member per month amount (capitation) for each Member. Capitated ancillary service vendors are responsible for paying their contracted providers and do so on a fee-for-service basis.

Radiology Services

We contract with a radiology service company, which provides a network of participating radiology providers and is paid a per Member per month amount (capitation) for each Member. This radiology service company pays its affiliated providers on a fee-for-service and/or capitated basis.

Mental Health

A behavioral health management company (BHM) administers most of our mental health/substance abuse Covered Services, provides a network of participating BHM Providers and processes related claims. The BHM is paid a per Member per month amount (capitation) for each Member and is responsible for paying its contracted providers on a fee-for-service basis. This company capitates its outpatient providers in this area, and PCPs may select a particular behavioral health outpatient site as its primary mental health provider, so Members are encouraged to use the site that their PCP is working with. *However, Members are free to choose any behavioral health outpatient site.* The contract with the BHM includes performance-based payments related to quality, provider access, service, and other such parameters. One of our affiliate companies has a less than three percent ownership interest in this BHM.

Pharmacy

A pharmacy benefits management company (PBM) administers our HMO pharmacy benefits, provides a network of Participating Pharmacies and processes pharmacy claims. The PBM also processes and provides all mail order Prescription Orders, negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. Rebates and discounts reduce the overall cost of pharmacy benefits. Most outpatient Prescription Drugs are purchased on a fee-for-service basis from pharmacies. The PBM is paid an administrative fee for processing each pharmacy claim and providing other pharmacy related services. Most regional network pharmacies also have the opportunity to receive a small incentive payment if their generic drug-dispensing rate is better than the network average.

If you desire additional information about how our Primary Care Physicians or any other Providers in our Service Area are compensated, you may do either of the following. You may call Member Services at the number on the back of your ID card. Or, you may write to AmeriHealth HMO, Inc., AmeriHealth Service Center, P.O. Box 41574, Philadelphia, PA 19101-1574.

The laws of the State of New Jersey, at N.J.S.A. 45:9-22.4 et seq., mandate disclosure of the following. If a physician, chiropractor or podiatrist who is permited to make Referrals to other health care Providers the following must be disclosed, if applicable. The physician, chiropractor or podiatrist must inform his or her patients of any significant financial interest he or she may have in a health care Provider or facility when making a Referral to that health care Provider or facility. If you want more information about this, contact your physician, chiropractor or podiatrist. If you believe that you are not receiving the information to which you are entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504-6200 OR (800) 242-5846.

Who provides my health care?

AmeriHealth HMO is an individual practice plan (IPP) HMO. The Plan is comprised of over 29,000 private practice doctor sites who practice from their own private offices. Over 7,900 of these doctors are participating primary care doctors. A wide range of specialty care is represented throughout the Plan. Inpatient services are available and can be provided at 185 hospitals conveniently located throughout the Plan's service area.

It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when there has been a referral by the member's primary care doctor except for eye exams, dental care, and visits to the OB/GYN for preventive care, routine maternity or for problems related to gynecological conditions when medically necessary. Non-routine care provided by Reproductive Endocrinologists/Infertility Specialists, and Gynecologic Oncologists continue to require a referral from the primary care physician. Treatment for mental conditions and substance abuse may be obtained directly from Magellan Behavioral Health at 1-800-809-9954. Magellan Behavioral Health, or any other mental health administrator for AmeriHealth HMO, manages all care related to mental health and substance abuse services. Magellan Behavioral Health will determine what specialty care is appropriate and which specialists will be utilized.

Your rights

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

If you want more information about us, call 1-800-877-9829, or write to AmeriHealth HMO, Inc., P.O. Box 41574, Philadelphia, PA 19103. You may also visit our website at www.amerihealth.com.

Service Area

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

Outside Service Area

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care and urgent care benefits.

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

Section 2. How We change for 2003

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

- A Notice of the Office of Personnel Management's Privacy Practices is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

Changes to this Plan

- Your share of the non-Postal premium will increase by 19.9% for Self Only or 29.1% for Self and Family.
- You will now pay a $100 copay for outpatient surgery.
- You will now pay a $200 copay per day; up to a 3 day maximum per admission.
- You will now pay a $20 copay per prescription order or refill for formulary generic drugs; a $40 copay per prescription order or refill for formulary brand name drugs; and a 50% coinsurance per prescription order or refill for covered non-formulary drugs. The above copays refer to a 30-day supply.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-877-9829.

Where you get covered care

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

- **Plan providers**

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

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. Contract holders must select a PCP within the state of New Jersey.

- **Primary care**

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

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

• Specialty care

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see a participating physician for eye exams, dental care, and visits to the OB/GYN for preventive care, routine maternity or for problems related to gynecological conditions when medically necessary. You may also visit a participating facility for all mammograms. Non-routine care provided by Reproductive Endocrinologists/Infertility Specialists, and Gynecologic Oncologists continues to require a referral from the primary care physician. Treatment for mental conditions and substance abuse may be obtained directly from Magellan Behavioral Health at 1-800-809-9954.

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 develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:

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

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

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

  you may be able to continue seeing your specialist for up to 4 months after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-877-9829. 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 practices.

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

- All Non-Emergency Hospital Admissions
- All Same Day Surgery/Short Procedure Unit Admissions
- Outpatient Therapies: Speech, Cardiac, Pulmonary, Respiratory, Home Infusion
- Other Facility Services: Skilled Nursing, Home Health, Hospice, Birthing Center
- Rental/Purchase of Durable Medical Equipment and Prosthesis (purchase over $100.00 and all rentals)
- Non-Emergency Ambulance Services
- Spinal Manipulation Services
- Inpatient Psychiatric Care
- Inpatient Alcohol and Substance Abuse Treatment
- Some Medications that have specific uses and are administered in Outpatient Settings or Physician Offices

- Your physician must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Before giving approval, we determine if the service is medically necessary, and if it follows generally accepted medical practices. Members are not responsible for payment of services if the provider does not obtain preauthorization for services rendered.

Section 4. Your costs for covered services

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

- **Copayments** — A copayment is a fixed amount of money you pay to the provider when you receive services.

  Example: When you see your primary care physician you pay a copayment of $30 per office visit or a copayment of $35 per office visit to a specialist.

- **Deductible** — We do not have a deductible.

- **Coinsurance** — You will pay coinsurance for non-formulary drugs.

Your catastrophic protection out-of-pocket maximum

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

- Prescription drugs
- Dental services

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

Section 5. Benefits — OVERVIEW

(*See page 10 for how our benefits changed this year and page 61 for a benefits summary.*)

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

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- Preventive care, children
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- Vision services (testing, treatment, and supplies)
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Section 5 (a). Medical services and supplies provided by physicians and other health care professionals

I M P O R T A N T

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.
- 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.

I M P O R T A N T

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion	 $30 per office visit to your primary care physician $30 per office visit to your primary care physician $35 per office visit to a specialist
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility	$30 per office visit
At home.	$35 per home visit
Not covered: • *Charges for missed appointments* • *Charges for completion of insurance forms*	*All charges.*

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: • X-rays • Non-routine pap tests • Pathology • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	X-rays, $35; nothing for all other tests
Preventive care, adult	
Routine screenings, based on medical necessity and risk such as: • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including — Fecal occult blood test — Sigmoidoscopy, screening – every five years starting at age 50 • Colonoscopy – once every 10 years, starting at age 50	$30 per office visit
Routine Prostate Specific Antigen (PSA) – one annually for men age 40 and older	$30 per office visit
Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnosis and Treatment,* above.	$35 per office visit

Preventive care, adult *(Continued)*	**You pay**
Routine mammogram	Nothing, if you receive these services during your office visit, otherwise $35 per visit
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.*	*All charges.*
Routine adult immunizations limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older.	$30 per office visit
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	$30 per office visit
• Well-child care charges for routine examinations, immunizations and care (through 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 (through age 22)	$30 per office visit

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • 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).	$35 copayment applies to first visit only
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges.*
Family planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives (such as Norplant). Insertion and removal covered under Medical – Drug covered under Rx • Injectable contraceptive drugs (such as Depo Provera) – Covered under Rx • Intrauterine devices (IUDs) and Diaphragms – Device covered under Rx	$35 per office visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling* • *Removal of surgically implanted time-release medication before the end of the expected life, unless medically necessary and approved by the Plan.*	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: — intravaginal insemination (IVI) — intracervical insemination (ICI) — intrauterine insemination (IUI) • Services and supplies related to ART • In Vitro Fertilization • GIFT (Gamete Intra Fallopian Transfer) • ZIFT (Zygote Intra Fallopian Transfer) • Embryo Transfer • Fertility Injections administered in a physician's office • Oral Fertility drugs	$35 per office visit
Not covered: • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges.*
Allergy care	
Testing and treatment Allergy injection	If treated at PCP office, $30 per office visit. At specialist office, $35 per office visit.
Allergy serum	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges.*

Treatment therapies	You pay
• 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 25. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: We will only cover GHT when we preauthorize the treatment. If we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	Nothing
Not covered: See Section 6 General Exclusions	*All charges.*

Physical and occupational therapies	You pay
• 60 consecutive days per condition if significant improvement can be expected in the two month period for the services of each of the following: — qualified physical therapists; — occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 12 weeks. • Spinal manipulations will be provided for up to 60 consecutive days per condition if significant improvement can be expected in the two month period.	$35 per visit
Not covered: · *Long-term rehabilitative therapy* · *Exercise programs*	*All charges.*
Speech therapy	
• 60 consecutive days per condition	$35 per visit
Hearing services (testing, treatment, and supplies)	
• Hearing testing for children through age 17 (see *Preventive care, children*)	$30 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
• One eye refraction every two calendar years.	$35 per office visit
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	Nothing
• Eye exam to determine the need for vision correction for children through age 17 (see preventive care)	$30 per office visit
Not covered: • *Eyeglasses or contact lenses and, after age 17, examinations for them; but see non-FEHB page* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*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.	$35 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* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*

Orthopedic and prosthetic devices	You pay
• Artificial limbs (initial devices only); stump hose • Artificial lenses following cataract surgery • Externally worn breast prostheses – initial device only • Surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices and their replacements, such as artificial joints, pacemakers, and surgically implanted breast implant, external and shown above, following mastectomy. Note: See Section 5(b) for coverage of the surgery to insert the device.	Nothing
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics, unless for treatment of diabetes* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than three years after the last one we covered* • *Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome* • *Dental prosthetics*	*All charges.*
Durable medical equipment (DME)	
Rental or purchase, at our option, including repair and adjustment, of standard durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • standard hospital beds • standard wheelchairs • crutches • walkers • blood glucose monitors • insulin pumps	Nothing
Not covered: • *Motorized wheelchairs* • *Customized durable medical equipment*	*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.	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All charges.*
Chiropractic	
Spinal manipulation will be provided for up to 60 consecutive days per condition if significant improvement can be expected in the two month period.	$35 per visit
Alternative treatments	
Not covered: • *Acupuncture* – see Section 5(j) non-FEHB benefits available to Plan members • *Naturopathic services* • *Hypnotherapy* • *Biofeedback*	*All charges.*
Educational classes and programs	
Coverage is limited to: • Diabetes self-management training and education through community-based programs certified by the American Diabetes Association or Department of Health. Covered services may also be provided by these contracted providers; a licensed health care professional; or at a hospital on an outpatient basis.	Nothing
Not covered: • *Smoking Cessation* – see Section 5(j) non-FEHB benefits available to Plan members.	

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.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.)
- YOUR PRIMARY CARE PHYSICIAN OR SPECIALIST MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

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 • Insertion of internal prosthetic devices. See Section 5(a) – *(Orthopedic and prosthetic devices)* for device coverage information.	Nothing*

*There is a $100 copay for surgery rendered at a covered outpatient facility.

Surgical procedures continued on next page.

Surgical procedures *(Continued)*	**You pay**
• Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • 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	
Your physician must obtain approval from us before providing service. • 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. • 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.*

*There is a $100 copay for surgery rendered at a covered outpatient facility.

Oral and maxillofacial surgery	You pay
Oral surgical procedures require preapproval by the Plan, and are 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.	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	
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – Double • 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. Note: We cover related medical and hospital expenses of the member donor when we cover the recipient.	Nothing*
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges.*

*There is a $100 copay for surgery rendered at a covered outpatient facility.

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*

*There is a $100 copay for surgery rendered at a covered outpatient facility.

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

I M P O R T A N T

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.
- 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 Section 5(a) or (b).

I M P O R T A N T

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care or cardiac 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.	$200 copay per day, up to a 3 day maximum per admission

Inpatient hospital continued on next page.

Inpatient hospital *(Continued)*	**You pay**
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 • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	$200 copay per day, up to a 3 day maximum per admission
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing home and schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Blood and blood derivatives not replaced by the member*	*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.	$100 facility copay
Not covered: blood and blood derivatives not replaced by the member	*All charges.*

Extended care benefits/skilled nursing care facility benefits	You pay
Skilled nursing facility (SNF): Up to 180 days per calendar year when full-time skilled nursing care is necessary and confinement in a skill ed nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan.	$200 copay per day per admission, up to a 3 day maximum unless admitted directly from an inpatient hospitalization
Not covered: • *Custodial care* • *Rest cures* • *Domiciliary or convalescent care* • *Personal comfort items, such as telephones and television*	*All charges.*
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.	$200 copay per day per admission, up to a 3 day maximum unless admitted directly from an inpatient hospitalization
Not covered: • *Independent nursing* • *Homemaker services* • *Custodial care* • *Rest cures* • *Domiciliary or convalescent care* • *Personal comfort items, such as telephones and television*	*All charges.*
Ambulance	
• Local professional ambulance service when medically appropriate. Preapproval is required, unless for emergency.	Nothing

Section 5 (d). Emergency services/accidents

I M P O R T A N T	**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. • 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.	I M P O R T A N T

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within the service area:

If you are in an emergency situation, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition. To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Emergencies outside our service area:

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

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

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

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office	$30 per office visit
• Emergency care at an urgent care center	$30 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services (copayment waived if admitted or you are referred to the emergency room by your PCP and services could have been provided by your doctor)	$75 per visit
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office	$30 per office visit
• Emergency care at an urgent care center	$30 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services (copayment waived if admitted or you are referred to the emergency room by your PCP and services could have been provided by your doctor)	$75 per 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 or air ambulance service when medically appropriate. See Section 5(c) *Ambulance* 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 illness and conditions.

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

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

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 illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$35 per office visit
• Diagnostic tests	X-rays, $35; nothing for all other tests
• 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	$200 copay per day, up to a 3 day maximum per admission
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.*

Mental health and substance abuse benefits continued on next page.

Network out-of-pocket maximums

After your copayments total $1,500 per person or $3,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. This is called a catastrophic limit. However, copayments for your prescription drugs and dental services do not count toward these limits and you must continue to make these payments.

Preauthorization

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

Treatment for mental conditions and substance abuse is coordinated directly by Magellan Behavioral Health or other behavioral health administrator designated by the Plan. Magellan Behavioral Health, acting as behavioral health administrator for AmeriHealth HMO, Inc., manages all care related to mental health and substance abuse services including referrals to mental health and substance abuse specialists. Questions about related benefits and pre-certification should be addressed to Magellan Behavioral Health at 1-800-809-9954.

Limitation

We may limit your benefits if you do not follow your 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 do not have a deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** A licensed Plan physician or licensed Plan dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a retail pharmacy, or by mail at a Plan mail order pharmacy for maintenance medications.
- **We use a formulary.** Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's formulary. A formulary is a list of selected drugs that have been evaluated for their medical effectiveness and value. Plan formulary is designed to include all therapeutic categories, provide coverage for all types of drugs and provide physicians with prescribing options.
- **Prior Authorization.** Your pharmacy benefits plan requires prior authorization of certain covered drugs to ensure that the drug prescribed is medically necessary and appropriate and is being prescribed according to the Food and Drug Administration (FDA) guidelines. The approval criteria were developed and endorsed by the AmeriHealth Pharmacy and Therapeutics Committee, which is an established group of pharmacists, Medical Directors and representatives from the physician and pharmacy communities.
- **These are the dispensing limitations.** Prescription drugs prescribed by a Plan or referral doctor and obtained at a retail Plan pharmacy will be dispensed in the following quantities:

  1-30 days: One Copay or Non-Formulary Coinsurance
  31-60 days: Two Copays; or Non-Formulary Coinsurance
  61-90 days: Three Copays; or Non-Formulary Coinsurance

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

  1-30 days: One Copay or Non-Formulary Coinsurance
  31-90 days: Two Copays; or Non-Formulary Coinsurance

  Prescription refills will be dispensed only if 75% of the previously dispensed quantity has been consumed based on the dosage prescribed.
- **When you have to file a claim.** Prescription drugs obtained from a non-Plan pharmacy are eligible with a higher out-of-pocket expense except for an out-of-area emergency which will be reimbursed after your copay. You must submit acceptable proof-of-payment with a direct reimbursement form. All claims for payment must be received within ninety (90) days of the date of proof-of-purchase. **Direct reimbursement forms may be obtained by calling 1-800-877-9829.**

Prescription drug benefits continued on next page.

Benefit Description	You pay
Covered medications and supplies	**Retail Dispensing**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a pharmacy or through our mail order program: • Drugs for which a prescription is required by Federal law of the United States • Oral and Injectable contraceptive drugs • Contraceptive diaphragms and IUDs • Implanted time-release medications, such as Norplant • Insulin, with copay charges applied to each vial • Diabetic supplies, including disposable insulin needles and syringes, diabetic blood testing strips, lancets and glucometers obtained through a Participating Pharmacy • Disposable needles and syringes needed to inject covered prescribed medications • Prenatal and Pediatric Vitamins • Drugs to treat sexual dysfunction may be subject to dosage limitations. Contact the Plan for dose limits	Plan Pharmacy: $20 per covered generic formulary prescription/refill (up to a 30 day supply) $40 per covered generic formulary prescription/refill (31-60 day supply) $60 per covered generic formulary prescription/refill (61-90 day supply) $40 per covered brand formulary prescription/refill (up to a 30 day supply) $80 per covered brand formulary prescription/refill (31-60 day supply) $120 per covered brand formulary prescription/refill (61-90 day supply) 50% coinsurance per covered non-formulary prescription/refill (up to a 90 day supply) Non-Plan Pharmacy: 70% of the total cost except for emergency purchases which are covered at 100% less the appropriate copay or coinsurance as indicated above
	Mail Order Dispensing
• Maintenance Medications	$20 per covered generic formulary prescription/refill (up to a 30 day supply) $40 per covered generic formulary prescription/refill (31-90 day supply) $40 per covered brand formulary prescription/refill (up to a 30 day supply) $80 per covered brand formulary prescription/refill (31-90 day supply) 50% coinsurance per covered non-formulary prescription/refill (up to a 90 day supply)

Covered medications and supplies *(Continued)*	**You pay**
Here are some things to keep in mind about our prescription drug program: • We have a formulary. You will receive increased benefits by using formulary drugs.	
Not covered: • *Drugs available without a prescription or for which there is a nonprescription equivalent available* • *Vitamins and nutritional substances that can be purchased without a prescription* • *Medical supplies such as dressings and antiseptics* • *Contraceptive devices to include Norplant* • *Drugs for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs to aid in smoking cessation* • *The cost of a prescription drug when the usual and customary charge is less than the member's prescription drug copayment* • *Non-formulary injectable drugs*	*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.
Services for deaf and hearing impaired	*TDD 1-888-857-4816*
Reciprocity benefit	If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.
Travel benefit	Ordinarily, you must get your care from providers who contract with us. However, emergency (described in Section 5(d)) and urgent care provided outside the service area will be covered. Urgent care includes covered services provided in order to treat an unexpected medical or psychiatric illness or injury that is not life-threatening and requires care by a provider within 24 hours. The services must be required in order to prevent a serious deterioration in your or your covered family member's health, if treatment were delayed. If you become ill or are injured while traveling outside the service area, AmeriHealth will provide coverage for urgent care services. For more information on how to access these services, please contact us by calling the phone number found on the back of your I.D. card. Your prescription drug card works in more than 50,000 pharmacies nationwide. No coverage will be provided for urgent care that has not been preauthorized or for routine or elective services rendered outside the service area.

Section 5 (h). Dental benefits

I M P O R T A N T

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

I M P O R T A N T

Benefit Description	You pay
Accidental injury benefit	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth when provided by Plan dentists. The need for these services must result from an accidental injury and be treated within six (6) months or as other medical conditions permit after the accident.	$35 per office visit

Dental benefits are continued on next page.

Dental Benefits	
Service	**You Pay**
Preventive Services: Oral examination and diagnosis (limited to once in 6 months); prophylaxis/teeth cleaning to include scaling and polishing (limited to once in six months); topical fluoride (includes child and adult); oral hygiene instruction. Diagnostic Services: Complete series x-rays; intraoral occlusal film; bitewings (limited to once in 6 months); emergency examinations; panaramic film; cephalometric film. Restorative Services: Amalgam (silver) restoration to primary and permanent teeth; anterior and posterior composite restoration to primary and permanent teeth; pin restoration; sedative restoration (per tooth); emergency treatment for covered restorative services (palliative). Out-of-Area Dental Services: The program will reimburse the member for covered dental services in connection with dental emergencies requiring palliative treatment (relieve pain) when the member is 50 miles or more from the member's Primary Dental Office, up to a maximum of $50 for each occurrence less the $5 copay. To receive payment for Out-of-Area dental services, the member must submit a receipt to AmeriHealth HMO Member Services. The receipt must itemize charges and dental services performed. **CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS**	$5 copay per office visit

Section 5 (i). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket expenses.**

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

New Fitness Reimbursement Program – To give members added incentive to maintain an active lifestyle, we will reimburse members up to $150 of their annual fitness club fees. Members can now enjoy the flexibility of joining any approved fitness club and working out at multiple fitness clubs. Visits can be recorded by swipe-card, computer printout, telephone or logbook.

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

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

BabyFootSteps Program – AmeriHealth HMO members can receive educational materials and free gifts for you and your baby in our prenatal program. Plus, you can receive a 100% reimbursement (up to $50) of the cost of a childbirth class.

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

Child Safety – Offers tips on how to reduce children's risk for household accidents such as burns, injuries from firearms, choking, and accidental poisonings. Our newly enhanced Family Health Portfolio includes a child identification record, "Mr. Yuk" stickers to place on poisonous substances, coupons for free bottle of Syrup of Ipecac, tips for safe bicycling and more. Reimbursement up to $25 for bike helmet.

American Red Cross CPR and First Aid Course Reimbursements – AmeriHealth HMO members can receive up to $25 reimbursement on any course offered by the American Red Cross.

Alternative Health Discounts – In response to our members' interest in alternative health services, we developed our Alternative Health Directory, which includes a list of practitioners who offer members up to 40% discounts on acupuncture, massage therapy, and nutritional counseling.

Medicare Prepaid Plan Enrollment – This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 18, 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 than later re-enroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on changing your FEHB enrollment. Contact us at 1-800-898-3492 for information on Plan benefits under the Medicare plan and the cost of that enrollment. If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 1-800-898-3492 for information on the benefits available under the Medicare HMO.

Section 6. General exclusions — things we do not 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) or out-of-area urgent care;
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-Plan providers or non-Plan pharmacies. 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 800-877-9829.

When you must file a claim – such as for services you receive outside of the Plan's network – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Submit your claims to:

AmeriHealth HMO, Inc.
P.O. Box 41574
Philadelphia, PA 19101

Prescription drugs

Submit your claims to:

Medco Health Prescription Solutions, Inc.
P.O. Box 727
Parsippany, NJ 07054-0727

Other supplies or services

Submit your claims to:

AmeriHealth HMO, Inc.
P.O. Box 41574
Philadelphia, PA 19101

Deadline for filing your claim

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

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny 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: 1901 Market Street, Philadelphia, PA 19103; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial – go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request – go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street NW, Washington, DC 20415-3630. Send OPM the following information • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

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

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

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.

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 preauthorized/prior approval, then call us at 1-800/227-3114 and we will expedite our review; or

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Benefits Contracts Division 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you, or a covered family member, have coverage 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 disablilities, 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 managed care plan is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

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

The Original Medicare Plan (Original Medicare) is a Medicare+Choice plan that is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits. 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, 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. We will not waive any of our copayments.

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 then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claims, call us at 800-877-9829.

(Primary payer chart begins on next page.)

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

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

- **Medicare Managed Care Plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan – a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4277) or at www.medicare.gov.

If you enroll in a Medicare managed care plan, the following options are available to you:

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

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

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

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the program.

Workers' Compensation

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. 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 56.

Covered services

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

Custodial Care

Care provided primarily for maintenance of the patient or care designed essentially to assist the patient in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision of self-administration of medications which do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively. Custodial care that lasts 90 days or more is sometimes known as Long Term Care.

Experimental or Investigational services

To establish if a biological, medical device, drug or procedure is experimental/investigative or not, a technology assessment is performed. The results of the assessment provide the basis for the determination of the service's status (e.g., medically effective, experimental, etc.). Technology assessment is the review and evaluation of available data from multiple sources using industry standard criteria to assess the medical effectiveness of the service. Sources of data used in technology assessment include but are not limited to clinical trials, position papers or articles published by local and/or nationally accepted medical organizations or peer-reviewed journals, information supplied by government agencies, as well as regional and national experts and/or panels and, if applicable, literature supplied by the manufacturer.

Us/We

Us and we refer to AmeriHealth HMO, Inc.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

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

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

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

Types of coverage available for you and your family

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive 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.

Children's Equity Act

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option,

- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or

- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

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

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.

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. This is the case even when the court has ordered your former spouse to supply health coverage for you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees, or other information about your coverage choices. You can also download this guide from OPM's website, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your 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

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 information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Still Available!

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, your premiums are based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called "custodial care", long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

You Can Also Apply Later, But . . .

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action — you won't receive an application automatically. You must request one through the toll-free number or website listed below.
- Open Season ends December 31, 2002 — act NOW so you won't miss the abbreviated underwriting available to employees and their spouses, and the July 1 "age freeze"!

Find Out More — Contact LTC Partners by calling **1-800-LTC-FEDS (1-800-582-3337) (TDD for the hearing impaired: 1-800-843-3557)** or visiting www.ltcfeds.com to get more information and to request an application.

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

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Summary of benefits for the AmeriHealth HMO – 2003

- **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	$30 copay per office visit $35 copay per specialist visit	15-25
Services provided by a hospital: • Inpatient	$200 copay per day, up to a 3 day max/admission	30-31
• Outpatient	$100 facility copay	31
Emergency benefits: • In-area • Out-of-area	$75 copay for emergency room visit and any charges for services that are not covered by this Plan, waived if admitted. $200 copay per day, up to a 3 day max/admission.	33-34 34
Mental health and substance abuse treatment	Regular cost sharing.	35-36
Prescription drugs:		37-39
• Drugs prescribed by any doctor and obtained at a participating pharmacy	$20 generic formulary copayment $40 brand formulary copayment 50% non-formulary copayment	
• A Mail Order program is available for up to a 90 day supply of maintenance medications	$40 generic formulary copayment $80 brand formulary copayment 50% non-formulary copayment	
• Drugs obtained at a non-participating pharmacy	70% of the total cost of the drug except for emergency prescription purchases which are covered at 100% less the appropriate copays	
Dental Care:		41-42
• Accidental injury benefit	$35 copay per visit	
• Preventive, Diagnostic, and Restorative dental care	$5 copay per visit	
Vision Care:		23
• Exam and refraction once every two years	$35 copay per visit	
Protection against catastrophic costs (your out-of-pocket maximum)	$1,500 per person or $3,000 per family per calendar year. This copay maximum does not include prescription drugs or dental services.	14

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2003 Rate Information for
AmeriHealth HMO, Inc.

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
AmeriHealth HMO NJ							
Self Only	FK1	$109.30	$ 37.97	$236.82	$ 82.27	$129.03	$18.24
Self and Family	FK2	$249.62	$101.38	$540.84	$219.66	$294.70	$56.30