

ADVANTAGE Health Solutions, Inc.

<http://www.advantageplan.com>



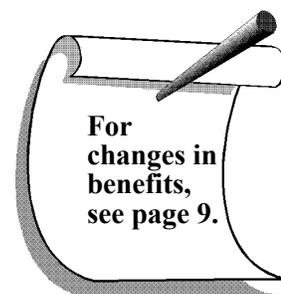
...rising above the service you expect™

2008

A Health Maintenance Organization With a high deductible health plan option

Serving: Most of Indiana

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



Enrollment code for this Plan:

6Y1 High Option – Self-Only

6Y2 High Option – Self and Family

6Y4 HDHP Option – Self-Only

6Y5 HDHP Option – Self and Family



Authorized for distribution by the:



**United States
Office of Personnel Management**

Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

RI 73-803

**Important Notice from ADVANTAGE Health Solutions About
Our Prescription Drug Coverage and Medicare**

OPM has determined that the ADVANTAGE's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of ADVANTAGE Health Solutions under our contract (CS 2862) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for ADVANTAGE Health Solutions administrative offices is:

ADVANTAGE Health Solutions, Inc.

9490 Priority Way, West Drive

Indianapolis, Indiana 46240

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, 2008, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2008 and changes are summarized on page 9. 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 *ADVANTAGE Health Solutions*.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States 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 at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 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 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 that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits 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) forms 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 1-800-553-8933 and explain the situation.

If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- 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, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- 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.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That’s about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.

- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any question.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
 - Exactly what will you be doing?
 - About how long will it take?
 - What will happen after surgery
 - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety.

- www.ahrq.gov/consumer/pathqpack.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

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. We give you a choice of enrollment in a High Option or a High Deductible Health Plan (HDHP).

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

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

General features of our High Option Plan

When you elect the High Option you are electing a plan with no deductible. Most services require that you pay a copayment or a coinsurance amount.

How we pay providers

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

General features of our High Deductible Health Plan

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans. FEHB Program HDHPs also offer health savings accounts or health reimbursement arrangements. Please see below for more information about these savings features.

Preventive care services

Preventive care services are generally paid as first dollar coverage or after a small deductible or copayment. First dollar coverage is limited to a maximum dollar amount each year.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care, vision exam and preventive dental services.

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.

- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, are limited to \$5,250 for Self-Only enrollment, or \$10,500 for Self and Family coverage.

Your rights

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

- ADVANTAGE HMO, Inc. received its Certificate of Authority to operate a prepaid health care delivery system in Indiana on April 27, 2000 and meets the State’s financial solvency requirements as of that date.
- The Plan was incorporated in November 1999 and began operations as a new a health plan on May 1, 2000.
- The Plan is incorporated in Indiana as a For-profit company.
- The Plan has no ownership or interest in any health care facilities.
- The Plan and its contracted providers use nationally recognized clinical protocols, practice guidelines and utilization review standards published by Milliman USA and InterQual, to direct a patient’s care.

ADVANTAGE HMO, Inc. is a privately held Indiana corporation owned by four Catholic health care systems: Ascension Health, Sisters of St. Francis Health Services, Inc., Saint Joseph Regional Medical Center, Inc. and Ancilla Systems, Inc. ADVANTAGE HMO, Inc. is a managed care company licensed to operate a prepaid health plan under a Certificate of Authority issued by the State of Indiana on April 27, 2000. The managed care benefit plans are marketed as “ADVANTAGE Health Solutions”.

As a Catholic owned organization, ADVANTAGE HMO, Inc. supports the Ethical and Religious Directives for Catholic Health Care Services (Directives). Our organization encourages individuals to apply their values in reaching a decision of conscience in matters of health.

ADVANTAGE Health Solutions includes primary care physicians (PCP), specialty care physicians (SCP), hospitals and other health care providers. Each provider is affiliated with a Provider Network (PN) or Physician Hospital Organization (PHO). All care is coordinated by your selected primary care physician, and to the extent possible, services are arranged and provided within your PCP’s affiliated network.

The first and most important decision each member must make is the selection of a PCP. The PCP you choose will be your primary health care provider. Your PCP is the key to the HMO Network because he/she is responsible for coordinating all of your health care needs. The PCP is committed to providing you with the most appropriate care to meet your medical needs. Your PCP should always be contacted first for your health care needs. Your PCP will arrange for you to be referred to a specialist when medically necessary. When your PCP authorizes your referral to a specialist, he/she will obtain a referral authorization number for you. The PCP will also arrange for any hospital stays which may be required.

Specialty providers are generally limited to those participating within your PCP's network. The Provider Directory lists specialists by type of practice and by affiliated network. If you want more information about us, call 1-800-553-8933 or write to ADVANTAGE Health Solutions Member Services, P.O. Box 80069, Indianapolis, Indiana 46280. You may also contact us by fax at (317) 573-2839 or visit our Web site at www.advantageplan.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. Members must select a Primary Care Physician within a 30-mile radius of their residence or where they work. This is where our providers practice. Our service area includes the following counties: Bartholomew (partial zip codes, 47201, 47202, 47203, 47226, 47246, 47280), Blackford, Benton, Boone, Brown, Carroll, Cass, Clay (partial zip codes 47833, 47834, 47837, 47840, 47841, 47846, 47853, 47857, 47881), Clinton, Decatur, Delaware, Elkhart, Fayette, Fountain, Fulton, Grant, Hamilton, Hancock, Hendricks, Henry, Howard, Jasper, Jay, Johnson, Kosciusko, LaPorte, LaGrange, Madison, Marion, Marshall, Miami, Monroe, Montgomery, Morgan, Newton, Owen, Parke, Pulaski, Putnam, Randolph, Rush, Shelby, St. Joseph, Starke, Tippecanoe, Tipton, Union, Wabash, Warren, Wayne, and White.

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

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

We have network providers:

Our HDHP offers services through many different networks. These are the same networks offered in the High Option plan. When you select a PCP, your PCP will refer you to his affiliated network providers. Contact us for the names of primary care physicians and to verify their continued participation. You can also go to our Web page, which you can reach through the FEHB Web site, www.opm.gov/insure. Contact ADVANTAGE Health Solutions at 1-800-553-8933 or log on to www.advantageplan.com to request a provider directory. Provider networks may be more extensive in some areas than others. We can not guarantee the availability of every specialty in all areas.

Section 2. How we change for 2008

Do not rely only on these change descriptions; this section 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.

Changes to this Plan:

- United States Postal Service non- law enforcement career employees may now be covered either by Postal Category 1 or Postal Category 2 premium rates. See page 103.

Changes to High Option Plan:

- Your share of the non-Postal premium will decrease for Self Only or decrease for Self and Family. See page 103.
- Decrease the primary care physician (PCP) office visit copay from \$15 per office visit to \$10 per office visit.
- Increase the specialty care physician (SCP) office visit copay from \$30 per office visit to \$35 per office visit.
- Change the maternity care copay from “\$15 primary care physician (PCP) / \$30 specialty care physician (SCP) per visit for first ten visits” to “a global fee of \$100 primary care physician (PCP) / \$350 specialty care physician (SCP). Fee is determined by who (PCP/SCP) delivers the baby.
- Add a \$150 copay instead of inclusion in PCP / SCP office visit copay for each of the following procedures:
 - MRI
 - CAT Scan
 - PET Scan
 - SPECT Scan
- Increase the copay for treatment therapies from “\$15 primary care physician (PCP) / \$30 specialty care physician (SCP) per visit” to “\$35 per visit.”
- Increase the copay for physical and occupational therapies from “\$15 primary care physician (PCP) / \$30 specialty care physician (SCP) per visit” to “\$35 per visit.”
- Decrease the speech therapy coverage from “up to three (3) months per condition” to “up to two (2) months per condition.”
- Increase the copay for home health services from “\$15 per visit” to “\$35 per visit.”
- Eliminate coverage for chiropractic care.
- Decrease the copay for Pervasive Developmental Disorder (PDD) care from “\$400 per admission, limited to two (2) copayments per member per calendar year” to “\$100 per day up to 5 days per admission.”
- Increase the copay for Pervasive Developmental Disorder (PDD) care from “\$100 per outpatient hospital visit” to “\$125 per outpatient hospital visit.”
- Pervasive Developmental Disorder (PDD) care is included in PCP / SCP office visit copay.
- Decrease the copay for inpatient hospital care, extended care / skilled nursing facility care from “\$400 per admission, limited to two (2) copayments per member per calendar year” to “\$100 per day up to 5 days per admission.”
- Increase the copay for outpatient hospital or ambulatory surgical center care from \$100 per visit to \$125 per visit.
- Increase the copay for mental health and substance abuse services from “nothing if you receive these services during your office visit, otherwise \$30 per visit” to “nothing if you receive these services during your office visit, otherwise \$35 per visit.”
- Decrease the copay for mental health and substance abuse services provided by a hospital or other facility from “\$400 per admission, limited to two (2) copayments per member per calendar year” to “\$100 per day up to 5 days per admission.”
- Increase the prescription drug retail copay from \$10 / \$30 / \$50 (Generic / Name Brand / Non-formulary) respectively to \$10 / \$40 / 50% up to a maximum \$100 (Generic / Name Brand / Non-formulary) respectively;

- A 3 month supply of maintenance prescription drugs obtained through mail order while enrolled in a disease management program will cost the same as the retail copay for medications used to treat the same disease;
- A 3 month supply of maintenance prescription drugs obtained through mail order while not enrolled in a disease management program will cost the equivalent of 2 retail copays.
- Change the copay for growth hormone and prescription biotech drugs (including chemotherapy drugs identified as such) from “\$125 per 30 day supply in addition to the office visit copay” to “a coinsurance of 20% of the usual, customary, and reasonable charge up to a maximum of \$2500 (no charge thereafter).”

Changes to High Deductible Health Plan (HDHP):

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. See page 103.
- Basic, Inc. will no longer manage the HSA and HRA components. Canopy Financial, Inc. will manage these functions. Fifth Third Bank will continue to be the fiduciary and Canopy Financial, Inc. will provide debit cards (through Fifth Third Processing Solutions) for HSA and HRA accounts.
- Decrease the speech therapy coverage from “up to three (3) months per condition” to “up to two (2) months per condition.”
- Eliminate coverage for chiropractic care.

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 electronic enrollment system (such as 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 1-800-553-8933 or write to us at ADVANTAGE Health Solutions, Inc. 9490 Priority Way, West Drive, Indianapolis, Indiana 46240. You may also request replacement cards through our Web site at www.advantageplan.com.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance and you will not have to file claims. Under the HDHP option you will need to satisfy the deductible.

- **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. The Plan’s Primary Care Physicians (PCPs) specialize in Family Practice, General Practice, Internal Medicine, and Pediatrics. The Plan’s Specialists are practitioners who have furthered their training in specific areas of health care such as cardiology, surgery, dermatology, and oncology. The Plan arranges access to a broad range of participating providers through contracting with provider networks who directly contract with PCPs, specialists, hospitals, and other facilities making up that provider network’s delivery system.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site. You may contact a Member Service Representative to obtain additional information about participating providers such as: method of compensation, ownership or interest in health care facilities, professional education, medical school and residency training, current board certification status, number of years in practice, and member satisfaction rates.

- **Plan facilities**

Plan facilities are hospital s 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 Web site. When you select a PCP, you agree to utilize the physician’s affiliated hospital or hospital services. When your physician authorizes inpatient or outpatient hospital services, you may contact us to obtain more information about the hospital, such as: hospital accreditation status, experience/volume in performing certain procedures, and comparable measures of quality and consumer satisfaction.

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 (PCP). This decision is important since your primary care physician provides or arranges for most of your health care. At the time of enrollment, you are given a Provider Directory to select your PCP.

The ADVANTAGE Health Solutions Provider Directory lists primary care physicians with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the ADVANTAGE Health Solutions Member Services Department at 1-800-553-8933. You can also find out if your doctor participates with ADVANTAGE Health Solutions by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates and is accepting new patients under this Plan. Note: When you enroll in ADVANTAGE Health Solutions, services (except for emergencies) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider cannot be guaranteed.

- **Primary care**

Your primary care physician can be a . 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 an Obstetrician/ Gynecologist, midwife or nurse practitioner affiliated with your PCP provider network for the woman's annual routine examination without a referral. All other specialty care must be referred and arranged by your PCP in advance. Your PCP will coordinate your total care and work directly with your specialist. When your PCP authorizes your referral to a specialist, he/she will obtain a referral authorization number for you. Please do not schedule an appointment with a specialist until you have been properly authorized to do so.

If your PCP determines that you require treatment for a covered health service that is not available in your PCP's network, he/she will refer you to an appropriate provider outside of the network. An out-of-network provider will only be allowed to collect from you the copayment amount listed in your benefit plan that you would be responsible to pay if the services had been provided by an in-network provider.

Here are some 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 and 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 program Plan; or
- Reduce our service area and you enroll in another FEHB Plan,

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

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

- **Hospital care** Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.
- **If you are hospitalized when your enrollment begins** We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-553-8933. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

How to get approval for...

- **Your hospital stay** Your Plan primary care physician, who coordinates your total care, will arrange your admission to a hospital in the provider network. Hospital care must be properly referred and authorized by your primary care physician for you to receive benefits.
- **How to precertify an admission** Check with your primary care physician to ensure that he/she has received precertification for your admission.
- **Maternity care** You do not need to precertify your normal delivery.

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process Precertification Review. Your physician must obtain Precertification for the following services: These services include but are not limited to:

- Diagnostic procedures such as CAT Scans and MRIs
- Elective hospital admissions
- Transplants
- Outpatient surgical procedures
- Bariatric surgery

The Precertification Review process is initiated by a physician referral to the appropriate medical management department (most of the Plan's provider networks are delegated medical management and Precertification Review). A Registered Nurse applying nationally accepted clinical guidelines and criteria performs the review. Any referral not meeting medical necessity guidelines is referred to a physician consultant. Only a licensed physician will render a denial of the referral and only after consultation with the requesting physician. All denial letters include the principal reason for denial, specific details regarding your appeal rights, and how to obtain a copy of the actual clinical guidelines used during the review process. Precertification Review determinations are made within two business days of receiving all necessary information unless the request is urgent. Urgent precertification requests are completed within one business day of receipt. If procedures requiring Precertification are not appropriately reviewed, the services may be denied for coverage and may result in nonpayment by the plan.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care.

Copayments A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: When you see your primary care physician you pay a copayment of \$15 per office visit and when you go in the hospital, you pay \$400 per admission.

Cost-sharing Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

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

- The calendar year deductible is \$1,550 per person under the HDHP. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$3,100 under the HDHP.

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

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

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

Example: In our Plan, you pay 50% of our allowance for durable medical equipment.

Your catastrophic protection out-of-pocket maximum After your (copayments and coinsurance) total \$4,050 per person or \$8,100 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 catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

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

Carryover If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indiana Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

Section 5. High Option Benefits

See page 9 for how our benefits changed this year. Page 101 is a benefits summary of the high option plan. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Summary of benefits for the ADVANTAGE High Option - 2008101

Section 5. High Option Benefits Overview

This Plan offers a High Option Plan. The High Option benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

High Option Section 5, which describes the High Option benefits, is divided into subsections. Please read *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 claim forms, claims filing advice, or more information about High Option benefits, contact us at 1-800-553-8933 or at our Web site at www.advantageplan.com.

When you elect the High Option you are electing a plan with no deductible. Most services require that you pay a copayment or a coinsurance amount.

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

Important things you should 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.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- We have no deductible for the High Option.
- 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.

Benefit Description	You pay
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>	
Diagnostic and treatment services	High Option
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office 	\$10 per visit to your primary care physician \$35 per visit to a specialty care physician
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultation • Second surgical opinion 	Nothing
At home (within the service area)	\$35 per visit
Lab, X-ray and other diagnostic tests	High Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-Rays • Non-routine Mammograms • Ultrasound • Electrocardiogram and EEG 	Nothing, included in PCP/SCP office visit copay
Tests, such as: <ul style="list-style-type: none"> • MRI • CAT Scan • PET Scan • SPECT Scan 	\$150 copay

Benefit Description	You pay
<p>Preventive care, adult</p> <p>Routine physical every 12 months which includes:</p> <p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 <p>Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older</p> <p>Routine pap test</p> <p>Note: You do not pay a separate copay for a Pap test performed during your routine annual physical; see <i>Diagnostic and treatment services</i>, above.</p> <p>Routine mammogram – covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years <p>Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):</p> <p>Annual eye refraction for all ages</p>	<p>High Option</p> <p>\$10 per office visit</p>
<p><i>Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i></p>	<p><i>All charges.</i></p>
<p>Preventive care, children</p> <ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: <ul style="list-style-type: none"> - Eye exams through age 17 to determine the need for vision correction - Ear exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22) 	<p>High Option</p> <p>\$10 per office visit</p>

Benefit Description	You pay
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery • 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. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits - Section 5(c) and Surgery benefits - Section 5(b). 	<p>High Option</p> <p>Global fee of \$100 primary care physician (PCP) / Global fee of \$350 specialty care physician (SCP)</p>
<i>Not covered: Routine sonograms to determine fetal age, size, or sex</i>	<i>All charges</i>
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>50% of actual charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling</i> 	<i>All charges</i>
Infertility services	
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) 	<p>50% of actual charges for each procedure</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • Assisted reproductive technology (ART) procedures, such as: • in vitro fertilization • embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT) 	<i>All charges</i>

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	High Option
<ul style="list-style-type: none"> • Services and supplies related to ART procedures • Injectable or oral fertility drugs • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<i>All charges</i>
Allergy care	High Option
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	Nothing, included in PCP/SCP office visit copay
Allergy Serum	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Provocative food testing and sublingual allergy desensitization</i> 	<i>All charges</i>
Treatment therapies	High Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 29.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy 	\$35 per visit
Physical and occupational therapies	High Option
<p>Up to two (2) consecutive months per condition for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>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.</p> <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to a three (3) month period.</p>	<p>\$35 per office visit</p> <p>Nothing per visit during covered inpatient admission</p>
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<i>All charges</i>
Speech therapy	High Option
Up to two (2) months per condition for the services of speech therapists	50% of actual charges

Benefit Description	You pay
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17, which include; (see <i>Preventive care, children</i>) 	Nothing, included in PCP/SCP office visit copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> • <i>Hearing aids, testing and examinations for them</i> 	<i>All charges</i>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Eye exam to determine the need for vision correction for children through age 17 (see <i>Preventive care, children</i>) • Annual eye refractions for all ages <p>Note: See <i>Preventive care, children</i> for eye exams for children.</p>	Nothing, included in PCP/SCP office visit copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses, except as shown above</i> • <i>Eye exercises and orthotics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges.</i>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	Nothing, included in PCP/SCP office visit copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<i>All charges</i>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	50% of the charges
<p><i>Not covered:</i></p>	<i>All charges</i>

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	High Option
<ul style="list-style-type: none"> • Orthopedic and corrective shoes • Arch supports • Foot orthotics • Heel pads and heel cups • Lumbosacral supports • Corsets, trusses, elastic stockings, support hose, and other supportive devices • Prosthetic replacements provided less than two (2) years after the last one we covered 	All charges
Durable medical equipment (DME)	High Option
<p>We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. <p>Note: Call your Plan physician who will prescribe this equipment and direct you to a contracted supplier.</p>	50% of the charges
<p>Not covered:</p> <ul style="list-style-type: none"> • Motorized wheelchairs; • Swimming pools and spas; • Exercise equipment; • Repair of DME when malfunction is directly a result of misuse or neglect 	All charges
Home health services	High Option
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. • Transparenteral Therapy (TPN) • Sleep Apnea Studies • Ventilator Management • Wound Care 	\$35 per visit

Home health services - continued on next page

Benefit Description	You pay
Home health services (cont.)	High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Nursing care requested by, or for the convenience of, the patient or the patient's family; • Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative. 	All charges
Chiropractic	High Option
No benefits	All Charges
Alternative treatments	High Option
No benefits	All charges
Educational classes and programs	High Option
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Smoking Cessation – if enrolled in an approved smoking cessation program. Approved prescription drugs are subject to the prescription copay. • Diabetes self management • Asthma disease management • Congestive Heart Failure • CAD (Coronary Artery Disease) • Hypertension/Cardiovascular Disease • Weight Managment • Prenatal <p>Note: You may call our health education department at (877) 901-2237 ext. 2245 for a list of approved classes.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Over-the-counter smoking cessation aids • More than one (1) smoking cessation class per calendar year and more than three (3) classes per lifetime. 	All charges
Pervasive Developmental Disorder (PDD)	High Option
<p>Pervasive Developmental Disorder is defined as a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.</p> <p>Benefits for Pervasive Developmental Disorder include but are not limited to:</p> <ul style="list-style-type: none"> • Evaluation and Testing to confirm diagnosis • Physical, speech, occupational therapy • Dietary evaluation <p>Benefits are limited to treatment that is prescribed by a physician in accordance with the patient's treatment plan. No other exclusions or limitations in this brochure that conflict with this benefit apply.</p>	<p>Nothing, included in PCP/SCP office visit copay</p> <p>\$100 per day up to 5 days per admission</p> <p>\$125 per outpatient visit (facility charge)</p>

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay
<p>Surgical procedures</p>	<p>High Option</p>
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • Treatment of burns • Surgical treatment of morbid obesity (Bariatric Surgery) <p>A condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; has a body mass index (BMI) over 40 kilograms/meters²; or has a BMI over 35 or over kilograms/meters² and a high risk co-morbid condition. In addition the eligible members must be age 18 or over, failed to lose a significant amount of weight or has regained weight despite compliance with a medically supervised, multidisciplinary, non-surgical program including low calorie or very low calorie diet, supervised exercise, behavioral modification and support and treatment of co-morbid condition; does not have a correctable cause for obesity; and is being treated in a surgical program with experience in obesity surgery including but not only surgeons, but also a multidisciplinary team including all of the following:</p>	<p>Nothing, included in PCP/SCP office visit copay</p> <p>Nothing for inpatient or outpatient hospital procedures; See Section 5(c) for facility copay</p>

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	High Option
<ul style="list-style-type: none"> - Preoperative medical and approval (See <i>Services requiring our prior approval</i> in Section 3) - Psychiatric consultation and approval (See <i>Services requiring our prior approval</i> in Section 3) - Nutritional counseling - Psychological counseling - Support group meetings <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>Nothing, included in PCP/SCP office visit copay</p> <p>Nothing for inpatient or outpatient hospital procedures; See Section 5(c) for facility copay</p>
Voluntary sterilization (e.g., Tubal ligation, Vasectomy)	50% of the charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<i>All Charges</i>
Reconstructive surgery	High Option
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member’s appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>Included in PCP/SCP office visit copay</p> <p>Nothing for inpatient or outpatient hospital procedures; See Section 5(c) for facility copay</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> • <i>Surgical procedures for body fat reduction, such as liposuction</i> 	<i>All Charges</i>

Benefit Description	You pay
Oral and maxillofacial surgery	High Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • Treatment of TMJ, including surgical and non-surgical intervention, corrective orthopedic appliance and physical therapy. 	<p>Nothing, included in PCP/SCP office visit copay</p> <p>Nothing for inpatient or outpatient hospital procedures; See Section 5(c) for facility copay</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<p><i>All charges</i></p>
Organ/tissue transplants	High Option
<p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	<p>Nothing for inpatient or outpatient hospital procedures; See Section 5(c) for facility copay</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia 	<p>Nothing for inpatient or outpatient hospital procedures; See Section 5(c) for facility copay</p>

Organ/tissue transplants - continued on next page
High Option Section 5(b)

Benefit Description	You pay
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myeleogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) <p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced Neuroblastoma • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Amyloidosis <p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols for:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • National Transplant Program (NTP) - <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>High Option</p> <p>Nothing for inpatient or outpatient hospital procedures; See Section 5(c) for facility copay</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<p><i>All Charges</i></p>

Benefit Description	You pay
Anesthesia	High Option
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	Nothing, included in PCP/SCP office visit copay Nothing for outpatient hospital procedures; See Section 5(c) for facility copay

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

Important things you should 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, and you must be hospitalized in a Plan facility.
- We have no calendar year deductible for the High Option Plan.
- 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 in Sections 5(b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Inpatient hospital	High Option
<p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p> <p>When your Plan physician determines it is medically necessary, the physician may prescribe private accommodations or private duty nursing care.</p>	\$100 per day up to 5 days per admission
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> 	<i>All Charges</i>

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	High Option
<ul style="list-style-type: none"> • <i>Take-home prescription drugs</i> • <i>Hospitalization for dental procedures</i> 	<i>All Charges</i>
Outpatient hospital or ambulatory surgical center	High Option
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma , if not donated or replaced • Pre-surgical testing and services • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	\$125 per visit
Extended care benefits/Skilled nursing care facility benefits	High Option
<p>Extended care benefit: Up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate and determined by your plan physician and approved by the Plan.</p> <ul style="list-style-type: none"> • Bed, board, and general nursing care; • Drugs, biologicals, supplies, equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by the Plan physician 	\$100 per day up to 5 days per admission
<p>Not covered:</p> <ul style="list-style-type: none"> • Custodial care, rest cures, domiciliary or convalescent care or homemaker services; • Personal comfort items such as telephone or television 	<i>All Charges.</i>
Hospice care	High Option
<p>Provided for a terminally ill member in accordance with a treatment plan developed before admission to the Hospice Care Program. The treatment plan must be approved by ADVANTAGE Health Solutions or its designated agent.</p> <p>Note: Limited to services provided under the direction of a Plan physician who certifies the patient is in the terminal stage of illness with a life expectancy of approximately six months or less.</p>	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All Charges</i>

Benefit Description	You pay
Ambulance	High Option
Local professional ambulance service when medically appropriate	20% of actual charges

Section 5(d). Emergency services/accidents

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.
- We have no calendar year deductible for the High Option Plan.
- 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.

What is a medical emergency?

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

What to do in case of emergency:

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

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in a non-Plan facility and a Plan doctor believes care can be better provided in a Plan facility, 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 physician must be approved by your Plan physician with a prior referral.

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, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan physician believes care can be better provided in a Plan facility, 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 an emergency room physician must be approved by the Plan or provided by a Plan physician.

If you are required to pay for services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims process described on page 85.

Benefit Description	You pay
Emergency within and outside our service area	High Option
Emergency care at a doctor's office	Nothing, included in PCP/SCP office visit copay
Emergency care at an urgent care center	\$50 per visit
Emergency care as an outpatient at a hospital, including doctor's services	\$125 per visit; waived if admitted
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> 	<i>All Charges</i>
Ambulance	High Option
<p>Professional ambulance service when medically appropriate; includes air ambulance services when medically appropriate.</p> <p>Note: See 5(c) for non-emergency service.</p>	20% of actual charges

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

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

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.
- We have no calendar year deductible for the High Option Plan.
- 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 FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay
Mental health and substance abuse benefits	High Option
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management • Diagnostic tests 	Nothing if you receive these services during your office visit; otherwise \$35 per visit.
<ul style="list-style-type: none"> • 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 	\$100 per day up to 5 days per admission
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All charges</i>
Preauthorization	To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:

	<ul style="list-style-type: none"> • Mental Health and Substance Abuse services do not require an authorization from your primary care physician and may be obtained on self-referral basis. However, the contracting ADVANTAGE providers available to you will depend on the primary care physician you have selected. The Mental Health and Substance Abuse Service 24-hour access phone number is listed on the bottom of your ADVANTAGE Health Solutions Member ID Card. Inpatient and Outpatient treatment plans require authorization from a Mental Health and Substance Abuse Plan physician. • If you would like more information about your Mental Health and Substance Abuse benefits, please contact an ADVANTAGE Health Solutions Member Service Representative for assistance.
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f). Prescription drug benefits

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.
- 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.
- We have no calendar year deductible for the High Option Plan.
- 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.

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

- **Who can write your prescription?** A licensed physician must write the prescription.
- **Where can you obtain them?** You must fill the prescription at a plan pharmacy or by mail for a maintenance medication.

We use a formulary. A formulary is a list of generic and brand-name prescription medications that have been approved by the Food and Drug Administration (FDA). ADVANTAGE Health Solutions has a team of physicians and pharmacists who meet regularly throughout the year to review and update that list. It includes medications for most conditions treated outside the hospital. Your physician can use the list to select medications that are appropriate to meet your healthcare needs while helping you maximize your prescription drug benefit.

We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 1-800-553-8933.

Your health plan/employer has chosen a prescription drug program that has three different co-pay levels. This program allows you to pay a lower copay for covered drugs that are on the formulary. We cover Non-Formulary drugs prescribed by a Plan doctor but at a higher copay. Step Therapy may apply to new prescriptions, usually Non-Formulary; Step Therapy means the plan requires you to have used a certain medication in the past before another (second line) medication will be allowed.

If a prescription for a Non-Formulary medication is written, the pharmacist will receive an on-line message at the pharmacy. The pharmacist should contact the physician to request a change to a formulary product. If the physician is unwilling to change or is unavailable, the pharmacist will dispense the prescription as written. Patients will be required to pay a higher copay when a Non-Formulary product is dispensed. This policy will reflect the patient's prescription drug benefit.

- **These are the dispensing limitations.** Prescription drugs prescribed by a plan or referral doctor and obtained at a plan pharmacy will be dispensed up to a 30-day supply; or one commercially prepared unit (i.e. one inhaler, one vial ophthalmic medication or insulin). You pay a \$10 copay per prescription unit or refill for Generic Formulary drugs or a \$40 copay per prescription unit or refill for Brand-Name Formulary drugs when generic substitution is not available. You pay a 50% (up to a maximum of \$100) for Non-Formulary drugs. When generic substitution is available, but you request the name brand drug or non-formulary drug, you pay the price difference and the required copay per prescription unit or refill as written. You will always pay the appropriate copayment or the actual cost of the drug, whichever is less.
- If your physician orders more than a 30 day supply of covered drugs, up to a 90 day supply, mail service is available. Initially you request your prescription information by completing a PharmaCare Mailer and enclosing your original written prescription. You may also reach PharmaCare (www.pharmacare.com) by calling 1-800-346-9113. If you are currently taking a medication, you must call your physician's office and request a new prescription for the maximum day supply. You pay a \$20 copay per Generic Formulary, a \$80 copay per name Brand-Name Formulary (when generic is not available), and 50% (up to a maximum of \$200) for Non-Formulary for up to a 90 day supply. When generic substitution is available, but you request the name brand or non-formulary drug, you pay the price difference and the required copay. Plan members called to active military duty or in time of national emergency who need to obtain prescribed medication should call our Member Services department at 1-800-553-8933.

PharmaCare's system incorporates on-line drug reviews at the point of dispensing medications. Elements reviewed include, Drug-Drug Interaction, Refill Too Soon, Therapeutic Duplication, Duplication of Therapy, Over Dosage and Under Dosage.

A generic equivalent will be dispensed if it is available unless your physician specifically requires a name brand. If you receive a name brand drug when a federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic in addition to the copay amount.

- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.

You can save money by using generic drugs. However, you and your physician have the option to request a name-brand if a generic option is available. Using the most cost-effective medication saves money.

The prescription drug mail order benefit will allow a 3 month supply of maintenance medication for the 30 day retail supply copay of \$10 / \$40 / 50% (up to a maximum of \$100) (Generic Formulary/Brand-name Formulary/Non-formulary respectively) if the member enrolls in one of the following applicable disease management programs: asthma, diabetes, congestive heart failure, hypertension/cardiovascular disease, or depression. This applies only to those medications specifically used to treat those conditions or diseases.

- **When you do have to file a claim.** You will not be required to file claims with this plan.

Benefit Description	You pay
Covered medications and supplies	High Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (sometimes called lifestyle drugs) are limited. Contact the Plan for dose limitations, such as Viagra quantity limited to six (6) tabs/month • Oral and injectable contraceptive drugs and devices • Glucose test strips and lancets 	<p>\$10 per Generic Formulary</p> <p>\$40 per Brand-Name Formulary</p> <p>50% (up to a maximum of \$100) per Non-Formulary</p> <p>50% coinsurance for drugs used to treat sexual dysfunction (sometimes called lifestyle drugs)</p> <p>50% of charges for glucose test strips and lancets</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p> <p>If enrolled in the disease management program, the copay for a 3-month supply of mail order maintenance medications used to treat that same disease is:</p> <p>\$10 per Generic Formulary</p> <p>\$40 per Brand-Name Formulary</p> <p>50% (up to a maximum of \$100) per Non-Formulary</p> <p>If not enrolled in the disease management program, the copay for a 3-month supply of prescription mail order maintenance medications is:</p> <p>\$20 per Generic Formulary</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	High Option
	<p>\$80 per Brand-Name Formulary</p> <p>50% (up to a maximum of \$200) per Non-Formulary</p> <p><i>You must enroll each year after your plan effective date in January. Call (877) 901-2237 ext. 2425 to re-enroll.</i></p>
<p>Advanced Technology Drugs or Biopharmaceutical Drugs including (including chemotherapy drugs identified as such) and growth hormones.</p> <p>Biopharmaceutical drugs means a virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, an allergenic product, or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic Compound), applicable to the prevention, treatment, or cure of a disease or condition of human beings. Biological or biopharmaceutical products typically represent significant advancement in the treatment, diagnosis and prevention of disease or condition and often may be addressing an unmet need. Additionally, these products often require direct physician involvement, and significant member education. These services must be authorized by ADVANTAGE. Coinsurance applies to drugs dispensed up to a 30 day supply.</p> <p>Note: – We only cover GHT when we preauthorize the treatment. Call your Plan physician for preauthorization. GHT must be medically necessary, and authorized by your Plan physician before you begin treatment. If you do not obtain authorization or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See Services requiring our prior approval in Section 3.</p>	<p>20% up to \$2,500 maximum per calendar year (no charge thereafter)</p>
<p>Not covered</p> <ul style="list-style-type: none"> • Drugs and supplies for cosmetic purposes • Drugs to enhance athletic performance • Fertility drugs • Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies • Vitamins, nutrients and food supplements even if a physician prescribes or administers them • Nonprescription medicines 	<p><i>All Charges</i></p>

Section 5(g). Dental benefits

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
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- In order to maximize your benefits and eliminate the need to file your own claims, members are encouraged to seek care through a participating plan dentist.
- We have no calendar year deductible for the High Option Plan.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. 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.

Benefit Description	You Pay
Accidental injury benefit	High Option
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	\$30 per office visit
Dental benefits	High Option
<p>Preventive and Diagnostic Dental benefits limited to the following:</p> <ul style="list-style-type: none"> • Dental prophylaxis – limited to two per calendar with six month interval • Oral examinations are covered as a separate benefit only if no other service was provided during the visit other than X-rays. Limited to two (2) times per calendar year, limited to one (1) time every six (6) months. • Complete series or panorex radiographs are limited to one (1) time per 36 months. • Bitewing radiographs are limited to one (1) series of films per calendar year. • Extraoral Radiographs are limited to two (2) films per calendar year. • Diagnostic casts are limited to one (1) time per 24 months. • Fluoride treatments are limited to Covered Persons under the age of 16 years, and limited to two (2) times per calendar year. Treatment should be done in conjunction with dental prophylaxis. • Sealants are limited to Covered Persons under the age of 16 years and once per first or second permanent molar every five (5) years. <p>The Plan pays up to \$300 per member per calendar year.</p>	20% of the maximum allowable charge (MAC)

Dental benefits - continued on next page

Benefit Description	You Pay
Dental benefits (cont.)	High Option
<p>The plan provides the same comprehensive level of benefits whether a member seeks care through a participating dental provider or seeks care through a non-participating provider. However, if a member seeks care through a non-participating provider, the provider may require the member to submit the claim and the member could receive a bill from the non-participating provider if the provider's charges exceed the Maximum Allowable Charge (MAC).</p>	<p>20% of the maximum allowable charge (MAC)</p>

Section 5(h). Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services for deaf and hearing impaired	Toll Free: 1-800-743-3333
Disease Management	<p>We offer the following CareADVANTAGE programs (disease management programs):</p> <p><i>Call (877) 901-2237 ext 2425 Monday through Friday from 8 am until 5:30 pm year-round to enroll.</i></p> <ul style="list-style-type: none"> • Asthma • Congestive Heart Failure • Diabetes • Hypertension • Migraines • Prenatal
Online member service	<p>Online features that are no available on ADVANTAGE-<i>connect</i> are:</p> <ul style="list-style-type: none"> • Change PCP • Request an ID Card • Check Benefits • Change Demographic Information • Request Member Materials • View Claims
Vision	20% discount on frames, lens and contact lenses at participating vision providers. No discount on disposable contact lenses.
Fitness Clubs	<p>Members are eligible for health club membership discounts at participating fitness clubs throughout Indiana.</p> <p><i>* Please call (800) 553-8933 for more specific information and to verify the fitness clubs are still offering discounts at the time of interest.</i></p>

Section 5. High Deductible Health Plan Benefits

See page 9 for how our benefits changed this year. Page 102 is a benefits summary of the High Deductible Health Plan. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. High Deductible Health Plan Benefits Overview

This Plan offers a High Deductible Health Plan (HDHP). The HDHP benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read *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 claim forms, claims filing advice, or more information about HDHP benefits, contact us at 1-800-553-8933 or at our Web site at www.advantageplan.com.

Our High Deductible Health Plan (HDHP) Plan option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater flexibility over how you use your health care benefits.

When you enroll in this HDHP option, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility. Your full annual HRA credit will be available on your effective date of enrollment.

With this Plan, preventive care is covered up to \$500 per person per year with a \$15 copay per office visit. As you receive other non-preventive medical care, you must meet the Plan’s deductible before we pay benefits according to the benefit chart on page 102. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

This HDHP includes five key components: preventive care; network health care that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

- **Preventive care** The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs, obesity weight loss programs, disease management and wellness programs. These services are covered at 100% up to \$500 per person per year if you use a network provider and the services are described in Section 5 Preventive care. You do not have to meet the deductible before using these services.

- **Traditional medical coverage** After you have paid the Plan’s deductible, we pay benefits under traditional medical coverage described in Section 5. The Plan typically pays 80% for in-network care.

Covered services include:

 - Medical services and supplies provided by physicians and other health care professionals
 - Surgical and anesthesia services provided by physicians and other health care professionals
 - Hospital services; other facility or ambulance services
 - Emergency services/accidents
 - Mental health and substance abuse benefits
 - Prescription drug benefits
 - Dental benefits.

- **Savings** Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see Section 5 Savings for more details).

Health Savings Accounts (HSA)

By law, HSAs are available to members who are not eligible for Medicare or do not have other health insurance coverage. In 2008, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$66.66 per month for a Self-Only enrollment or \$133.33 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is \$3,100 for Self and Family. See maximum contribution information on page 47. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

HSA features include:

- Your HSA is administered by Canopy Financial.
- Your contributions to the HSA are tax deductible
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
- Your HSA earns tax-free interest
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents. (See IRS publication 502 for a complete list of eligible expenses.)
- Your unused HSA funds and interest accumulate from year to year
- It's portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- When you need it, funds up to the actual HSA balance are available.

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a HCFSA health care flexible spending account (such as FSAFEDS offers – see Section 12), this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you.

Health Reimbursement Arrangements (HRA)

If you aren't eligible for an HSA, for example you are enrolled in Medicare or have another health plan, we will administer an HRA instead. You must notify us that you are ineligible for an HSA.

In 2008, we will give you an HRA credit of \$66.66 per month for a Self-Only enrollment and \$133.33 per month Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by Canopy Financial.
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP

- Unused credits carryover from year to year
- HRA credit does not earn interest
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements. *See Who is eligible to enroll?* in Section 12 under The Federal Flexible Spending Account Program – *FSAFEDS*.

• **Catastrophic protection for out-of-pocket expenses**

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to \$4,050 for Self-Only or \$8,100 for Self and Family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s allowable amount or benefit maximum). Refer to Section 4 *Your catastrophic protection out-of-pocket maximum* and HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.

• **Health education resources and account management tools**

Section 5(i) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

Log onto www.advantageplan.com for information about our disease management programs and wellness programs. You can also contact a Member Services Representative for more information at 1-800-553-8933.

Log onto www.advantageplan.com for information about your HSA account and online banking. This website also provides answers to most frequently asked questions for HSA accounts.

Log onto www.advantageplan.com for information about your HRA account.

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	<p>The Plan will establish an HSA for you with Canopy Financial (the record keeper).</p> <p><i>Record keeper:</i> Canopy Financial, Inc. 230 W. Monroe St. Suite 2300 Chicago, IL 60606</p> <p><i>Fiduciary:</i> Fifth Third Bank 38 Fountain Square Plaza Cincinnati, OH 45202</p>	<p>The Plan will establish an HRA for you with Canopy Financial (the record keeper).</p> <p><i>Record keeper:</i> Canopy Financial, Inc. 230 W. Monroe St. Suite 2300 Chicago, IL 60606</p> <p><i>Fiduciary:</i> Fifth Third 38 Fountain Square Plaza Cincinnati, OH 45202</p>
Fees	<p>Set-up fee is paid by the HDHP</p> <p>Debit card: \$2 issuance fee (add'l card: \$2)</p> <p>Debit card monthly fee: \$.35 / issued card</p> <p>Non-Sufficient Funds / instance: \$25</p> <p>Incorrect Payee Designation / instance: \$25</p> <p>Investment Account: \$1.25 / account</p> <p>Investment Recordkeeping Fee: 10 bps / qtr</p> <p>Per fund transaction fee: \$3.50</p>	<p>Set-up fee is paid by the HDHP</p> <p>Debit card: \$2 issuance fee (add'l card: \$2)</p> <p>Debit card monthly fee: \$.35 / issued card</p> <p>Non-Sufficient Funds / instance: \$25</p> <p>Incorrect Payee Designation / instance: \$25</p> <p>Investment Account: \$1.25 / account</p> <p>Investment Recordkeeping Fee: 10 bps / qtr</p> <p>Per fund transaction fee: \$3.50</p>
Eligibility	<p>You must:</p> <ul style="list-style-type: none"> • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's tax return • Not have received VA benefits in the last three months • Complete and return all banking paperwork 	<p>You must enroll in this HDHP</p> <p>Eligibility for contributions is determined on the first day of the month following your effective date of enrollment and will be prorated for length of enrollment.</p>
Funding	<p>If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP.</p>	<p>Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon enrollment.</p>

	In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).	
• Self Only enrollment	For 2008, a monthly premium pass through of \$66.66 will be made by the HDHP directly into your HSA each month.	For 2008, your HRA annual credit is \$800 (prorated for mid-year enrollment).
• Self and Family enrollment	For 2008, a monthly premium pass through of \$133.33 will be made by the HDHP directly into your HSA each month.	For 2008, your HRA annual credit is \$1,600 (prorated for mid-year enrollment).
Contributions/credits	<p>The maximum that can be contributed to your HSA is an annual contribution of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of \$2,900 for an individual and \$5,800 for a family.</p> <p>If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution.</p> <p>You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year.</p> <p>If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.</p> <p>You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP.)</p> <p>HSAs earn tax-free interest (does not affect your annual maximum contribution).</p>	The full HRA credit will be available subject to proration, on the effective date of enrollment. The HRA does not earn interest.

	Catch-up contribution discussed on page 54.	
• Self Only enrollment	You may make an annual maximum contribution of \$750.	You cannot contribute to the HRA.
• Self and Family enrollment	You may make an annual maximum contribution of \$1,500	You cannot contribute to the HRA.
Access funds	<p>You can access your HSA by the following methods:</p> <ul style="list-style-type: none"> • HealthDirectSM - Canopy's online platform • Debit Cards • Customer Service Representatives 	<p>For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through the HDHP. For expenses not covered by the HDHP, such as orthodontia, a reimbursement form will be sent to you upon your request.</p> <p>You can access your HRA by the following methods:</p> <ul style="list-style-type: none"> • HealthDirectSM - Canopy's online platform • Debit Cards • Customer Service Representatives
Distributions/withdrawals • Medical	<p>You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses, including over-the-counter drugs.</p>	<p>You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP.</p> <p>Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan.</p> <p>See <i>Availability of funds</i> below for information on when funds are available in the HRA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses. Over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.</p>
• Non-medical	<p>If you are under age 65, withdrawal of funds for non-medical expenses will create a 10% income tax penalty in addition to any other income taxes you may owe on the accumulated funds.</p> <p>When you turn age 65, distributions can be used for any reason without being subject to the 10% penalty, however they will be subject to ordinary income tax.</p>	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.
Availability of funds	Funds are not available until all the following steps are completed:	The entire amount of your HRA will be available to you upon your enrollment in the HDHP.

	<ul style="list-style-type: none"> • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change) • The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA • The fiduciary sends out HSA paperwork for the enrollee to complete and the fiduciary receives the completed paperwork. 	
Account owner	FEHB enrollee	HDHP
Portable	<p>Yes, you can take this account with you when you separate or retire.</p> <p>If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 50 for HSA eligibility.</p>	<p>If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA.</p> <p>If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.</p>
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If you have an HSA

- **Contributions**

All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or you may make lump sum contributions at any time, in any amount not exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

If you newly enroll in an HDHP during Open Season and your effective date is January 1st or you otherwise have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet the requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

- **Catch-up contributions**

If you are age 55 or older, the IRS permits you to make additional “catch-up” contributions to your HSA. In 2008, you may contribute up to \$900 in catch-up contributions. The allowable catch-up contribution will be \$1,000 in 2009 and beyond. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury Web site at www.ustreas.gov/offices/public-affairs/hsa/.

- **If you die**

If you do not have a named beneficiary, if you are married, it becomes your spouse’s HSA; otherwise, it becomes part of your taxable estate.

- **Qualified expenses**

You can pay for “qualified medical expenses,” as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, over-the-counter drugs, LASIK surgery, and some nursing services.

When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS Web site at www.irs.gov and click on “Forms and Publications.” Note: Although over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

- **Non-qualified expenses**

You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.

- **Tracking your HSA balance**

You will receive a periodic statement that shows the “premium pass through”, withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.

- **Minimum reimbursements from your HSA**

There is no minimum reimbursement amount on your HSA.

If you have an HRA

- **Why an HRA is established**

If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.

- **How an HRA differs**

Please review the chart on page 50 which details the differences between an HRA and an HSA. The major differences are:

- You cannot make contributions to an HRA
- Funds are forfeited if you leave the HDHP
- An HRA does not earn interest, and
- HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include 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.

Section 5. Preventive care

Important things you should keep in mind about these benefits:

- Preventive care services listed in this Section are not subject to the deductible. You only owe your copay for covered preventive care services.
- You must use providers that are part of our network. Preventive care is covered at 100% up to \$500 per person in a calendar year when you use network providers.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the deductible.*

Benefit Description	You pay HDHP
Preventive care, adult	HDHP
<ul style="list-style-type: none"> • Routine screenings, such as: • Blood tests • Urinalysis • Total Blood Cholesterol • Routine physical exam which include: <ul style="list-style-type: none"> - One exam every 24 months up to age 65 - One exam every 12 months age 65 and older • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 • Annual eye refraction for all ages • Routine annual digital rectal exam (DRE) for men age 40 and older • Routine Prostate Specific Antigen (PSA) test - one annually for men age 40 and older • Routine well-woman exam including Pap test, one visit every 12 months from last date of service <p>Note: You do not pay separate copay for a Pap test performed during your routine annual physical.</p> <ul style="list-style-type: none"> • Routine mammogram - covered for women age 35 and older, as follows: <ul style="list-style-type: none"> - From age 35 through 39, one during this five year period - From age 40 through 64, one every calendar year - At age 65 and older, one every two consecutive calendar years • Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): 	\$15 per office visit; <i>No deductible applies</i>
Maternity care - prenatal care	\$15 primary care physician (PCP) / \$30 specialty care physician (SCP) per visit; <i>No deductible applies</i>
Not covered:	<i>All Charges</i>

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	HDHP
<ul style="list-style-type: none"> • Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel. • Routine sonograms to determine fetal age, size, or sex 	<i>All Charges</i>
Preventive care, children	HDHP
<p>Professional services, such as:</p> <ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: <ul style="list-style-type: none"> - Eye exams through age 17 to determine the need for vision correction - Hearing exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22) 	\$15 per office visit; <i>No deductible applies</i>
Dental Preventive Care	HDHP
<p>Preventive care limited to:</p> <ul style="list-style-type: none"> • Dental prophylaxis – limited to two per calendar with six month interval • Oral examinations are covered as a separate benefit only if no other service was provided during the visit other than X-rays. Limited to two (2) times per calendar year, limited to one (1) time every six (6) months. • Complete series or panorex radiographs are limited to one (1) time per 36 months. • Bitewing radiographs are limited to one (1) series of films per calendar year. • Extraoral Radiographs are limited to two (2) films per calendar year. • Diagnostic casts are limited to one (1) time per 24 months. • Fluoride treatments are limited to Covered Persons under the age of 16 years, and limited to two (2) times per calendar year. Treatment should be done in conjunction with dental prophylaxis. • Sealants are limited to Covered Persons under the age of 16 years and once per first or second permanent molar every five (5) years. <p>The Plan pays up to \$300 per member per calendar year.</p> <p>The plan provides the same comprehensive level of benefits whether a member seeks care through a participating dental provider or seeks care through a non-participating provider. However, if a member seeks care through a non-participating provider, the provider may require the member to submit the claim and the member could receive a bill from the non-participating provider if the provider's charges exceed the Maximum Allowable Charge (MAC).</p>	<p>20% of the maximum allowable charge (MAC);</p> <p><i>No deductible applies</i></p>

Section 5. Traditional medical coverage subject to the deductible

Important things you should 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.
- In-network preventive care is covered at the PCP / SCP copay (see page 55 &56) up to the annual limit and is not subject to the calendar year deductible. After the annual limit on in-network preventive care has been reached, additional preventive care is covered under Traditional medical coverage subject to the deductible.
- The deductible is \$1,550 per person or \$3,100 per family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your coinsurance and copayments for covered expenses.
- When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments and deductibles total \$4,050 per person or \$8,100 per family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum
- 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.

Benefit Description	You pay After the calendar year deductible...
Deductible before Traditional medical coverage begins	HDHP
The deductible applies to almost all benefits in this Section. In the You pay column, we say “No deductible applies” when it does not apply. When you receive covered services from network provider, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of \$1,550 per person or \$3,100 per family enrollment
After you meet the deductible, we pay the allowable charges (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum	After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA or HRA, or you can pay for them out-of-pocket.

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

Important things you should 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.
- The deductible is \$1,550 for Self Only enrollment and \$3,100 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- 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.

Benefit Description	You pay After the calendar year deductible...
Diagnostic and treatment services	HDHP
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion At home (within the service area)	20% of the charges
Lab, X-ray and other diagnostic tests	HDHP
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	20% of the charges

Benefit Description	You pay After the calendar year deductible...
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery • 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. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See <i>Hospitalbenefits</i>– (Section 5c) and <i>Surgerybenefits</i> (Section 5b). 	<p>HDHP</p> <p>20% of the charges</p>
Family planning	
<p>No benefit offered</p>	<p>HDHP</p> <p><i>All charges</i></p>
Infertility services	
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intrauterine insemination (IUI) <p>Coverage for the above procedure shall be available only if:</p> <ul style="list-style-type: none"> • You have not undergone four completed Oocyte Retrievals, except that if a live birth follows a completed Oocyte Retrieval, then there is coverage for two more completed Oocyte Retrievals; and • Your procedures are performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines. 	<p>HDHP</p> <p>50% of the charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>in vitro fertilization</i> - <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>uterine embryo lavage</i> • <i>Services and supplies related to ART procedures</i> • <i>Injectable or oral fertility drugs</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> • <i>Sterilizations</i> • <i>Reversal of voluntary sterilizations</i> 	<p><i>All Charges</i></p>

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible...
Infertility services (cont.)	HDHP
<ul style="list-style-type: none"> • <i>Payment for medical services to a surrogate for purposes of child birth</i> • <i>Costs associated with cryo preservation and storage of sperm, eggs and embryos</i> • <i>Selected termination of an embryo</i> • <i>Infertility treatments deemed experimental in nature</i> 	<i>All Charges</i>
Allergy care	HDHP
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	20% of the charges
Allergy serum	Nothing
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All Charges</i>
Treatment therapies	HDHP
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on page 68.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: – We only cover GHT when we preauthorize the treatment. Call your Plan physician for preauthorization. GHT must be medically necessary, and authorized by your Plan physician before you begin treatment. If you do not obtain authorization or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	20% of the charges
Physical and occupational therapies	HDHP
<p>Up to two (2) consecutive months per condition for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>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.</p> <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to a three (3) month period.</p>	20% of the charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<i>All Charges</i>

Benefit Description	You pay After the calendar year deductible...
Speech therapy	HDHP
Up to two (2) months per condition for the services for speech therapists	20% of the actual charges
Hearing services (testing, treatment, and supplies)	HDHP
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury 	20% of the chargers
<ul style="list-style-type: none"> • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	\$15 per office visit; <i>No deductible applies</i>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> • <i>Hearing aids, testing and examinations for them</i> 	<i>All Charges</i>
Vision services (testing, treatment, and supplies)	HDHP
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Eye exam to determine the need for vision correction for children through age 17 (see <i>Preventive care, children</i>) 	20% of the charges
<ul style="list-style-type: none"> • Annual eye refractions for all ages <p>Note: See <i>Preventive care, children</i> for eye exams for children.</p>	\$15 per office visit: annual eye refraction <i>No deductible applies</i>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<i>All Charges</i>
Foot care	HDHP
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above • Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery) 	<i>All Charges</i>

Benefit Description	You pay After the calendar year deductible...
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	50% of the charges
<p>Not covered:</p> <ul style="list-style-type: none"> • Orthopedic and corrective shoes • Arch supports • Foot orthotics • Heel pads and heel cups • Lumbosacral supports • Corsets, trusses, elastic stockings, support hose, and other supportive devices • Prosthetic replacements provided less than two (2) years after the last one we covered 	<i>All Charges</i>
Durable medical equipment (DME)	
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. <p>Note: Call your Plan physician who will prescribe this equipment and direct you to a contracted supplier.</p>	50% of the charges
<p>Not covered:</p> <ul style="list-style-type: none"> • Motorized wheelchairs; • Swimming pools and spas; • Exercise equipment; • Repair of DME when malfunction is directly a result of misuse or neglect 	<i>All Charges</i>

Benefit Description	You pay After the calendar year deductible...
Home health services	HDHP
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. • Transparenteral Therapy (TPN) • Sleep Apnea Studies • Ventilator Management • Wound Care 	20% of the charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of the patient or the patient’s family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<i>All Charges</i>
Chiropractic	HDHP
<i>No benefits</i>	<i>All charges</i>
Alternative treatments	HDHP
<i>No benefits</i>	<i>All charges</i>
Educational classes and programs	HDHP
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Smoking Cessation – if enrolled in an approved smoking cessation program. Approved prescription drugs are subject to the prescription copay. • Diabetes self management • Asthma disease management • Congestive Heart Failure • CAD (Coronary Artery Disease) • Hypertension/Cardiovascular Disease • Weight Managment • Prenatal <p>Note: You may call our health education department at (877) 901-2237 ext. 2245 for a list of approved classes.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Over-the-counter smoking cessation aids</i> • <i>More than one (1) smoking cessation class per calendar year and more than three (3) classes per lifetime.</i> 	<i>All charges</i>

Benefit Description	You pay After the calendar year deductible...
Pervasive Developmental Disorder (PDD)	HDHP
<p>Pervasive Developmental Disorder is defined as a neurological condition, including Asperger’s syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.</p> <p>Benefits for Pervasive Developmental Disorder include but are not limited to:</p> <ul style="list-style-type: none"> • Evaluation and Testing to confirm diagnosis • Physical, speech, occupational therapy • Dietary evaluation <p>Benefits are limited to treatment that is prescribed by a physician in accordance with the patient’s treatment plan. No other exclusions or limitations in this brochure that conflict with this benefit apply.</p>	<p>20% of the charges</p>

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

Important things you should 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.
- The deductible is \$1,550 for Self Only enrollment and \$3,100 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR 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.

Benefit Description	You pay After the calendar year deductible...
Surgical procedures	HDHP
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity (Bariatric Surgery) - A condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; has a body mass index (BMI) over 40 kilograms/meters²; or has a BMI over 35 or over kilograms/meters² and a high risk co-morbid condition. In addition the eligible members must be age 18 or over, failed to lose a significant amount of weight or has regained weight despite compliance with a medically supervised, multidisciplinary, non-surgical program including low calorie or very low calorie diet, supervised exercise, behavioral modification and support and treatment of co-morbid condition; does not have a correctable cause for obesity; and is being treated in a surgical program with experience in obesity surgery including but not only surgeons, but also a multidisciplinary team including all of the following: 	<p>20% of the charges</p>

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible...
Surgical procedures (cont.)	
<ul style="list-style-type: none"> - Preoperative medical and approval (See <i>Services requiring our prior approval</i> in Section 3) - Psychiatric consultation and approval (See <i>Services requiring our prior approval</i> in Section 3) - Nutritional counseling - Psychological counseling - Support group meetings • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>HDHP</p> <p>20% of the charges</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • Abortion • Sterilization • Mechanical devices used to induce abortion (eg. IUD) • Reversal of voluntary sterilization • Routine treatment of conditions of the foot; see Foot care • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) 	<p><i>All Charges</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> • the condition produced a major effect on the member’s appearance and • the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are protruding ear deformities, cleft lip, cleft palate, birth marks, webbed fingers, and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> • surgery to produce a symmetrical appearance of breasts; • treatment of any physical complications, such as lymphedemas; • breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>HDHP</p> <p>20% of the charges</p>

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...
Reconstructive surgery (cont.)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> • <i>Surgical procedures for body fat reduction, such as liposuction</i> 	<i>All Charges</i>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Other surgical procedures that do not involve the teeth or their supporting structures; and • Treatment of TMJ, including surgical and non-surgical intervention, corrective orthopedic appliance and physical therapy. 	20% of the charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone).</i> 	<i>All Charges</i>
Organ/tissue transplants	
<p>Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	20% of the charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	HDHP
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses. Medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myeleogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced Neuroblastoma - Chronic myeleogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) <p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Advanced Neuroblastoma • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Amyloidosis <p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols for:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • National Transplant Program (NTP) - 	<p>20% of the charges</p>

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	HDHP
Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	20% of the charges
Not covered: <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered 	<i>All Charges</i>
Anesthesia	HDHP
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	20% of the charges

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

Important things you should 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 and you must be hospitalized in a Plan facility.
- The deductible is \$1,550 for Self Only enrollment and \$3,100 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- 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 care (i.e. physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay After the calendar year deductible...
Inpatient hospital	HDHP
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. When your Plan physician determines it is medically necessary, the physician may prescribe private accommodations or private duty nursing care.	20% of the charges
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	20% of the charges
Not covered: <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools 	All Charges

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year deductible...
Inpatient hospital (cont.)	HDHP
<ul style="list-style-type: none"> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> • <i>Take-home prescription drugs</i> • <i>Hospitalization for dental procedures</i> 	<i>All Charges</i>
Outpatient hospital or ambulatory surgical center	HDHP
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Pre-surgical (or pre-operative) diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	20% of the charges
Extended care benefits/Skilled nursing care facility benefits	HDHP
<p>Extended care benefit: Up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate and determined by your plan physician and approved by the Plan.</p> <ul style="list-style-type: none"> • Bed, board, and general nursing care; • Drugs, biologicals, supplies, equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by the Plan physician 	20% of the charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care, rest cures, domiciliary or convalescent care or homemaker services;</i> • <i>Personal comfort items such as telephone or television</i> 	<i>All Charges</i>
Hospice care	HDHP
<p>Provided for a terminally ill member in accordance with a treatment plan developed before admission to the Hospice Care Program. The treatment plan must be approved by ADVANTAGE Health Solutions or its designated agent.</p> <p>Note: Limited to services provided under the direction of a Plan physician who certifies the patient is in the terminal stage of illness with a life expectancy of approximately six months or less.</p>	20% of the charges
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<i>All charges</i>

Benefit Description	You pay After the calendar year deductible...
Ambulance	HDHP
Local professional ambulance service when medically appropriate	20% of the actual charges

Section 5(d). Emergency services/accidents

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$1,550 for Self Only enrollment and \$3,100 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- 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.

What is a medical emergency?

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

What to do in case of emergency:

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

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in a non-Plan facility and a Plan doctor believes care can be better provided in a Plan facility, 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 physician must be approved by your Plan physician with a prior referral.

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, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan physician believes care can be better provided in a Plan facility, 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 an emergency room physician must be approved by the Plan or provided by a Plan physician.

If you are required to pay for services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan’s decision, you may request reconsideration in accordance with the disputed claims process described on 89.

Benefit Description	You pay After the calendar year deductible...
Emergency within and outside our service area	HDHP
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctor’s services 	20% of all charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> 	<i>All Charges</i>
Ambulance	HDHP
<p>Professional ambulance service when medically appropriate; includes air ambulance services when medically appropriate.</p> <p>Note: See 5(d) for non-emergency service.</p>	20% of the actual charges

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

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$1,550 for Self Only enrollment and \$3,100 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- 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 FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits	HDHP
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management • Diagnostic 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 	<p>20% of the charges</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All Charges</i></p>

Preauthorization

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

- Mental Health and Substance Abuse services do not require an authorization from your primary care physician and may be obtained on self-referral basis. However, the contracting ADVANTAGE providers available to you will depend on the primary care physician you have selected. The Mental Health and Substance Abuse Service 24-hour access phone number is listed on the bottom of your ADVANTAGE Health Solutions Member ID Card. Inpatient and Outpatient treatment plans require authorization from a Mental Health and Substance Abuse Plan physician.
- If you would like more information about your Mental Health and Substance Abuse benefits, please contact an ADVANTAGE Health Solutions Member Service Representative for assistance.

Limitation

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

Section 5(f). Prescription drug benefits

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.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$1,550 for Self Only enrollment and \$3,100 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses or copayments for eligible prescriptions.
- 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.

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

- **Who can write your prescription?** A licensed physician must write the prescription.
- **Where can you obtain them?** You must fill the prescription at a plan pharmacy or by mail for a maintenance medication.
- **We use a formulary.** A formulary is a list of generic and brand-name prescription medications that have been approved by the Food and Drug Administration (FDA). ADVANTAGE Health Solutions has a team of physicians and pharmacists who meet regularly throughout the year to review and update that list. It includes medications for most conditions treated outside the hospital. Your physician can use the list to select medications that are appropriate to meet your healthcare needs while helping you maximize your prescription drug benefit.

We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 1-800-553-8933.

Your health plan/employer has chosen a prescription drug program that has three different co-pay levels. This program allows you to pay a lower copay for covered drugs that are on the formulary. We cover non-formulary drugs prescribed by a Plan doctor but at a higher copay. Step Therapy may apply to new prescriptions, usually non-formulary; Step Therapy means the plan requires you to have used a certain medication in the past before another (second line) medication will be allowed.

If a prescription for a non-formulary medication is written, the pharmacist will receive an on-line message at the pharmacy. The pharmacist should contact the physician to request a change to a formulary product. If the physician is unwilling to change or is unavailable, the pharmacist will dispense the prescription as written. Patients will be required to pay a higher copay when a non-formulary product is dispensed. This policy will reflect the patient’s prescription drug benefit.

- **These are the dispensing limitations.** Prescription drugs prescribed by a plan or referral doctor and obtained at a plan pharmacy will be dispensed up to a 30-day supply; or one commercially prepared unit (i.e. one inhaler, one vial ophthalmic medication or insulin). You pay a \$10 copay per prescription unit or refill for generic formulary drugs or a \$30 copay per prescription unit or refill for name brand drugs when generic substitution is not available. You pay a \$50 copay for non-formulary drugs. When generic substitution is available, but you request the name brand drug or non-formulary drug, you pay the price difference and the required copay per prescription unit or refill as written. You will always pay the appropriate copayment or the actual cost of the drug, whichever is less.

- If your physician orders more than a 30 day supply of covered drugs, up to a 90 day supply, mail service is available. Initially you request your prescription information by completing a PharmaCare Mailer and enclosing your original written prescription. You may also reach PharmaCare (www.pharmacare.com) by calling 1-800-346-9113. If you are currently taking a medication, you must call your physician’s office and request a new prescription for the maximum day supply. You pay a \$20 copay per generic, a \$60 copay per name brand (when generic is not available), and \$100 for non-formulary for up to a 90 day supply. When generic substitution is available, but you request the name brand or non-formulary drug, you pay the price difference and the required copay. Plan members called to active military duty or in time of national emergency who need to obtain prescribed medication should call our Member Services department at 1-800-553-8933.

PharmaCare’s system incorporates on-line drug reviews at the point of dispensing medications. Elements reviewed include, Drug-Drug Interaction, Refill Too Soon, Therapeutic Duplication, Duplication of Therapy, Over Dosage and Under Dosage.

- **A generic equivalent will be dispensed if it is available** unless your physician specifically requires a name brand. If you receive a name brand drug when a federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic in addition to the copay amount.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.

You can save money by using generic drugs. However, you and your physician have the option to request a name-brand if a generic option is available. Using the most cost-effective medication saves money.

The prescription drug mail order benefit will allow a 3 month supply of maintenance medication for the 30 day retail supply copay of \$10 / \$30 / \$50 (Generic/Brand name/Non-formulary respectively) if the member enrolls in one of the following applicable disease management programs: asthma, diabetes, congestive heart failure, hypertension/cardiovascular disease, or depression. This applies only to those medications specifically used to treat those conditions or diseases.

- **When you do have to file a claim.** You will not be required to file claims with this plan.

Benefit Description	You pay After the calendar year deductible...
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (sometimes called lifestyle drugs) are limited. Contact the Plan for dose limitations, such as Viagra quantity limited to six (6) tabs/month • Glucose test strips and lancets 	<p>HDHP</p> <p>\$10 per Generic</p> <p>\$30 per Brand-Name</p> <p>\$50 per Non-Formulary</p> <p>50% coinsurance for drugs used to treat sexual dysfunction (sometimes called lifestyle drugs)</p> <p>50% of charges for glucose test strips and lancets</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p> <p>If enrolled in the disease management program, the copay for a 3-month supply of mail order maintenance medications used to treat that same disease is:</p> <p>\$10 per Generic</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies (cont.)	HDHP
	<p>\$30 per Brand-Name</p> <p>\$50 per Non-Formulary</p> <p>If not enrolled in the disease management program, the copay for a 3-month supply of prescription mail order maintenance medications is:</p> <p>\$20 per Generic Formulary</p> <p>\$60 per Brand-Name Formulary</p> <p>\$100 per Non-Formulary</p> <p><i>You must enroll each year after your plan effective date in January. Call (877) 901-2237 ext. 2425 to re-enroll.</i></p>
<p>Advanced Technology Drugs or Biopharmaceutical Drugs including (including chemotherapy drugs identified as such).</p> <p>Biopharmaceutical drugs means a virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, an allergenic product, or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic Compound), applicable to the prevention, treatment, or cure of a disease or condition of human beings. Biological or biopharmaceutical products typically represent significant advancement in the treatment, diagnosis and prevention of disease or condition and often may be addressing an unmet need. Additionally, these products often require direct physician involvement, and significant member education. These services must be authorized by ADVANTAGE. Coinsurance applies to drugs dispensed up to a 30 day supply.</p>	<p>\$125 copay per 30 day supply in addition to 20% coinsurance for office visit</p>
<p><i>Not covered (medications and supplies)</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Injectable or oral fertility drugs</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> • <i>Oral contraceptives</i> 	<p><i>All charges</i></p>

Section 5(g). Dental benefits

Important things you should 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.
- The deductible is \$1,550 for Self Only enrollment and \$3,100 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. 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.

Accidental injury benefit	HDHP
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	20% coinsurance
Dental benefits	HDHP
<p>Preventive and Diagnostic Dental benefits limited to the following:</p> <ul style="list-style-type: none"> • Dental prophylaxis – limited to two per calendar with six month interval • Oral examinations are covered as a separate benefit only if no other service was provided during the visit other than X-rays. Limited to two (2) times per calendar year, limited to one (1) time every six (6) months. • Complete series or panorex radiographs are limited to one (1) time per 36 months. • Bitewing radiographs are limited to one (1) series of films per calendar year. • Extraoral Radiographs are limited to two (2) films per calendar year. • Diagnostic casts are limited to one (1) time per 24 months. • Fluoride treatments are limited to Covered Persons under the age of 16 years, and limited to two (2) times per calendar year. Treatment should be done in conjunction with dental prophylaxis. • Sealants are limited to Covered Persons under the age of 16 years and once per first or second permanent molar every five (5) years. <p>The Plan pays up to \$300 per member per calendar year.</p> <p>The plan provides the same comprehensive level of benefits whether a member seeks care through a participating dental provider or seeks care through a non-participating provider. However, if a member seeks care through a non-participating provider, the provider may require the member to submit the claim and the member could receive a bill from the non-participating provider if the provider’s charges exceed the Maximum Allowable Charge (MAC).</p>	<p>20% of the maximum allowable charge (MAC);</p> <p><i>No deductible applies.</i></p>

Section 5(h). Special features

Feature	Description
Flexible benefit option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services for deaf and hearing impaired	<p>Toll Free: 1-800-743-3333</p>
Disease Management	<p>We offer the following CareADVANTAGE programs (disease management programs):</p> <p><i>Call (877) 901-2237 ext 2425 Monday through Friday from 8 am until 5:30 pm year-round to enroll.</i></p> <ul style="list-style-type: none"> • Asthma • Congestive Heart Failure • Diabetes • Hypertension • Migraines • Prenatal
Online member service	<p>Online features that are no available on ADVANTAGE-<i>connect</i> are:</p> <ul style="list-style-type: none"> • Change PCP • Request an ID Card • Check Benefits • Change Demographic Information • Request Member Materials • View Claims
Vision	<p>20% discount on frames, lens and contact lenses at participating vision providers. No discount on disposable contact lenses.</p>
Fitness Clubs	<p>Members are eligible for health club membership discounts at participating fitness clubs throughout Indiana.</p> <p><i>* Please call (800) 553-8933 for more specific information and to verify the fitness clubs are still offering discounts at the time of interest.</i></p>

Section 5(i). Health education resources and account management tools

Special features	Description
<p>Health education resources</p>	<p>Visit our Health and Wellness section at www.advantageplan.com to find out more about:</p> <ul style="list-style-type: none"> • Preventive Health • Patient Safety • Fitness Discounts • Nutrition • Weight Management • Smoking Cessation <p>Members can also link to ADVANTAGE Health Zone which provides useful information and tools for researching, tracking, and maintaining your health and the health of those who are important to you.</p> <p>Whether you're searching for health condition-specific information or you're just curious about a health topic you've heard about, this Web site has a wide range of information and resources for you.</p>
<p>Account management tools</p>	<p>Canopy Financial will provide debit cards to each account holder through its card processor, Fifth Third Processing Solutions. Additional debit cards will also be available for family members.</p> <p>Members may pay for medical services a variety of ways: (1) Out of personal checking accounts or credit cards and "reimburs" themselves from their HSA via ACH payment, (2) Create a Bill Pay transaction for their provider through HealthDirect application, or (3) Use their HSA/HRA debit card at the point of care or after the EOB has been received.</p> <p>Members are also provided with monthly reporting via HealthDirect online portal.</p>
<p>Consumer choice information</p>	<p>As a member of this HDHP, you must choose a Primary Care Physician (PCP). Directories are available online at www.advantageplan.com.</p> <p>Pricing information for prescription drugs is available at <i>myPharmaCare</i> at www.pharmacare.com.</p> <p>Link to online pharmacy through www.pharmacare.com.</p> <p>Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.treas.gov/offices/public-affairs/hsa/faq2.html and www.irs.gov/pub/irs-pdf/p502.pdf</p>
<p>Care support</p>	<p>Case Management is included in the benefits for the HDHP Option and the High Option plan. Case Management is a process designed to promote the delivery of cost-effective medical care to all members. The Case Manager works with you to assure the use of appropriate procedures, place of service and resources. A Case Manager is a licensed registered nurse who is trained to identify patients receiving care who are at risk for serious and progressing illnesses or high risk pregnancy. The Case Manager provides early interventions through education, coordination with the physician, pre-certification, discharge planning, periodic review of care and proactive wellness initiatives. Your physician may refer you into a Case Management program, or you may request a Case Manager to be assigned to you by calling 1-800-553-8933.</p>

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **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** (see specifics regarding transplants).

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency Services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies 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 (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- 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.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 1-800-553-8933.

When you must file a claim – such as for services you received outside the Plan’s service area – 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: The claims address shown on your Member ID Card.

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 benefits for 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/prior approval required by Section 3. Disagreements between you and the HDHP Fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

- 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: ADVANTAGE Health Solutions, Inc., Appeals and Grievance Coordinator or Appeals Committee, 9490 Priority Way, West Drive, Indianapolis, Indiana 46240; 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: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group III, 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.

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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 preauthorization/prior approval, then call us at (800) 553-8933 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 Insurance Group 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has 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 or older;
- Some people with disabilities under 65 years of age; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four 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. ((If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) 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.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about our prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It’s easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

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

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

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

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

Claims process when you have the Original Medicare Plan – You will probably not need 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 claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 800-553-8933 or see our Web site at www.advantageplan.com.

We waive some costs if the Original Medicare Plan is your primary payer – We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other health care professionals.

We do not waive any costs if the Original Medicare Plan is your primary payer.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

This Plan and our Medicare Advantage plan:

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

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage 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 Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare 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 you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and... • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
5) 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) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) 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	✓ *	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

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 TRICARE or CHAMPVA.

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.

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB 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 under the State program.

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.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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 & ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 15.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 15.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Services that constitute personal care, such as (1) help in walking and getting in or out of bed, (2) assistance in bathing, dressing, feeding, and using the toilet, (3) preparation of special diets, and (4) supervision over medication that usually can be self-administered – and does not entail or require the continuing attention of trained medical or paramedical personnel.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 15.
Experimental or investigational service	ADVANTAGE Health Solutions has available participating specialists, sub-investigational services specialists, and a referral center to assist with the review and determination of experimental treatment, procedures, drugs or devices. Your PCP must request an approval, before the service date, regarding the recommended treatment or services that are to be reviewed. A review with Technology Evaluation Center (TEC) is done to determine the feasibility of the recommended treatment. If a review of new technology is made on your behalf by your PCP, ADVANTAGE Health Solutions will notify you of the determination for coverage within one business day following the determination. Review for urgent and emergent determinations will be communicated within 72 hours. For further information about the Medical Technology Assessment, please contact a Member Service Representative at 1-800-553-8933.
Medical necessity	<p>Medical necessity means health services or supplies that are skilled care; are required for the treatment of illness or injury; are consistent with your symptoms or diagnosis; are appropriate treatments with regard to standards of accepted medical practice; are not primarily for your convenience, your family’s convenience or the convenience of any health care provider; are not experimental, investigational or unproven; and do not exceed the level of care which is needed to provide a safe, adequate, and appropriate diagnosis of treatment.</p> <p>A health service does not meet medical necessity if your symptoms or condition indicates that it would be safe to provide the service or supply in a less comprehensive setting. The fact that a physician or other health care provider has furnished, ordered, or approved a service or supply does not, alone, make that service or supply a medical necessity.</p>
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: We determine our allowance based on the lesser of the fee arrangement between ADVANTAGE Health Solutions and the provider, or the billed charge. When covered services are provided by a Plan provider you are not responsible for charges above the allowance.
Us/We	“Us” and “we” refer to ADVANTAGE Health Solutions, Inc.
You	“Us” and “we” refer to ADVANTAGE Health Solutions, Inc.

High Deductible Health Plan (HDHP) Definitions

Calendar year deductible	The High Deductible Health Plan does have a deductible of \$1,550 per calendar year for Self-Only and a deductible of \$3,100 per calendar year for Self and Family. The deductible applies to all benefits except for those benefits in Section 5 that include a statement, “ <i>No deductible applies.</i> ”
Catastrophic limit	The maximum amount of certain covered charges you have to pay out of your pocket during the year. Setting a maximum amount protects you.
Health Reimbursement Arrangement (HRA)	<p>This is an account that provides a means to help you pay out-of-pocket expenses related to your health care. If you are not eligible to set up an HSA, you will be able to set up an HRA and benefit from the following and will have the following restrictions:</p> <ul style="list-style-type: none">• Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP• Unused credits carryover from year to year• HRA credit does not earn interest• HRA credit is forfeited if you leave Federal employment or switch health insurance plans. <p>Please see Section 5 <i>Savings – HSAs and HRAs</i> for more information on HRAs.</p>
Health Savings Account (HSA)	<p>This is an account that provide a means to help you pay out-of-pocket expenses related to your health care.</p> <ul style="list-style-type: none">• Your contributions to the HSA are tax deductible• Your HSA earns tax-free interest• You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents. (See IRS publication 502 for a complete list of eligible expenses.)• Your unused HSA funds and interest accumulate from year to year• It’s portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire• When you need it, funds up to the actual HSA balance are available. <p>Please see Section 5 <i>Savings – HSAs and HRAs</i> for more information on HSAs.</p>
Premium contribution to HSA/HRA	The amount of money that can be contributed to your HSA during a calendar year. This contribution cannot exceed the amount of the deductible for your plan type. For instance, \$1,550 for Self-only and \$3,100 for Self and Family.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition 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/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits*, 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 benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorcé, or when your child under age 22 marries.

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 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 cancel your coverage, change to Self-Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

• **When benefits and premiums start**

The benefits in this brochure are effective 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. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2008 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2007 benefits until the effective date of your coverage with your new plan. 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.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Upon divorce**

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 provide health coverage to you. However, you may be eligible for your own FEHB coverage under either 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 Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the 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 Federal 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 Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

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

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

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

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

- **Getting a Certificate of Group Health Plan Coverage**

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

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; refer to the “TCC and HIPAA” frequently asked questions. 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.

Section 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

Second, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Third, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, provides comprehensive dental and vision insurance at competitive group rates.. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents.

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election of \$5,000.

- **Health Care FSA (HCFSA)** – Pays for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses for your child(ren) under age 13 or for dependants unable to care for themselves that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program has no pre-existing condition limitations. FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Premiums are withheld from salary on a pre-tax basis.
Dental Insurance	Dental plans provide a comprehensive range of services, including all the following: <ul style="list-style-type: none"> • Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays. • Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments. • Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures. • Class D (Orthodontic) services with up to a 24-month waiting period
Vision Insurance	Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on Lasik surgery may also be available. Other benefits such as discounts on LASIK surgery may also be available.
Additional Information	You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dental/vision . This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.
How do I enroll?	You enroll on the Internet at www.BENEFEDS.com . For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877-889-5680).

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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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- Substance abuse...9, 37, 38, 47, 76, 77, 101,
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- Surgery...5, 11, 14, 22, 23, 24, 27, 28, 29,
32, 54, 60, 61, 62, 63, 66, 67, 68, 71, 99
- Syringes.....40, 79
- Temporary Continuation of Coverage
(TCC)**.....4, 96, 97
- Transplants...14, 23, 29, 30, 61, 68, 69, 70,
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- Treatment therapies.....9, 23, 61
- Vision care**.....6, 98, 101, 102
- Vision services.....24, 62, 92
- Wheelchairs**.....25, 63
- Workers' Compensation.....91
- X-rays**...20, 32, 33, 42, 57, 59, 71, 72, 81,
99, 101

Summary of benefits for the ADVANTAGE High Option - 2008

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.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$10 primary care; \$35 specialty care	20
Services provided by a hospital:		
• Inpatient	\$100 per day up to 5 days per admission	32-33
• Outpatient	\$125 copay per visit	33
Emergency benefits:		
• In-area	\$125 per visit at a hospital; waived if admitted; \$50 per visit at an urgent care center	35-36
• Out-of-area	\$125 per visit at a hospital; waived if admitted; \$50 per visit at an urgent care center	35-36
Mental health and substance abuse treatment:	Regular cost sharing	37-38
Prescription drugs:		
• Retail pharmacy	\$10 Generic Formulary / \$40 Brand-Name Formulary / 50% (up to a maximum of \$100) Non-Formulary	39-41
• Mail order	\$20 Generic Formulary / \$80 Brand-Name Formulary / 50% (up to a maximum of \$200) Non-Formulary	39-41
Dental care:	20% of MAC for cleanings, oral examinations, X-rays, fluoride treatments and sealants subject to a \$300 calendar year maximum per person enrolled.	42-43
Vision care:	Nothing, included in PCP/SCP office visit copay	24
Special features:	Services for deaf and hearing impaired; Disease management programs with pharmacy copay discount, Vision hardware discount, online customer services, and discounts on select fitness clubs	44

Summary of benefits for the ADVANTAGE HDHP - 2008

Do not rely on this chart alone. All benefits 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.

Under this Plan, most medical care (other than preventive care) is subject to a deductible of \$1,550 for Self-only and \$3,100 for Self & Family. After you meet the deductible, you pay the indicated copayments or coinsurance up to the annual catastrophic protection maximum for out-of-pocket expenses

We only cover services provided or arranged by Plan Physicians except in emergencies.

HDHP Benefits	You Pay	Page
In-network medical and dental preventive care:	Medical - \$15 PCP; No deductible applies Dental – 20% of the maximum allowable charge (MAC); No deductible applies	56-57
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	20% of the charges	59
Services provided by a hospital:		
• Inpatient	20% of the charges	71-72
• Outpatient	20% of the charges	72
Emergency benefits:		
• In-area	20% of the charges	74-75
• Out-of-area	20% of the charges	74-75
Mental health and substance abuse treatment:	Regular cost sharing	76-77
Prescription drugs:		
• Retail pharmacy	\$10 Generic / \$30 Brand-Name / \$50 Non-Formulary; <i>Deductible applies</i>	78-80
• Mail order	\$20 Generic / \$60 Brand-Name / \$100 Non-Formulary; <i>Deductible applies</i>	78-80
Dental care:	20% of the charges	81
Vision care:	\$15 copay per office visit; No deductible applies	62
Special features:	Services for deaf and hearing impaired; Disease management programs with pharmacy copay discount, Vision hardware discount, online customer services, and discounts on select fitness clubs	82
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$4,050 Self-only or \$8,100 Self and Family enrollment per year	49

2008 Rate Information for ADVANTAGE Health Solutions

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

Postal Category 1 rates apply to certain career non-law enforcement Postal Service employees. **Postal Category 2 rates** apply to other career non-law enforcement Postal Service employees. *PostalEASE*, the employee self-service system used for FEHB enrollment, automatically provides the applicable premium to individual employees. Career non-law enforcement employees may also refer to the *Guide to Federal Benefits for United States Postal Service Employees, RI 70-2*, to determine their rates.

Different rates apply and a special Guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center

1-877-477-3273, Option 5

TTY: 1-866-260-7507

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 *Guide to Federal Benefits*.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	6Y1	\$145.04	\$71.80	\$314.25	\$155.57	\$47.62	\$45.61
High Option Self and Family	6Y2	\$329.30	\$179.84	\$713.48	\$389.66	\$124.96	\$120.38
HDHP Option Self Only	6Y3	\$115.36	\$38.45	\$249.95	\$83.31	\$19.23	\$17.30
HDHP Option Self and Family	6Y4	\$259.15	\$86.38	\$561.49	\$187.16	\$43.19	\$38.87