

ADVANTAGE Health Solutions, Inc.

<http://www.advantageplan.com>

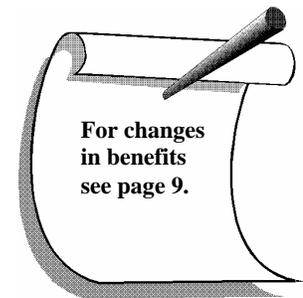


2005

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 7 for requirements.



This Plan has an Excellent Accreditation from the National Committee for Quality Assurance (NCQA), an independent, non-profit organization dedicated to improving health care quality and service. See the 2005 guide for more information on accreditation.

Special Notice: The High Deductible Health Plan (HDHP) Option of this plan is being offered for the first time in 2005.

Enrollment codes 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>



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

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

Welcome to the 2005 Open Season! By continuing to introduce pro-consumer health care ideas, the Office of Personnel Management (OPM) team has given you greater, cost effective choices. This year several national and local health plans are offering new options, strengthening the Federal Employees Health Benefits (FEHB) Program and highlighting once again its unique and distinctive market-oriented features. I remain firm in my belief that you, when fully informed as a Federal subscriber, are in the best position to make the decisions that meet your needs and those of your family. Plan brochures provide information to help subscribers make these fully informed decisions. Please take the time to review the plan's benefits, particularly Section 2, which explains plan changes.

Exciting new features this year give you additional opportunities to save and better manage your hard-earned dollars. For 2005, I am very pleased and enthusiastic about the new High Deductible Health Plans (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. This combination of health plan and savings vehicle provides a new opportunity to save and better manage your money. If an HDHP/HSA is not for you and you are not retired, I encourage you to consider a Flexible Spending Account (FSA) for health care. FSAs allow you to reduce your out-of-pocket health care costs by 20 to more than 40 percent by paying for certain health care expenses with tax-free dollars, instead of after-tax dollars.

Since prevention remains a major factor in the cost of health care, last year OPM launched the *HealthierFeds* campaign. Through this effort we are encouraging Federal team members to take greater responsibility for living a healthier lifestyle. The positive effect of a healthier life style brings dividends for you and reduces the demands and costs within the health care system. This campaign embraces four key "actions" that can lead to a healthy America: be physically active every day, eat a nutritious diet, seek out preventative screenings, and make healthy lifestyle choices. Be sure to visit *HealthierFeds* at www.healthierfeds.opm.gov for more details on this important initiative. I also encourage you to visit the Department of Health and Human Services website on Wellness and Safety, www.hhs.gov/safety/index.html, which complements and broadens healthier lifestyle resources. The site provides extensive information from health care experts and organizations to support your personal interest in staying healthy.

The FEHB Program offers the Federal team the widest array of cost-effective health care options and the information needed to make the best choice for you and your family. You will find comprehensive health plan information in this brochure, in the 2005 Guide to FEHB Plans, and on the OPM Website at www.opm.gov/insure. I hope you find these resources useful, and thank you once again for your service to the nation.

Sincerely,

A handwritten signature in black ink, appearing to read "Kay Coles James".

Kay Coles James

Director



Notice of the United States Office of Personnel Management's Privacy Practices

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

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

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

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

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

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

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

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

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

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

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.

- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202-606-0745 and ask for OPM's FEHB Program privacy official for this purpose.

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

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

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

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

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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, 2005, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2005, 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:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 1-800-553-8933 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.**

- Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
- Tell them about any drug allergies you have.
- Ask about side effects and what to avoid while taking the medicine.
- Read the label when you get your medicine, including all warnings.
- Make sure your medicine is what the doctor ordered and know how to use it.
- Ask the pharmacist about your medicine if it looks different than you expected.

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 reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.html. 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.

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.

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.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB 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 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 and Robertson, Inc. 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, specialists, 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 (PCP), 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.

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.

New High Deductible Health Plan (HDHP) Option in 2005:

This Plan is offering a High Deductible Health Plan (HDHP) option with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component as a new plan for 2005. An HDHP is a new health plan product that provides health care coverage and a tax advantaged way to help you build savings for future medical needs. An HDHP with an HSA or HRA is designed to give greater flexibility and discretion over how you use your health care benefits. As an informed consumer, you decide how to utilize your plan coverage with a high deductible and out-of-pocket expenses limited by catastrophic protection. And you decide how to spend the dollars in your HSA or HRA. You may consider:

- Actively pursuing a healthier lifestyle and utilizing your preventive care benefit;
- Becoming an informed health care consumer so you can be more involved in the treatment of any medical condition or chronic illness.

The type and extent of covered services, and the amount we allow, may be different from other plans. Read our brochure carefully to understand the benefits and features of this HDHP. Internal Revenue Service (IRS) rules govern the administration of all HDHPs. The IRS Website at <http://www.ustreas.gov/offices/public-affairs/hsa/faq1.html> has additional information about HDHPs.

General features of an HDHP:

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans.

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.

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

You are eligible for a Health Savings Account (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 care coverage), not eligible for 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. In addition, 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.
- 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.
- 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 \$3,000 for Self-Only enrollment, or \$6,000 for Self and Family coverage.

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 2005

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5.1 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes:

- In Section 9, we revised the **Medicare Primary Payer Chart** and updated the language regarding Medicare Advantage plans (formerly called Medicare + Choice plans);
- In Section 12, we revised the language regarding the Flexible Spending Account Program – *FSAFEDS* and the Federal Long Term Care Insurance Program.

Changes to this Plan:

- Your share of the non-Postal premium will increase by 10% for Self-Only or 11% for Self and Family.
- We offer a High Deductible Health Plan (HDHP) option for the first time in the 2005 open season.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 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, 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 hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our 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 Family Practice, General Practice, Internal Medicine, or Pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

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

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see 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 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.

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 case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

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

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

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

Copayments

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

Example: In the High Option Plan 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.

Deductible

We have no deductible in the High Option Plan.

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

The High Deductible Health Plan does have a deductible of \$1,050 per calendar year for Self-Only and a deductible of \$2,100 per calendar year for Self and Family. The deductible applies to all benefits except for those benefits in Section 5 that include a statement, “*No deductible applies to this benefit.*”

Coinsurance

Coinsurance is the percentage of our negotiated fee that you must pay for your care. In the HDHP option coinsurance doesn’t begin until you meet your annual deductible.

Example: In the HDHP option you pay 20% of our negotiated fee for emergency services and surgical services.

Note: If your provider routinely waives (does not require you to pay) your copayments, deductibles, or coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider’s fee by the amount waived.

For example, if your physician ordinarily charges \$100 for a service but routinely waives your 20% coinsurance, the actual charge is \$80. We will pay \$64 (80% of the actual charge of \$80).

Your catastrophic protection out-of-pocket maximum

The High Option Plan does not have a catastrophic protection out-of-pocket maximum.

In the HDHP option your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to \$3,000 for Self-Only or \$6,000 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 benefit maximum).

Differences between our allowance and the bill

- **In-network providers** agree to limit what they will bill you. Because of that, when you use a network provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a network physician who charges \$150, but our allowance is \$100. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just – 10% of our \$100 allowance (\$10). Because of the agreement, your network physician will not bill you for the \$50 difference between our allowance and his bill.
- **Out-of-network providers**, on the other hand, have no agreement to limit what they will bill you. When you use an out-of-network provider, you will pay your deductible and coinsurance – **plus** any difference between our allowance and charges on the bill. Here is an example: You see an out-of-network physician who charges \$150 and our allowance is again \$100. Because you’ve met your deductible, you are responsible for your coinsurance, so you pay 25% of our \$100 allowance (\$25). Plus, because there is no agreement between the out-of-network physician and us, he can bill you for the \$50 difference between our allowance and his bill.

The following table illustrates the examples of how much you have to pay out-of-pocket for services from an in-network physician vs. an out-of-network physician. The table uses our example of a service for which the physician charges \$150 and our allowance is \$100. The table shows the amount you pay if you have met your calendar year deductible.

EXAMPLE	In-network physician	Out-of-network physician
Physician's charge	\$150	\$150
Our allowance	We set it at: 100	We set it at: 100
We pay	90% of our allowance: 90	75% of our allowance: 75
You owe: Coinsurance	10% of our allowance: 10	25% of our allowance: 25
+Difference up to charge?	No: 0	Yes: 50
TOTAL YOU PAY	\$10	\$75

When Government facilities bill us

Facilities of the Department of Veteran Affairs, the Department of Defense, and the Indian Health Service 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.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

Section 5.1 Benefits - OVERVIEW

(See page 9 for how our benefits changed this year and page 73 &74 for a benefit summary.)

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Section 5.1 Benefits – OVERVIEW of HDHP

Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 1-800-553-8933.

Summary of new High Deductible Health Plan (HDHP) Option for 2005

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 control 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. Each month, we automatically pass through a portion of the total health Plan premium to your HSA based upon your eligibility as of the first day of the month. If we establish an HRA for you, we will credit your account monthly.

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 73. 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 with no deductible** 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. These services are covered up to \$500 per person per year when provided by your PCP if you use a network provider and are fully described in Section 5.1(a). *You do not have to meet the deductible before using these services.*

- **Traditional medical care** After you have paid the Plan’s deductible, we pay benefits at 80% described in Section 5.1(b). Covered services include:
 - Medical services and supplies provided by primary care physicians and other health care professionals referred by your PCP
 - 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
 - Hospice
 - Skilled Nursing Facility – limit of 100 days

- **Savings** Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see Section 5.1(c) for more details).
 - **HSA** By law, HSAs are available to members who are not eligible for Medicare or do not have other health insurance coverage. In 2005, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$45.83 per month for a Self-Only enrollment or \$93.83 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 \$2,100 for Self and Family. See maximum contribution information in Section 5.1(c). You can use funds in your HSA to help pay your health plan deductible, non-covered items such as eyeglasses, or other qualified expenses.

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 Benefit Administrative Services International Corporation (BASIC) and Keystone Community Bank.
 - 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.

- **HRA**

For members who aren't eligible for an HSA, are eligible for Medicare or have another health plan, we will administer an HRA.

In 2005, we will give you an HRA credit of \$45.83 per month for a Self-Only enrollment and \$93.83 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

BASIC HRA Administration
9246 Portage Industrial Drive
Portage, MI 49024
(800) 444-1922, ext 241
www.HRAbasic.com

- 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

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

For the High Option Plan we do not have a catastrophic protection out-of-pocket maximum.

For the HDHP Option, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to \$3,000 for Self-Only or \$6,000 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 benefit maximum). Refer to Section 4 *Your catastrophic protection out-of-pocket maximum*, Section 5.1(b) *medical coverage subject to the deductible*, and Section 5.1(c) *Catastrophic protection for out-of-pocket expenses* for more details.

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

Section 5.1(e) 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.HSAbasic.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.HRAbasic.com for information about your HRA account.

Section 5.1(a) Preventive Care

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible for the High Option Plan.
- However, the High Deductible Health Plan does have a deductible of \$1,050 per calendar year for Self-Only and a deductible of \$2,100 per calendar year for Self and Family. The deductible applies to all benefits except for those benefits in Section 5.1 that include a statement, “*No deductible applies to this benefit.*”
- 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.

Note: The calendar year deductible applies to most HDHP Option benefits in this Section. We say “*No deductible applies to this benefit*” when the HDHP Option deductible does not apply. There is no calendar year deductible under the High Option Plan.

Benefit Description	You pay	You pay
	High Option Plan	High Deductible Health Plan
Annual Deductible	No deductible applies	\$1,050 for Self-Only \$2,100 for Self and Family
Annual Out-of-Pocket Maximum	There is no out-of-pocket maximum	\$3,000 for Self-Only \$6,000 for Self and Family Deductible, coinsurance and copayment amounts apply toward the out-of-pocket maximum
Preventive care, adult		
Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol • Routine physical exam • 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 	\$15 per office visit	\$15 per office visit <i>No deductible applies to this benefit</i>
Maternity care – prenatal care	\$15 for first visit only	\$15 for first visit only <i>No deductible applies to this benefit</i>
<i>Not covered: Routine sonograms to determine fetal age, size, or sex</i>	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	You Pay
Preventive Care Adult (<i>continued</i>)	High Option Plan	High Deductible Health Plan
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	\$15 per office visit	\$15 per office visit <i>No deductible applies to this benefit</i>
Routine pap test Note: The office visit is covered if pap test is received on the same day	\$15 per office visit	\$15 per office visit <i>No deductible applies to this benefit</i>
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 	\$15 per office visit	\$15 per office visit <i>No deductible applies to this benefit</i>
Routine immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older 	\$15 per office visit	\$15 per office visit <i>No deductible applies to this benefit</i>
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>	<i>All charges.</i>
Preventive care, children		
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	\$15 per office visit	\$15 per office visit <i>No deductible applies to this benefit</i>
<ul style="list-style-type: none"> • 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) 	\$15 per office visit	\$15 per office visit <i>No deductible applies to this benefit</i>

Section 5.1(b)(1) Medical services and supplies provided by physicians and other health care professionals

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Here are some 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.
- However, the High Deductible Health Plan does have a deductible of \$1,050 per calendar year for Self-Only and a deductible of \$2,100 per calendar year for Self and Family. The deductible applies to all benefits except for those benefits in Section 5.1 that include a statement, *“No deductible applies to this benefit.”*
- 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.

Note: The calendar year deductible applies to most HDHP Option benefits in this Section. We say *“No deductible applies to this benefit”* when the HDHP Option deductible does not apply. There is no calendar year deductible under the High Option Plan.

Benefit Description	You pay	After the deductible is met You Pay
Diagnostic and treatment services	High Option Plan	High Deductible Health Plan
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office 	\$15 per visit to your primary care physician \$30 per visit to a specialist	20% of the charges
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion 	Nothing	20% of the charges
At home (within the service area)	\$25 per visit	20% of the charges

Benefit Description	You pay	After the deductible is met You Pay
Lab, X-ray and other diagnostic tests	High Option Plan	High Deductible Health Plan
<p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	<p>Nothing if you receive these services during your office visit; otherwise, \$15 per office visit to your Primary Care Physician or \$30 per office visit to a specialist.</p>	<p>20% of the charges</p>
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. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits - Section 5.1(b)(3) and Surgery benefits - Section 5.1(b)(2). 	<p>\$15 for first visit only</p>	<p>20% of the charges</p>

Benefit Description	You pay	After the deductible is met You Pay
Family planning	High Option Plan	High Deductible Health Plan
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	50% of actual charges	50% of actual charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Reversal of voluntary surgical sterilization • Genetic counseling 	<i>All charges</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"> – <i>intra-vaginal insemination (IVI)</i> – <i>intra-cervical insemination (ICI)</i> – <i>intra-uterine insemination (IUI)</i> 	50% of actual charges for each procedure	50% of actual charges for each procedure
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Assisted reproductive technology (ART) procedures, such as: <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> • Services and supplies related to ART procedures • Injectable or oral fertility drugs • Cost of donor sperm • Cost of donor egg 	<i>All charges</i>	<i>All charges</i>
Allergy care		
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	\$15 per office visit	20% of the charges
Allergy serum	Nothing	Nothing
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	After the deductible is met You Pay
Treatment therapies	High Option Plan	High Deductible Health Plan
<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 28.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We 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>	\$15 per office visit	20% of the charges
Physical and occupational therapies		
<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> <ul style="list-style-type: none"> • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to a three (3) month period. 	\$15 per office visit Nothing per visit during covered inpatient admission	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>	<i>All charges</i>
Speech therapy		
<p>Up to three (3) months per condition for the services of the following:</p> <ul style="list-style-type: none"> • Speech therapists 	50% of actual charges	20% of actual charges

Benefit Description	You pay	After the deductible is met You Pay
Hearing services (testing, treatment, and supplies)	High Option Plan	High Deductible Health Plan
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury 	\$15 per office visit	<ul style="list-style-type: none"> • 20% of the charges
<ul style="list-style-type: none"> • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	\$15 per office visit	<ul style="list-style-type: none"> • \$15 per office visit
<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>	<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>) 	\$15 per office visit	20% of the charges
<ul style="list-style-type: none"> • Annual eye refractions for all ages 	\$15 per office visit	\$15 per office visit: annual eye refraction
<ul style="list-style-type: none"> • Note: See <i>Preventive care, children</i> for eye exams for children. 		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses and after age 17, examinations for them</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges</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 <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts.</p>	\$15 per office visit	20% of the charges
<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>	<i>All charges</i>

Benefit Description	You pay	After the deductible is met You Pay
Orthopedic and prosthetic devices	High Option Plan	High Deductible Health Plan
<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. 	Nothing	20% of the charges
<ul style="list-style-type: none"> Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	50% of charges	50% of the charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Orthopedic and corrective shoes</i> <i>Arch supports</i> <i>Foot orthotics</i> <i>Heel pads and heel cups</i> <i>Lumbosacral supports</i> <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> <i>Prosthetic replacements provided less than two (2) years after the last one we covered</i> 	<i>All charges</i>	<i>All charges</i>
Durable medical equipment (DME)		
<p>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"> 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 all charges	50% of the charges

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	After the deductible is met You Pay
Durable medical equipment (DME) (continued)	High Option Plan	High Deductible Health Plan
<p><i>Not covered:</i></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>	<i>All charges</i>
Home health services		
<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 	\$30 per office visit	20% of the charges
<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. 	<i>All charges</i>	<i>All charges</i>
Chiropractic		
<ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application <p>Up to two (2) consecutive months per condition for the services of Chiropractors</p>	\$30 per office visit	50% of all charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Labs, x-rays, diagnostic testing 	<i>All charges</i>	<i>All charges</i>
Alternative treatments		
No benefits	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	After the deductible is met You Pay
Educational classes and programs	High Option Plan	High Deductible Health Plan
<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 <p>Note: You may call our health education department at (317) 573-2922 for a list of approved classes.</p>	Nothing	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>	<i>All charges</i>
Pervasive Developmental Disorder (PDD)		
<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>\$15 per office visit to your primary care physician</p> <p>\$30 per visit to a specialist</p> <p>\$400 per (inpatient) admission; limited to two (2) copayments per member per calendar year</p> <p>\$100 per (outpatient) admission</p>	20% of the charges

Section 5.1(b)(2) Surgical and anesthesia services provided by physicians and other health care professionals

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible for the High Option Plan.
- However, the High Deductible Health Plan does have a deductible of \$1,050 per calendar year for Self-Only and a deductible of \$2,100 per calendar year for Self and Family. The deductible applies to all benefits except for those benefits in Section 5.1 that include a statement, *“No deductible applies to this benefit.”*
- 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 5.1(b)(3) 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.

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Note: The calendar year deductible applies to most HDHP Option benefits in this Section. We say *“No deductible applies to this benefit”* when the HDHP Option deductible does not apply. There is no calendar year deductible under the High Option Plan.

Benefit Description	You pay	After the deductible is met You Pay
Surgical procedures	High Option Plan	High Deductible Health Plan
A comprehensive range of services, such as: <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) 	\$30 per office visit	20% of the charges

Surgical procedures - continued on next page

Benefit Description	You pay	After the deductible is met You Pay
Surgical procedures (<i>continued</i>)	High Option Plan	High Deductible Health Plan
<ul style="list-style-type: none"> • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; 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: <ul style="list-style-type: none"> ▪ Preoperative medical consultation and approval ▪ Preoperative psychiatric consultation and approval ▪ Nutritional counseling ▪ Exercise counseling ▪ Psychological counseling ▪ Support group meetings • Insertion of internal prosthetic devices. See 5.1(b)(1) – 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>	\$30 per office visit	20% of the charges
<ul style="list-style-type: none"> • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) 	\$30 per office visit	50% of 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>	<i>All charges</i>

Benefit Description	You pay	After the deductible is met You Pay
Reconstructive surgery	High Option Plan	High Deductible Health Plan
<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>	\$30 per office visit	20% of the charges
<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> • Surgical procedures for body fat reduction, such as liposuction 	<i>All charges</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. 	\$30 per office visit	20% of the charges

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay	After the deductible is met You Pay
Oral and maxillofacial surgery (<i>continued</i>)	High Option Plan	High Deductible Health Plan
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone). 	<i>All charges</i>	<i>All charges</i>
Organ/tissue transplants		
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • National Transplant Program (NTP) - <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided 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.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	Nothing	20% of the charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	After the deductible is met You Pay
Anesthesia	High Option Plan	High Deductible Health Plan
Professional services provided in – • Hospital (inpatient)	Nothing	20% of the charges
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	\$30 per office visit	20% of the charges

Section 5.1(b)(3) Services provided by a hospital or other facility, and ambulance services

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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.
- However, the High Deductible Health Plan does have a deductible of \$1,050 per calendar year for Self-Only and a deductible of \$2,100 per calendar year for Self and Family. The deductible applies to all benefits except for those benefits in Section 5.1 that include a statement, “No deductible applies to this benefit.”
- 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 5.1(b)(1).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

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Note: The calendar year deductible applies to most HDHP Option benefits in this Section. We say “No deductible applies to this benefit” when the HDHP Option deductible does not apply. There is no calendar year deductible under the High Option Plan.

Benefit Description	You pay	After the deductible is met You Pay
Inpatient hospital	High Option Plan	High Deductible Health Plan
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.	\$400 per admission; limited to two (2) copayments per member per calendar year.	20% of the charges

Inpatient hospital - continued on next page

Benefit Description	You pay	After the deductible is met You Pay
Inpatient hospital (<i>continued</i>)	High Option Plan	High Deductible Health Plan
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 • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	Nothing	20% of the charges
<i>Not covered:</i> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care • Take-home prescription drugs • Hospitalization for dental procedures 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	After the deductible is met You Pay
Outpatient hospital or ambulatory surgical center	High Option Plan	High Deductible Health Plan
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	\$100 per visit	20% of the charges
Extended care benefits/Skilled nursing care facility benefits		
<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 	\$400 per admission; limited to two (2) copayments per member per calendar year.	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>	<i>All charges</i>
Hospice care		
<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	20% of the charges
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges</i>	<i>All charges</i>
Ambulance		
<ul style="list-style-type: none"> • Local professional ambulance service when medically appropriate 	20% of actual charges	20% of actual charges

Section 5.1(b)(4) Emergency services/accidents

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible for the High Option Plan.
- However, the High Deductible Health Plan does have a deductible of \$1,050 per calendar year for Self-Only and a deductible of \$2,100 per calendar year for Self and Family. The deductible applies to all benefits except for those benefits in Section 5.1 that include a statement, “*No deductible applies to this benefit.*”
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If 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 58.

Benefit Description	You pay	After the deductible is met You Pay
Emergency within our service area	High Option Plan	High Deductible Health Plan
<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 	\$15 per office visit \$50 per visit \$125 per visit; waived if admitted	20% of all charges
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>	<i>All charges</i>
Emergency outside our service area		
<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 doctors’ services 	\$15 per office visit \$50 per visit \$125 per visit; waived if admitted	20% of all charges
<i>Not covered:</i> <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>	<i>All charges</i>
Ambulance		
Professional ambulance service when medically appropriate; includes air ambulance services when medically appropriate. Note: See 5.1(b)(4) for non-emergency service.	20% of actual charges	20% of actual charges

Section 5.1(b)(5) Mental health and substance abuse benefits

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

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

- 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.
- However, the High Deductible Health Plan does have a deductible of \$1,050 per calendar year for Self-Only and a deductible of \$2,100 per calendar year for Self and Family. The deductible applies to all benefits except for those benefits in Section 5.1 that include a statement, “*No deductible applies to this benefit.*”
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

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Note: The calendar year deductible applies to most HDHP Option benefits in this Section. We say “*No deductible applies to this benefit*” when the HDHP Option deductible does not apply. There is no calendar year deductible under the High Option Plan.

Benefit Description	You pay	After the deductible is met You Pay
Mental health and substance abuse benefits	High Option Plan	High Deductible Health Plan
<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 those 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 	<p>Nothing if you receive these services during your office visit; otherwise \$30 per visit.</p>	<p>20% of the charges</p>
<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 	<p>\$400 per admission; limited to two (2) copayments per member per calendar year</p>	<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>	<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 5.1(b)(6) Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible for the High Option Plan.
- However, the High Deductible Health Plan does have a deductible of \$1,050 per calendar year for Self-Only and a deductible of \$2,100 per calendar year for Self and Family. The deductible applies to all benefits except for those benefits in Section 5.1 that include a statement, “*No deductible applies to this benefit.*”
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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There are important features 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.

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.

Prescription drugs (continued)

- **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.

Note: The calendar year deductible applies to most HDHP Option benefits in this Section. We say “*No deductible applies to this benefit*” when the HDHP Option deductible does not apply. There is no calendar year deductible under the High Option Plan.

Benefit Description	You pay	After the deductible is met You Pay
Covered medications and supplies	Both High Option <u>AND</u> High Deductible Health Plan	
<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> <p><i>Covered medications and supplies</i></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 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 \$30 per name brand \$50 per non-formulary</p> <p>50% coinsurance for drugs used to treat sexual dysfunction</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 \$30 per name brand \$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 \$60 per name brand \$100 per non-formulary</p>	
	<i>Covered medications & supplies continued. on next page</i>	

Benefit Description	You pay	After the deductible is met You Pay
Covered medications and supplies <i>(continued)</i>	High Option Plan	High Deductible Health Plan
<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>Fertility drugs</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> 	<i>All charges</i>	<i>All charges</i>

Section 5.1(b)(7) 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 disease management programs:</p> <ul style="list-style-type: none"> • Asthma • Diabetes • Congestive Heart Failure • Hypertension/Cardiovascular Disease • Depression
Online member service	<p>By visiting our website at www.advantageplan.com you may change your Primary Care Physician, your address, your phone number, request a duplicate or replacement ID card and access a range of member service and information options. This site is easy to use and we welcome any suggestions you may have for improving our service by using the site's "Contact Us" section located under the 'ABOUT US' TAB on our homepage.</p>
Vision	<ul style="list-style-type: none"> • 20% discount on frames, lens and contact lenses at participating vision providers. No discount on disposable contact lenses.

Section 5.1(b)(8) Dental benefits

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- 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. However, the High Deductible Health Plan does have a deductible of \$1,050 per calendar year for Self-Only and a deductible of \$2,100 per calendar year for Self and Family. The deductible applies to all benefits except for those benefits in Section 5.1 that include a statement, *“No deductible applies to this benefit.”*
- 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 5.1(b)(3) 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.

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Benefit Description	You pay	
Accidental injury benefit	High Option Plan	High Deductible Health Plan
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	20% of all charges
Dental benefits		
<p>Preventive and Diagnostic Dental benefits limited to the following:</p> <ul style="list-style-type: none"> • 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>	20% of the maximum allowable charge (MAC)	20% of the maximum allowable charge (MAC) <i>No deductible applies to this benefit</i>

Section 5.1(c) Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	<p>Your HSA is administered by</p> <p>BASIC 9246 Portage Industrial Drive Portage, MI 49024 (800) 444-1922, ext 888 www.HSAbasic.com</p> <p>and</p> <p>Keystone Community Bank Attn: Health Savings Account Department 107 West Michigan Avenue Kalamazoo, MI 49007 (269) 553-9100 www.keystonebank.com</p>	<p>Your HRA is administered by</p> <p>BASIC HRA Administration 9246 Portage Industrial Drive Portage, MI 49024 (800) 444-1922, ext 241 www.HRAbasic.com</p>
Fees	\$2.25 per month administrative fee charged by the fiduciary is included in the premium contributions going to the account balance.	None
Eligibility	<ul style="list-style-type: none"> • Enrolled in ADVANTAGE Health Solutions HDHP option • No other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not eligible for Medicare Part A or Part B • Not claimed as a dependent on someone else's tax return • Complete and return all banking paperwork • Eligibility is determined on the first day of the month 	<ul style="list-style-type: none"> • Enrolled in ADVANTAGE Health Solutions HDHP option • Eligibility is determined on the first day of the month

Feature Comparison	HSA	HRA
<p>Funding</p> <ul style="list-style-type: none"> • Self-Only coverage • Self and Family coverage 	<p>\$550 premium pass through by HDHP directly into account</p> <p>\$1,126 premium pass through by HDHP directly into account</p> <p>Eligibility for contributions will be determined on the first day of the month and will be prorated for length of enrollment.</p>	<p>A credit of \$45.83 per month for Self-Only and a credit of \$93.83 per month for Self and Family provided by the HDHP upon effective date</p> <p>The full HRA credit will accumulate each month beginning with the effective date of enrollment. The HRA does not earn interest. You cannot contribute to the HRA.</p> <p>Eligibility for credit will be determined on the first day of the month and will be prorated for length of enrollment.</p>
<p>Contributions/credits</p> <ul style="list-style-type: none"> • Self-Only coverage • Self and Family coverage 	<p>The maximum that can be contributed to your HRA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the amount of the deductible, which is \$1,050 Self-Only and \$2,100 Self and Family.</p> <p>For each month you are eligible for HSA contributions,</p> <p>The HDHP will make a premium pass through of \$45.83. You may make an maximum annual contribution of \$1,050.</p> <p>The HDHP will make a premium pass through of \$93.83. Your annual maximum contribution cannot exceed \$2,100.</p> <p>If you choose to contribute to your HSA,</p> <p>-You must deduct 1/12 of total annual maximum contribution for every month you are not eligible for the HDHP the whole month. For instance, if your enrollment in this Plan was not effective on January 1, 2005, you cannot receive a credit for January and you would need to deduct 1/12 of the annual maximum contribution.</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>	<p>The full HRA credit will accumulate each month beginning with the effective date of enrollment. The HRA does not earn interest. You cannot contribute to the HRA.</p>

Feature Comparison	HSA	HRA
Access funds	<p>You can access your HSA by the following methods:</p> <ul style="list-style-type: none"> • Debit card • Withdrawal form • Checks 	<p>For qualified medical expenses under your HDHP, you will be automatically reimbursed when you submit claims, receipts or Explanations of Benefits to BASIC at:</p> <p style="text-align: center;">BASIC HRA Administration 9246 Portage Industrial Drive Portage, MI 49024</p>
Distributions/withdrawals <ul style="list-style-type: none"> • Medical 	<p>After meeting the deductible, 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>Medical expenses are not allowable if they occur before the first full month your enrollment is effective, and they are not reimbursable from your HSA until the first of the month following the effective date of your enrollment in this HDHP and the date your HSA account is established.</p> <p>For most Federal enrollees (those not paid on a monthly basis), the earliest date medical expenses will be allowable is February 1, 2005.</p> <p>See IRS Publication 502 for a complete list of eligible expenses.</p>	<p>After meeting the deductible, 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 complete list of eligible expenses.</p>
<ul style="list-style-type: none"> • 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</p>	<p>Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses</p>
Availability of funds	<p>Funds are not available until:</p> <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. <p>After the fiduciary receives the completed paperwork from the enrollee, the enrollee can withdraw funds for any expenses incurred on or after the date the HSA was initially established.</p>	<p>Funds are not available until:</p> <p>An eligible claim is submitted for reimbursement.</p>

Feature Comparison	HSA	HRA
Account owner	FEHB enrollee	HDHP
Portable	Yes, you can take this account with you when you separate or retire.	<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.

HSAs

Is the “premium pass through” to my HSA considered taxable income?

“Premium pass through” contributions by the HDHP are not considered taxable income.

Can I contribute to my HSA?

Yes. All contributions are aggregated and cannot exceed the annual maximum contribution. You may contribute your own money to your account through payroll deductions (if available), or you may make a lump sum contribution at any time, in any amount up to an annual maximum limit. Others can also make contributions to your HSA on your behalf. If you (or someone on your behalf) contribute a lump-sum, you can claim the total amount contributed for the year as a tax deduction when you file your income taxes. You receive tax advantages in any case. You have until April 15 of the following year to make HSA contributions for the current year.

IRS contribution rules reduce the total annual maximum contribution if you are not eligible for the HDHP during the whole month. For instance, if your enrollment in this Plan was not effective on January 1, 2005, you cannot receive a credit for January and you would need to deduct 1/12 of the annual maximum contribution. Contact Keystone Community Bank for more details.

Catch-up contributions

If you are age 55 or older, the IRS permits you to make additional catch-up contributions to your HSA. In 2005, you may contribute up to \$500 in “catch-up” contributions. Catch-up contributions in later years increase up to a maximum of \$1,000 in 2009 and beyond. Contributions must stop once an individual is eligible for Medicare. Additional details are available on the IRS Web site at www.irs.gov.

Rate of interest earned

The interest rate and payment of interest will vary. Contact Keystone Community Bank for more details on the investment options available to you.

What happens to my HSA if I leave my health plan or job?

You own your account, so you keep your HSA even if you change health plans, leave Federal employment, become eligible for Medicare, or any of the other events which may make you ineligible for further contributions to your HSA. Even when you are not eligible to make contributions to your HSA, you may request withdrawals.

What happens to my HSA if I die?

Your HSA would pass to your surviving spouse or named beneficiary tax free. If you do not have a named beneficiary, the money is disbursed to your estate and is taxable.

What expenses can I pay for with my HSA?

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, and health insurance premiums if you are receiving Federal unemployment compensation, over-the-counter drugs, LASIK surgery, and some nursing services.

When you become Medicare-eligible, you can use the account to purchase any health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are Medicare eligible.

For the complete 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.”

Non-qualified health 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” and withdrawals, and interest earned on your account.

Minimum reimbursements from your HSA There is no minimum reimbursement amount for your HSA.

HRAs

How do I know if I qualify for an HRA? If you don’t qualify for an HSA when you enroll, or later become ineligible for an HSA, the HDHP will establish an HRA for you. If you are Medicare eligible, even if you have not elected to enroll in Medicare, you are ineligible for an HSA and your HDHP will establish an HRA for you.

HRA and HSA differences Please review the chart at the beginning of this Section which details the differences. The major differences are:

- you cannot make contributions to an HRA
- 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.

Section 5.1(d) Catastrophic protection for out-of-pocket expenses

The High Option plan does not have a catastrophic protection out-of-pocket maximum.

The HDHP Option includes protection against catastrophic expenses incurred due to deductibles, coinsurance and copayments. You are responsible for an annual maximum out-of-pocket amount of \$3,000 for Self-Only and \$6,000 for Self and Family. The out-of-pocket maximum applies to only those services covered under the HDHP. Once you reach the out-of-pocket maximum described above, you are no longer responsible for paying any amounts for covered services received through the end of the calendar year. However, you will be responsible for the payment of any service that is not covered under the HDHP. Also, you may be responsible for charges that exceed the maximum allowable charges (MAC) for services received from a non-participating dental provider. Charges exceeding the MAC from non-participating dental providers are NOT included in the out-of-pocket maximum.

ADVANTAGE Health Solutions keeps track of your out-of-pocket expenses for covered services under the HDHP. If you have questions about the amount you have spent toward your annual out-of-pocket maximum, please contact a Member Services Representative at 1-800-553-8933.

Section 5.1(e) Health education resources and account management tools

Special features	Description
Health education resources	<p>We publish an e-newsletter to keep you informed on a variety of issues related to your good health. Visit our Web site at www.advantageplan.com for ADVANTAGE Health Zone and information about our Disease Management Programs.</p> <p>Visit our 'PROGRAMS' tab on our Web site at www.advantageplan.com for information on:</p> <ul style="list-style-type: none"> • General health topics - www.advantageplan.com/Wellness.asp • Links to health care news • Cancer and other specific diseases - www.advantageplan.com/HealthMgmt.asp • Drugs/medication interactions • Kids' health • Patient safety information - www.advantageplan.com/PatientSafety.asp • and several helpful Web site links.
Account management tools	<p>For each HSA and HRA account holder, we maintain a complete claims payment history online through www.HSAbasic.com and www.HRAbasic.com</p> <ul style="list-style-type: none"> • Your balance will also be shown on your explanation of benefits (EOB) form. • You will receive an EOB after every claim. • If you have an HSA, <ul style="list-style-type: none"> ✓ You will receive a monthly statement from the Keystone Community Bank outlining your account balance and activity for the month. ✓ You may also access your account on-line at www.HSAbasic.com. • If you have an HRA, <ul style="list-style-type: none"> ✓ Your HRA balance will be available online through www.HRAbasic.com ✓ Your balance will also be shown on your EOB form.
Consumer choice information	<ul style="list-style-type: none"> • As a member of this HDHP, you must choose a Primary Care Physician (PCP). Directories are available online at www.advantageplan.com. • Pricing information for prescription drugs is available at <i>myPharmaCare</i> at www.pharmacare.com. • Link to online pharmacy through www.pharmacare.com. • 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
Care support	<p>Care Management is included in the benefits for the HDHP Option and the High Option plan. Care Management is a process designed to promote the delivery of cost-effective medical care to all members. The Care Manager works with you to assure the use of appropriate procedures, place of service and resources. A Care 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 Care 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 Care Management program, or you may request a Care 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. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest ;
- Services, drugs, or supplies related to sex transformations;
- 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 receive 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 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. Disagreements between you and the HDHP Fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: ADVANTAGE Health Solutions, Inc., Appeals and Grievance Coordinator or Appeals Committee, 9490 Priority Way, West Drive, Indianapolis, Indiana 46240; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial – go to step 4; orAsk you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>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.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none">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; andYour daytime phone number and the best time to call. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p>

The disputed claims process (*continued*)

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

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

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

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

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

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at xxx 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 have coverage under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage”.

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or older.
- Some people with disabilities under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

• 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 both 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. Some

things are not covered under Original Medicare, such as most prescription drugs (but coverage through private prescription drug plans will be available starting in 2006).

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.

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 1-800-553-8933 or see our Web site at www.advantageplan.com.

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

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

• Medicare Advantage

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) in some areas of the country. In most Medicare Advantage plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare Advantage plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare Advantage plan, 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: You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. In this case, we do not waive cost-sharing for your FEHB coverage.

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.

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

Medicaid

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

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.

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 14.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 14.
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	<p>We have no deductible in the High Option Plan.</p> <p>A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. Non-covered services do not count toward any deductible.</p> <p>The High Deductible Health Plan does have a deductible of \$1,050 per calendar year for Self-Only and a deductible of \$2,100 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 to this benefit.</i>”</p>
Experimental or investigational services	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 is 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	“You” refers to the enrollee and each covered family member.

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

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

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

- **Types of coverage available for you and your family**

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

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

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

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

- **Children’s Equity Act**

OPM has implemented the Federal Employees Health Benefits Children’s Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the 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 2005 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 2004 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.

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

- **Spouse equity coverage** If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse’s enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse’s employing or retirement office to get RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download 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 Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

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

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

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

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

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

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site 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. Two Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) 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. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

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. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have Self and Family health benefits coverage. **Note:** The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$4,000. **Note:** The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$4,000 each (\$8,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you, and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return (and who is mentally or physically incapable of self care).
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. **Note:** The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive.

• Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2005 FEHB Open Season. Even if you enrolled during 2004, you must make a new election to continue participating in 2005. Enrollment is easy!

- **Online:** visit www.FSAFEDS.com and click on **Enroll**.
- **Telephone:** call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (372-3337) Monday through Friday; from 9 a.m. until 9 p.m. Eastern Time. TTY: 1-800-952-0450.

What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is the largest FSA administrator in the nation and is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAs. However, if you enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), you are not eligible to participate in an HCFSA.

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

- **How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS places strict guidelines on how the money can be used. Under current IRS tax rules, you are required to forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “use-it-or-lose-it” rule. You will have until April 30, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through December 31. For example if you enroll in FSAFEDS for the 2005 Plan Year, you will have until April 30, 2006, to submit claims for eligible expenses.

The FSAFEDS Calculator at www.FSAFEDS.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

- **What can my HCFSA pay for?**

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page xx and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under this plan, typical out-of-pocket expenses include: Copayments for Infertility services, durable medical equipment, Diagnostic services, and prosthetic devices, or Care by non-Plan physicians or health care practitioners except for authorized referrals or emergencies, and experimental or investigational procedures, treatments, drugs or devices, are expenses not covered by the Plan.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at www.FSAFEDS.com/fsafeds/eligibleexpenses.asp. If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
Your tax savings:	\$576	-\$0-

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424 - a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal Income Tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

- **Health care expenses**

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

- **Dependent care expenses**

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.fsafeds.com and download the [Dependent Care Tax Credit Worksheet](#) from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the Plan Year, resulting in the forfeiture of funds remaining in your account (the IRS "use-it-or-lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at www.fsafeds.com, or contact SHPS directly via email or by phone. SHPS Benefits Counselors are available Monday through Friday, from 9:00 a.m. until 9:00 p.m. Eastern Time, Monday through Friday.

- E-mail: FSAFEDS@shps.net
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

The Federal Long-Term Care Insurance Program

- **It's important protection**

Why should you consider applying for coverage under the Federal Long-Term Care Insurance Program (FLTCIP)?

- **FEHB plans do not cover the cost of long-term care.** Also called “custodial care,” 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. The need for long-term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later. In order to qualify for coverage under the FLTCIP,** you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long-Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To find out more and to request an application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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

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Summary of benefits for ADVANTAGE High Option - 2005

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copay: \$15 primary care; \$30 specialist	22
Services provided by a hospital: • Inpatient	\$400 copay per admission (limit of 2 copays)	35
• Outpatient	\$100 copay per visit	36
Emergency benefits • In-area.....	\$125 per visit at a hospital; waived if admitted; \$50 per visit at an urgent care center	39
• Out-of-area	\$125 per visit at a hospital; waived if admitted; \$50 per visit at an urgent care center	39
Mental health and substance abuse treatment	Regular cost sharing	40
Prescription drugs	\$10 per generic \$30 per name brand formulary \$50 per non-formulary	42-43
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.	46
Vision care	\$15 copay per visit for annual eye refraction	26
Special features: Services for deaf and hearing impaired; Disease management programs with pharmacy copay discount, Vision hardware discount, online customer service.		45

Summary of benefits for ADVANTAGE High Deductible Health Plan Option - 2005

- **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.
- Under this Plan, most medical care (other than preventive care) is subject to a deductible. 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.

Benefits	You pay – HDHP Option	Page
Preventive care services provided by physicians.....	Office visit copay: \$15 primary care No deductible applies	20-21
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	20% of charges	22
Services provided by a hospital: • Inpatient..... • Outpatient	20% of charges	35 36
Emergency benefits • In-area..... • Out-of-area	20% of charges	39
Mental health and substance abuse treatment	Regular cost sharing	40
Prescription drugs	\$10 per generic \$30 per name brand formulary \$50 per non-formulary	42-43
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. No deductible applies	46
Vision care	\$15 copay per visit for annual eye refraction No deductible applies	26
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum).....	Nothing after \$3,000 Self-only or \$6,000 Self and Family enrollment per year Some costs do not count toward this protection	53
Special features: Services for deaf and hearing impaired; Disease management programs with pharmacy copay discount, Vision hardware discount, online customer service.		45

2005 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 FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable FEHB Guide.

		<i>Non-Postal Premium</i>				<i>Postal Premium</i>	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self-Only	6Y1	\$131.08	\$52.60	\$284.01	\$113.96	\$154.74	\$28.94
High Option Self and Family	6Y2	\$298.23	\$133.05	\$646.17	\$288.27	\$352.08	\$79.20
HDHP Self-Only	6Y4	\$130.84	\$43.61	\$283.49	\$94.49	\$154.74	\$19.71
HDHP Self and Family	6Y5	\$297.37	\$99.12	\$644.30	\$214.76	\$351.88	\$44.61