



SummaCare, Inc.

Formerly SummaCare Health Plan

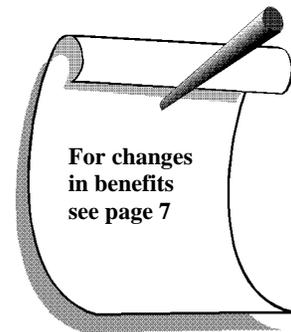
<http://www.summacare.com>

2006

A Health Maintenance Organization (group practice plan high option)

Serving: The Cleveland and Akron Metropolitan Area

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 6 for requirements.



Enrollment code for this Plan:

5W1 High Option – Self Only

5W2 High Option – Self and Family



Commercial HMO/POS
Medicare HMO

Authorized for distribution by the:



**United States
Office of Personnel Management**

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

RI 73-768

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 Government Accountability 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.

Important Notice from SummaCare, Inc. About Our Prescription Drug Coverage and Medicare

SummaCare has determined that the prescription drug coverage offered by SummaCare, Inc. is, on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

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

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

Please be advised

If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You may also have to wait until the next open enrollment period to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

You can get more information about Medicare prescription drug coverage from these places:

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

Table of Contents

Table of Contents.....	1
Introduction.....	3
Plain Language	3
Stop Health Care Fraud!	3
Preventing medical mistakes.....	4
Section 1 Facts about this HMO group practice plan high option	6
General Features of our High Option.....	6
How we pay providers	6
Your Rights.....	6
Service Area.....	6
Section 2 How we change for 2006	7
Changes to this Plan.....	7
Section 3 How you get care	8
Identification cards	8
Where you get covered care.....	8
• Plan providers	8
• Plan facilities.....	8
What you must do to get covered care.....	8
• Primary care	8
▪ Specialty care	8
• Hospital care	9
How to get approval for... ..	9
• Your hospital stay	9
• How to precertify an admission	10
• Maternity care	10
• What happens when you do not follow the precertification rules when using non-network facilities	10
Circumstances beyond our control.....	10
Services requiring our prior approval	10
Section 4 Your cost for covered services.....	11
Copayments	11
Deductible.....	11
Coinsurance	11
Your catastrophic protection out-of-pocket maximum	11
High Option Benefits	12
Section 5 High Option Benefits Overview.....	14
Section 5(a) Medical services and supplies provided by physicians and other health care professional.....	15
Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals	25
Section 5(c) Services provided by a hospital or other facility, and ambulance services	29
Section 5(d) Emergency services/accidents.....	32
Section 5(e) Mental health and substance abuse benefits	34
Section 5(f) Prescription drug benefits	36
Section 5(g) Special features	38
Section 5(h) Dental benefits	39
Section 5(i) Non-FEBH benefits available to Plan members	40

Section 6 General exclusions – things we don’t cover.....41

Section 7 Filing a claim for covered services42

Section 8 The disputed claims process.....43

Section 9 Coordinating benefits with other coverage45

When you have other health coverage45

What is Medicare?45

- Should I enroll in Medicare?.....45
- The Original Medicare Plan (Part A or Part B).....46
- Medicare Advantage (Part C).....46
- Medicare prescription drug coverage (Part D)46

TRICARE and CHAMPVA.....49

Workers’ Compensation49

Medicaid49

When other Government agencies are responsible for your care.....49

When others are responsible for injuries.....49

Section 10 Definitions of terms we use in this brochure.....50

Section 11 FEHB Facts.....51

Coverage information51

- No pre-existing condition limitation51
- Where you can get information about enrolling in the FEHB Program51
- Types of coverage available for you and your family51
- Children’s Equity Act52
- When benefits and premiums start52
- When you retire.....52

- When you lose benefits52
 - When FEHB coverage ends52
 - Spouse equity coverage.....53
 - Temporary Continuation of Coverage (TCC)53
 - Converting to individual coverage53
 - Getting a Certificate of Group Health Plan Coverage.....53

Section 12 Two Federal Programs complement FEHB benefits.....54

The Federal Flexible Spending Account Program – *FSAFEDS*.....54

The Federal Long Term Care Insurance Program.....57

Index58

Summary of benefits for the High Option of the - 200659

2006 Rate Information for SummaCare, Inc.....61

Introduction

This brochure describes the benefits of SummaCare, Inc. under our contract (CS 2830) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for SummaCare, Inc. administrative offices is:

SummaCare, Inc.

10 North Main Street

Akron, Ohio 44308

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.

OPM negotiates benefits and rates with each plan annually. 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 SummaCare, Inc.
- 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 330-996-8700 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 is about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicine.

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

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?

- <http://www.ahrq.gov/consumer/pathqpack.htm> The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/index.jsp. 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 group practice plan high option

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

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

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General Features of our High Option

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.

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.

SummaCare, Inc. has been in business since 1993 and has offered the FEBH Plan since 1998.

SummaCare, Inc. is a for-profit corporation

If you want more information about us, call 330-996-8700, or write to SummaCare, Inc., 10 North Main Street, Akron, Ohio 44308. You may also contact us by fax at 330-996-8415 or visit our Web site at www.summacare.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is: Ashtabula, Carroll, Cuyahoga, Geauga, Mahoning, Medina, Lorain, Portage, Stark, Summit, Trumbull, Tuscarawas and Wayne Counties.

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

Section 2 How we change for 2006

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

Changes to this Plan

Your share of non postal premium shall increase by 1.7% for self only and 18.0 % for self and Family.

There are no benefit changes to this Plan.

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 letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-996-8701 or write to us at SummaCare, Inc., 10 North Main Street, Akron, Ohio 44308. You may also request replacement cards through our Web site at www.summacare.com

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay co-payments and you will not have to file claims forms.

• Plan providers

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.

• 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.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

• Primary care

Your primary care physician can be a family/general practitioner, internist or pediatrician. Your primary care physician will provide most of your health care and coordinate your care 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 coordinate your care with a specialist.

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 a referral. 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. He or she will coordinate your care with 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 330-996-8700 or 800-996-8701. 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.

How to get approval for...

Your Primary Physician will obtain approval from SummaCare's Health Service Management Program. Before giving approval, we consider if the service is a covered benefit, medically necessary and follows generally accepted medical practice.

• Your hospital stay

Your Primary Care Physician will precertify any Inpatient Hospital Admissions by contacting SummaCare's Health Service Management Program. This includes admission to a skilled nursing facility.

- **How to precertify an admission**

Your Primary Care Physician will precertify any hospital admission or hospital stay by contacting SummaCare's Health Service Management Program.

- **Maternity care**

Prior Notification is required by your Primary Care Physician or OB/GYN.

- **What happens when you do not follow the precertification rules when using non-network facilities**

We do not provide services if you use a Non-network facility. You must use In-network contracted providers.

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. Your physician must obtain precertification for the following services: Your physician must obtain approval before sending you to a hospital or recommending outpatient services. Before giving approval, we consider if the service is medically necessary and if it follows generally accepted medical practices. You and your physician will receive a letter, which informs you if the services requested have been preauthorized and the number of visits that have been approved, if applicable. This letter will also contain information on how to contact us if you disagree about a decision regarding preauthorization.

Section 4 Your cost for covered services

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

Copayments

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

Example: When you see your primary care physician you pay a copayment of \$15 per office visit and when you go in the hospital, you pay \$250 per admission.

Deductible

We do not have a deductible.

Coinsurance

We do not charge coinsurance.

Your catastrophic protection out-of-pocket maximum

There is no catastrophic protection out-of-pocket maximum.

High Option Benefits

See page 7 for how our benefits changed this year. Page 15 is a benefits summary of our high option. Make sure that you review the benefits that are available under this option.

Section 5 High Option Benefits Overview..... 14

Section 5(a) Medical services and supplies provided by physicians and other health care professionals..... 15

Diagnostic and treatment services..... 15

Lab, X-ray and other diagnostic tests..... 16

Preventive care, adult..... 16

Preventive care, children..... 17

Maternity care 17

Family planning 18

Infertility services 19

Allergy care..... 19

Treatment therapies..... 20

Physical and occupational therapies 20

Speech therapy 21

Hearing services (testing, treatment and supplies)..... 21

Vision services (testing, treatment and supplies)..... 21

Foot care 22

Orthopedic and prosthetic devices 22

Durable medical equipment (DME)..... 23

Home health services 23

Chiropractic 23

Alternative treatments 24

Educational classes and programs..... 24

Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals..... 25

Surgical procedures..... 25

Reconstructive surgery..... 26

Oral and maxillofacial surgery..... 27

Organ/tissue transplants 27

Anesthesia..... 28

Section 5(c) Services provided by a hospital or other facility, and ambulance services..... 29

Inpatient hospital..... 29

Outpatient hospital or ambulatory surgical center 30

Extended care benefits/Skilled nursing care facility benefits 31

Hospice care..... 31

Ambulance..... 31

Section 5(d) Emergency services/accidents 32

Emergency within our service area 32

Emergency outside our service area..... 33

Ambulance 33

Section 5(e) Mental health and substance abuse benefits 34

Mental health and substance abuse benefits..... 34

Section 5(f) Prescription drug benefits 36

Covered medications and supplies..... 37

Section 5(g) Special features 38

24 hour nurse line 38

Healthy Lifestyles Health Management Program 38

NCQA 38

Travel benefit/services overseas 38

Centers of Excellence 38

Section 5(h) Dental benefits..... 39

 Accidental injury benefit 39

 Dental benefits..... 39

Section 5(i) Non-FEBH benefits available to Plan members..... 40

Summary of benefits for the High Option of the - 2006 59

Section 5 High Option Benefits Overview

This Plan offers a High Option. The benefit package is described in Section 5. Make sure that you review the benefits that are available under this option.

The High Option Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice or more information about High and Standard Option benefits, contact us at 330-996-8700 or 800-996-8701 or at our Web site at www.summacare.com.

The high option offers unique features.

- **High Option**

We offer a HMO Product with no deductible and no out-of-pocket maximums. You pay copayments for covered benefits. There is no Plan deductible.

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

Important Things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility co-payment applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- The calendar year deductible is: We add “*(No deductible)” to show when the calendar year deductible does not apply.
- 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 Medicare.

Benefit Description	You pay * (No Deductible)
Note: *(No Deductible)	
Diagnostic and treatment services	High Option
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office 	\$15 per visit to your primary care physician \$20 per visit to a specialist
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 	\$45 copayment per visit Nothing Nothing \$15 Primary Care Physician, \$20 Specialist \$20 for non Primary Care Physician
Second surgical opinion	
At home	\$15

Diagnostic and treatment services – continued on next page.

Diagnostic and treatment services <i>(continued)</i>	You Pay
	High Option
<i>Not covered</i>	All charges
Lab, X-ray and other diagnostic tests	
<p>Tests, <i>such as</i>:</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 	Nothing if you receive these services at an outpatient facility; otherwise \$15 office visit copayment applies for procedures done in a Primary Care Physicians Office or \$20 copayment in a specialist office;
Preventive care, adult	
<p>Routine physical every year which includes: Routine screenings, such as:</p> <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 – Double contrast barium enema – every five years starting at age 50 – Colonoscopy screening – every ten years starting at age 50 	\$15 per Primary Care Physician office visit
<p>Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older</p>	\$15 per office visit
<p>Routine Pap test</p> <p>Note: You do not pay a separate co-pay for a Pap test performed during your routine annual physical; see <i>Diagnostic and treatment services</i>, above.</p>	<p>\$15 per Primary Care Physician office visit</p> <p>\$20 per specialist office visit</p>

Preventive care, adult – continued on next page.

Preventive care, adult <i>(continued)</i>	You pay
	High Option
<p>Routine mammogram – covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	<p>\$15 per Primary Care Physician office visit</p> <p>\$20 per specialist office visit</p>
<p>Routine immunizations, such as:</p> <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 	<p>\$15 per Primary Care Physician office visit</p> <p>No co-payment for immunizations, but an office visit co-payment may apply.</p>
<p><i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools, camp, or travel.</i></p>	<p><i>All charges</i></p>
Preventive care, children	
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	<p>\$15 per office visit. No co-payment for immunizations, but an office visit co-payment may apply.</p>
<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, which include: – Hearing exams through age 17 to determine the need for hearing correction, which include: – Examinations done on the day of immunizations (up to age 22) 	<p>\$15 per office visit</p>
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care 	<p>\$20 for initial office visit only - OB/GYN</p>

Maternity care –continued on next page.

Maternity care <i>(continued)</i>	You pay
	High Option
<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; see page 19 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex.</i></p>	<p><i>All charges.</i></p>
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$15 per Primary Care Physician office visit.</p> <p>\$20 per office visit for an OB/GYN</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling</i> 	<p><i>All charges.</i></p>

Infertility services	You pay
	High Option
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI) <p>Fertility drugs</p> <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p>	<p>\$20 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> – <i>in vitro fertilization</i> – <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<p><i>All charges</i></p>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	<p>\$20 per office visit at a Specialist. No copayment for injections only.</p>
<p>Allergy serum</p>	<p>Nothing</p>
<p><i>Not covered: Provocative food testing and sublingual allergy desensitization</i></p>	<p><i>All charges</i></p>

Treatment therapies	You pay
	High Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 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. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>Nothing if services are received in an Outpatient facility, otherwise \$20 co-payment applies for specialist office visits.</p>
Physical and occupational therapies	
<p>30 visits per calendar year (combined) physical and occupational therapies for the services of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 36 sessions.</p>	<p>\$20 per office visit</p> <p>\$20 per outpatient visit</p> <p>Nothing per visit during covered inpatient admission</p> <p>\$20 per outpatient visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<p><i>All charges.</i></p>

Speech therapy	You pay
	High Option
30 visits	\$20 per office visit \$20 per outpatient visit Nothing per visit during covered inpatient admission.
Hearing services (testing, treatment and supplies)	
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17, which include; (see <i>Preventive care, children</i>) 	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • All other hearing testing • Hearing aids, testing and examinations for them 	<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) • Annual eye refractions • Note: See <i>Preventive care, children</i> for eye exams for children. 	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Eyeglasses or contact lenses, except as shown above • Eye exercises and orthoptics • Radial keratotomy and other refractive surgery 	<i>All charges</i>

Foot care	You pay
	High Option
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses or the free edge of toenails and similar routine treatment of conditions of the foot, except as stated above.</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery).</i> 	<i>All charges</i>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. • Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	<p>If obtained in a specialist office a \$20 co-payment may apply</p> <p>Appliances are not covered for TMJ</p>
<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 {3} years after the last one we covered</i> 	<i>All charges</i>

Durable medical equipment (DME)	You pay
	High Option
<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 us at 330-996-8700 or 800-996-8701 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>Nothing if device or equipment is obtained at a Durable Medical Equipment Provider; otherwise, \$15 co-payment per Primary Care Physician office visit or \$20 co-payment per Specialist office visit.</p>
<p><i>Not covered: Deluxe versions of Durable Medical Equipment are not covered. Example Motorized wheelchairs.</i></p>	<p><i>All charges</i></p>
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. 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative.</i> 	<p><i>All charges</i></p>
Chiropractic	
<p><i>No Benefit</i></p>	<p><i>All charges</i></p>
<p><i>Not covered:</i></p>	<p><i>All charges.</i></p>

Alternative treatments	You pay
	High Option
<p>Not Covered</p> <ul style="list-style-type: none"> • Acupuncture – by a doctor of medicine or osteopathy for: anesthesia, pain relief • Naturopathic services • Hypnotherapy • Biofeedback 	<i>All Charges</i>
Educational classes and programs	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Smoking cessation – Up to \$100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. • Diabetes self management 	\$15 per office visit

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The calendar year deductible is: We added * "(No deductible)" to show when the calendar year deductible does not apply.
- 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 Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay * (No deductible)
---------------------	------------------------------

Note: * (No deductible)

Surgical procedures	High Option
---------------------	-------------

A comprehensive range of services, such as:

- Operative procedures
- Treatment of fractures, including casting
- Normal pre- and post-operative care by the surgeon
- Correction of amblyopia and strabismus
- Endoscopy procedures
- Biopsy procedures
- Removal of tumors and cysts
- Correction of congenital anomalies (see Reconstructive surgery)
- Surgical treatment of morbid obesity (bariatric surgery)
 - Must be under the age of 65
 - Must be morbidly obese with a BMI (Body Mass Index) of 40 or extremely obese with a BMI of 35
 - Must have continued obesity despite a supervised physician program to include supervision, exercise, weight reduction, and behavior modification.
 - Surgery must be precertified by SummaCare's Health Service Management Program and meet all criteria.

\$15 co-payment for Primary Care Physician office visit

\$20 co-payment for Specialist Office visit

\$100 Co-payment for Outpatient Surgical Procedure

Surgical procedures - continued on next page.

Surgical procedures <i>(continued)</i>	You pay
	High Option
<ul style="list-style-type: none"> • Insertion of internal prosthetic devices. See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>\$15 Co-payment for Primary Care Physician office visit \$20 Co-payment for Specialist office visit \$100 Copayment per Outpatient Surgical Procedure</p>
<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> 	<p><i>All charges</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct if 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 <i>Prosthetic devices</i>) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$15 Copayment for a Primary Care Physician office visit. \$20 Co-payment for Specialist office visit. \$100 Copayment per Surgical Outpatient Procedure</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form,</i> 	<p><i>All charges</i></p>

<p><i>except repair of accidental injury</i></p> <ul style="list-style-type: none"> • <i>Surgeries related to sex transformation</i> 	
<p>Oral and maxillofacial surgery</p>	<p>You pay</p>
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>High Option</p> <p>\$15 Co-payment for Primary Care Physician Office visit \$20 Co-payment for Specialist Office visit \$100 Co-payment per Outpatient Surgical Procedure</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<p><i>All charges</i></p>
<p>Organ/tissue transplants</p>	
<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 	<p>\$20 Co-payment per Specialist Office visit</p>

Organ/tissue transplants	You pay
	High Option
<ul style="list-style-type: none"> • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach and pancreas • Autologous tandem transplants for testicular tumors and other germ cell tumors • 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>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered 	<i>All charges</i>
Anesthesia	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) 	Nothing
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>Nothing if done in an Outpatient Setting</p> <p>\$15 co-payment per Office visit by Primary Care Physician</p> <p>\$20 co-payment per specialist office visit</p>

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- 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 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(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay *(No deductible)
Note: * (No deductible).	
Inpatient hospital	High Option
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.	\$250 copayment per admission
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 • Dressings, splints, casts and sterile tray services • Medical supplies and equipment, including oxygen 	Nothing – Part of the Inpatient Facility co-payment

Inpatient hospital - continued on next page.

Inpatient hospital <i>(continued)</i>	You pay
	High Option
<ul style="list-style-type: none"> • 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 - Part of the Inpatient co-payment
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care (except when medically necessary)</i> 	<i>All charges</i>
Outpatient hospital or ambulatory surgical center	
<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 Co-payment per Outpatient Surgical Procedure
<p><i>Not covered: Blood and blood derivatives not replaced by the member.</i></p>	<i>All charges</i>

Extended care benefits/Skilled nursing care facility benefits	You pay
	High Option
<p>Extended care benefit:</p> <ul style="list-style-type: none"> The Plan covers a comprehensive range of benefits for up to 100 days of skilled care after hospitalization when full-time nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan physician and approved by SummaCare. 	Nothing
<i>Not covered: Custodial care</i>	<i>All charges</i>
Hospice care	
<ul style="list-style-type: none"> Hospice care is supportive and palliative care for a terminally ill member and is covered in the home or an approved hospice facility. Services include inpatient and outpatient care and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. 	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges</i>
Ambulance	
<ul style="list-style-type: none"> Local professional ambulance service when medically appropriate 	\$50 Co-payment/ Copayment waived if admitted

Section 5(d) Emergency services/accidents

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.
- 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 Medicare.

What is a medical emergency?

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

What to do in case of emergency: If you are in an emergency situation, please go to the nearest hospital. In extreme emergencies, contact the local emergency system by calling 911.

Emergencies within our service area: Go to the nearest hospital in an emergency situation. Please tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or your family member should notify SummaCare within 48-hours unless it is not reasonably possible to do so. Follow up care should be provided by a Plan Provider. The emergency co-payment is waived if admitted to the hospital. If you are in the service area and have been taken to a non-plan hospital and you need to be hospitalized as an inpatient, in this non-plan hospital, you may be transferred to an in plan hospital as soon as it is medically feasible.

Emergencies outside our service area: If you are outside of the Service Area and an emergency occurs go to the nearest hospital. Benefits are available for any medically necessary health service that is immediately required because of injury or and emergency situation. If you need to be hospitalized as a result of this emergency, please notify SummaCare within 48 hours or on the first working day following your admission, unless it is not reasonably possible. If a Plan physician believes care can be provided in a Plan hospital, you will be transferred when medically feasible. To be covered by SummaCare, any follow-up care recommended by a non-plan provider must be approved by SummaCare. The Emergency room co-payment is waived if admitted to the hospital out of our service area.

When outside the Service area go to an Urgent Care center for urgently needed services. Routine service will not be covered outside of the service area.

Benefit Description	You pay * (No deductible)
Emergency within our service area	High Option
<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 <p>Note: We waive the ER co-pay if you are admitted to the hospital.</p>	<p>\$15 co-payment per Primary Care Physician \$45 co-payment at an approved Urgent Care Facility \$75 co-payment at an Emergency Room – co-payment waived if admitted</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>

Emergency outside our service area	You pay
	High Option
<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 <p>Note: We waive the ER co-pay if you are admitted to the hospital.</p>	<p>\$15 co-payment per Primary Care Physician</p> <p>\$45 co-payment per visit at an urgent care</p> <p>\$75 co-payment at an Emergency Room – co-payment waived if admitted</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> 	<p><i>All charges</i></p>
Ambulance	
<p>Professional ambulance service when medically appropriate.</p> <p>Note: See 5(c) for non-emergency service.</p>	<p>\$50 co-payment per ambulance service (Waived if admitted)</p>
<p><i>Not covered: Air ambulance</i></p>	<p><i>All charges</i></p>

Section 5(e) Mental health and substance abuse benefits

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

Important things 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.
- 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 Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay *(No deductible)
Note: * (No deductible)	
Mental health and substance abuse benefits	High Option
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists or clinical social workers • Medication management 	<p>\$20 per visit</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>\$20 per visit</p>

Mental health and substance abuse benefits – continued on next page.

Mental health and substance abuse benefits <i>(continued)</i>	You pay
	High Option
<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 	\$250 co-payment per admission
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All charges</i>

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

You may self-refer to a Plan Mental Health Provider. Your Plan Provider may be asked to submit a treatment plan to SummaCare for authorization for continued treatment. Refer to your Provider Directory for a list of Plan Providers. Please have your physician call 800-996-8701 for authorization procedures.

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

Section 5(f) Prescription drug benefits

Important things you should 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.
- 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 Medicare.

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription at an in-network plan pharmacy, or by mail.
- **We use a formulary.** 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 current SummaCare Preferred Drug List, call Member Services at 330-996-8700 or 800-996-8701 or visit our Website at www.summadare.com for a current SummaCare Formulary.
- **These are the dispensing limitations.** A generic drug will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a generic drug, you will pay the lowest co-payment (see the next page for co-payment levels). If you receive a brand name drug which is included on the SummaCare Preferred Drug List, you will pay the middle level (tier) co-payment. If you receive a brand name drug which is not on the SummaCare Preferred Drug List, you will pay the highest level (tier) co-payment (regardless of the reason the drug was dispensed. On drugs purchased at a network pharmacy there is a 30-day supply dispensed. Through mail order there is a 90-day supply dispensed. The difference in co-payment is you pay double the retail co-payment amount for a 90-day supply thorough our mail order, thus saving you a 30 day co-payment. SummaCare follows FDA Guidelines. If a member is called to active duty he or she may obtain a medium-term supply of drugs and the member may obtain a supply to meet their needs in time of national or other emergency. You will only be able to fill your prescriptions at a network pharmacy every 30 days.
- **A generic equivalent will be dispensed if it is available,** unless your physician specifically requires a name brand.
- **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 to strength and dosage to the original brand name product. Generic drugs cost less than the equivalent brand-name products. The U.S. Food and Drug Administration sets qualified 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 medications saves money.
- **When you do have to file a claim.** You only need to file a claim form for your pharmacy if for some reason due to an emergency situation you are out of the service area and a network pharmacy is not available and you need to pay cash. You would then send in a claim form for the reimbursement of the prescription purchased. To obtain a prescription claim form call Member Services at 330-996-8700 or 800-996-8701. Mail your claim to SummaCare, Inc., 10 North Main Street, Akron, Ohio 44308.

Prescription drug benefits begin on the next page.

Prescription drugs (continued)	
Benefit Description	You pay *(No deductible)
Note: *(No deductible)	
Covered medications and supplies	High Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Diabetic supplies limited to • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (See Prior Authorization Requirement) • Contraceptive drugs and devices 	<p>30-Day supply purchased at an In-Network Pharmacy:</p> <p>Tier I Drugs (Generic) \$12 co-payment</p> <p>Tier II Drugs (Preferred Name Brand) \$30 co-payment</p> <p>Tier III Drugs (Name-Brand) \$50 co-payment</p> <p>90-Day supply purchased through our Mail Order Services:</p> <p>Tier I Drugs (Generic) \$24 co-payment</p> <p>Tier II Drugs (Preferred Brand Name) \$60 co-payment</p> <p>Tier III Drugs (Brand-Name) \$100 co-payment</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name co-pay</p>
<p><i>Not covered:</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 drug - Refer to the Infertility Benefit for clarification</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> 	<p><i>All charges</i></p>

Section 5(g) Special features

Feature	Description
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call and talk with a registered nurse who will discuss treatment options and answer your health questions.
Healthy Lifestyles Health Management Program	Healthy Lifestyles offers healthy management programs designed to help those diagnosed with chronic disease live better. Current programs available include Maternal Care, Asthma, Heart Failure, Diabetes and the SummaCare Cardiac Solutions Program.
NCQA	SummaCare received accreditation through the National Committee for Quality Assurance (NCQA) in 2004. SummaCare received Excellent accreditation for our Commercial HMO/POS and Medicare Products.
Travel benefit/services overseas	You are covered for emergency and urgent care services anywhere in the world. Follow-up care should be coordinated through your Primary Care Physician.
Centers of Excellence	SummaCare's network of hospitals includes a Centers of Excellence for many types of covered services. Refer to your Provider Directory for more information about the hospitals included in the plan's network.

Section 5(h) Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, your costs for covered services, for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including Medicare.

Accidental injury benefit	You pay
	High Option
We cover initial 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.	\$15 Co-payment at a Primary Care Physician's office \$20 Co-payment per Office visit at a Specialist office \$75 Co-payment in an Emergency room – Co-pay waived if admitted.

Dental benefits

We have no other dental benefits.

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

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

Medicare prepaid plan enrollment - This plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on Page 47 annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B Medicare Premium. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 888-464-8440 for information on the Medicare prepaid plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 888-464-8440 for information on the benefits available under the Medicare HMO.

Section 6 General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition.**

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- 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 co-payment, coinsurance or deductible.

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: Mail your claim to SummaCare, Inc., 10 North Main Street, Akron, Ohio 44308 or call us at 330-996-8700 or 800-996-8701 or contact us via our website www.summacare.com.

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 330-996-8700 or 800 996-8701.

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: SummaCare, Inc., 10 North Main Street, Akron, Ohio 44308.
Phone 330-996-8700 or 800-996-8701.**

Prescription drugs

**Submit your claims to: SummaCare, Inc., 10 North Main Street, Akron, Ohio 44308.
Phone 330-996-8700 or 800-996-8701.**

Other supplies or services

**Submit your claims to: SummaCare, Inc., 10 North Main Street, Akron, Ohio 44308.
Phone 330-996-8700 or 800-996-8701.**

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.

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: SummaCare, Inc., 10 North Main Street, Akron, Ohio 44308 ; 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> <p>90 days after the date of our letter upholding our initial decision; or</p> <p>120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or</p> <p>120 days after we asked for additional information.</p> <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street NW, Washington, DC 20415-3620.</p>

The disputed claims process (*continued*)

Send OPM the following information:

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

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

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

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

5

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

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

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

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

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

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 330-996-8700 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 four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (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.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). Most people pay monthly for Part D. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about our prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• Should I enroll in Medicare?

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

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

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

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

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

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

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

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 330-996-8700 or see our Web site at www.summacare.com.

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

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

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

- **Medicare Advantage (Part C)**

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

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

This Plan and our Medicare Advantage plan:

This Plan and another 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 co-payments, coinsurance or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D

drug coverage (Part D)

and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

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

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and you have FEHB coverage on your own or through your spouse who is also an active employee		✓
5) You have FEHB coverage through your spouse who is an annuitant	✓	
6) 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	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) 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... <ul style="list-style-type: none"> • 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... <ul style="list-style-type: none"> • This Plan was the primary payer before eligibility due to ESRD 		✓ for 30-month coordination period
<ul style="list-style-type: none"> • Medicare was the primary payer before eligibility due to ESRD 	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

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

TRICARE and CHAMPVA

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

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

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.
Co-payment	A co-payment is a fixed amount of money you pay when you receive covered services. See page 10.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	<i>Care comprised of service sand supplies, including room and board and other institutional services, that is provided to an individual whether disabled or not, primarily to assist in the activities of daily living. Custodial care that lasts more than 90 days or more is sometimes known as Long Term Care.</i>
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. We have no deductible on this plan.
Experimental or investigational services	<i>In determining if a service is experimental or investigational, the Plan researches the safety and effectiveness of medical treatment. The Plan's Utilization Review committee, which consists of physicians, may also be consulted to assist in determinations in the course of the determination process; numerous medical and healthcare industry journals and healthcare databases may be used. For many procedures, the Plan follows guidelines set by the Centers for Medicaid and Medicare Services (CMS).</i>
Medical necessity	<i>A service or supply must be necessary and appropriate for the diagnosis and treatment of an illness or injury.</i>
Us/We	Us and We refers to SummaCare, 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 2006 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 2005 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 Web site, 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 \$5,000. *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 \$5,000 each (\$10,000 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.*

• Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2006 FEHB Open Season. Even if you enrolled for 2005, you must make a new election to continue participating in 2006. Enrollment is easy!

- Online: visit www.fsafeds.com and click on Enroll.
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), 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 responsible for the 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 FSAFEDS accounts. *However, if you enroll in an FSA and enroll in a High Deductible Health Plan (HDHP), you are not eligible for a Health Savings Account (HSA) under your HDHP and will be enrolled in a Health Reimbursement Arrangement (HRA) instead.*

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 requires that you 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. FSAFEDS has adopted the “grace period” permitted by the IRS. You now have an additional 2 ½ months to incur eligible expenses and reduce any potential forfeitures. In addition, you will have until May 31, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through March 15 of the following year. For example if you enrolled in FSAFEDS for the 2006 Plan Year, you will have from January 1, 2006 until March 15, 2007 to incur eligible expenses and, you may submit claims for those expenses through May 31, 2007.

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 co-payments 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 61 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 the High Option of this plan, typical out-of-pocket expenses include:

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. Since Publication 502 is primarily meant to help on preparing your Federal income tax return, there are two important differences to note. **Note:** **While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes. In addition, over-the-counter medicines and products ARE an eligible expense under your HCFSA, and this is not included in Publication 502.** 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 <https://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.

Paperless Reimbursement – This plan participates in the FSAFEDS paperless reimbursement program. When you enroll for your HCFSA, you will have the opportunity to enroll for paperless reimbursement. You must re-enroll every Open Season to remain in the paperless reimbursement program. If you do, we will send FSAFEDS the information they need to reimburse you for your out-of-pocket costs so you can avoid filing paper claims.

- **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 during your period of coverage for the Plan Year plus 2 ½ month grace period, 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. FSAFEDS Benefits Counselors are available Monday through Friday, from 9 a.m. until 9 p.m. Eastern Time.

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 request an Information Kit and application**

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

Index

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

Accidental injury	21, 26, 40	Fecal occult blood test.....	16	Oxygen.....	23, 30, 31
Allogeneic (donor) bone marrow transplant.....	28	Fraud	2, 3, 4	Pap test.....	16
Alternative treatments.....	24	General exclusions	42	Physician	23, 25
Ambulance.....	30, 32, 34	Hearing services	21	Precertification	45
Anesthesia	5, 24, 25	Home health services.....	23	Preferred Provider Organization (PPO)....	6
Autologous bone marrow transplant.....	28	Hospital.....	4, 5, 6, 8, 9, 22, 23, 25, 26, 29, 30, 31, 33, 36, 40, 43, 47, 50, 60	Prescription drugs	43, 60
Biopsy.....	25	Immunizations	6, 17	Preventive care, adult.....	16
Blood and blood plasma	31	Infertility	19	Preventive care, children.....	17
Casts	30, 31	Inpatient hospital benefits.....	43	Preventive services.....	6
Catastrophic protection (out-of-pocket maximum).....	61	Insulin.....	38	Prior approval.....	44, 45
Changes for 2006	7	Magnetic Resonance Imagings (MRIs) ..	16	Prosthetic devices.....	26
Chiropractic	23	mammograms	16	Psychologist	35
Cholesterol tests.....	16	Maternity benefits	18	Room and board.....	30
Claims.....	43, 44, 53, 55	Medicaid.....	50	Second surgical opinion	15
Coinurance	6, 43, 47, 56	Medically necessary	15, 18, 25, 30, 33, 35, 37, 40, 42	Skilled nursing facility care.....	9, 15, 29
Colorectal cancer screening	16	Medicare.....	35, 46, 49	Social worker	35
Congenital anomalies	25	Original	47	Speech therapy	21
Contraceptive drugs and devices	18, 38	Members		Splints	30
Covered charges	47	Associate	62	Subrogation	50
Crutches.....	23	Family	52	Substance abuse	60
Deductible	6, 15, 25, 43, 47, 56, 60	Plan	8	Surgery.....	5, 18, 20, 21, 26
Definitions ...	15, 25, 30, 33, 35, 37, 40, 51, 60	Mental Health/Substance Abuse Benefits	35	Anesthesia.....	31
Dental care.....	40, 60	Newborn care	18	Oral	28
Diagnostic services.....	15, 30, 35, 60	Nurse		Outpatient	31
Donor expenses	29	Licensed Practical Nurse (LPN).....	23	Reconstructive	25
Dressings	30	Nurse Anesthetist (NA).....	31	Syringes	38
Durable medical equipment.....	23	Registered Nurse	39	Temporary Continuation of Coverage (TCC).....	53
Effective date of enrollment	9	Occupational therapy.....	20	Transplants.....	29
Emergency.....	6, 33, 34, 42, 43, 60	Ocular injury	21	Vision care	60
Experimental or investigational	42	Office visits	6	Vision services	21
Eyeglasses	21	Oral and maxillofacial surgical.....	28	Wheelchairs.....	23
Family planning.....	18	Out-of-pocket expenses	46	Workers Compensation	50
				X-rays.....	16, 30, 31

Summary of benefits for the High Option of the - 2006

Do not rely on this chart alone. All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

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

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit co-pay: \$15 primary care; \$20 specialist	15
Services provided by a hospital:		
Inpatient	\$250 per admission co-pay	30
Outpatient Procedure	\$100 co-payment per visit	31
Emergency benefits:		
In-area	\$75 per visit waived if admitted	33
Out-of-area	\$75 per visit waived if admitted	33
Mental health and substance abuse treatment:		
	Regular cost sharing \$250 Co-pay Inpatient per admission \$20 Co-pay per visit Outpatient	35
Prescription drugs:		
Retail pharmacy	<i>\$12 generic Tier I Drugs \$30 Preferred Name Brand Tier II Drugs \$50 Brand Name Tier III Drugs</i>	
Mail order	<i>\$24 Generic Tier I Drugs \$60 Preferred Name Brand Tier II Drugs \$100 Brand Name Tier III Drugs</i>	
Dental care:	No benefit for routine or preventive services; accidental injury covered for initial visit	40
Vision care:	No benefit. You pay \$20 for one eye exam every 24 months	22
Special features:	24 Hour Nurse Line; Centers for Excellence; NCQA	39

Protection against catastrophic costs (out-of-pocket maximum):	We do not have an out of pocket limit	11
---	---------------------------------------	----

2006 Rate Information for SummaCare, Inc.

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.

Type of Enrollment	Enrollment Code	<i>Non-Postal Premium</i> <u>Biweekly</u> Government Share	<i>Non-Postal Premium</i> <u>Biweekly</u> Your Share	<i>Non-Postal Premium</i> <u>Monthly</u> Government Share	<i>Non-Postal Premium</i> <u>Monthly</u> Your Share	<i>Postal Premium</i> <u>Biweekly</u> USPS Share	<i>Postal Premium</i> <u>Biweekly</u> Your Share
High Option Self Only	5W1	139.18	52.30	301.56	113.31	164.31	27.17
High Option Self and Family	5W2	316.08	143.49	684.84	310.90	373.15	86.42