Sagamore Advantage HMO, Inc.

http://www.sagamorehn.com

ADVANTAGE Health Plan

Sagamore Advantage HMO, Inc.

2001

A Health Maintenance Organization

Serving: *Most of Indiana*

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

Enrollment codes for this Plan:

6Y1 Self Only
6Y2 Self and Family

Special notice: This Plan is offered for the first time under the Federal Employees Health Benefits Program during the 2000 Open Season.

Authorized for distribution by the:

OPM
UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
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FEHB
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Introduction

Sagamore ADVANTAGE HMO, Inc.
11155 North Meridian, Suite 240
Carmel, IN 46032

This brochure describes the benefits of Sagamore Advantage HMO, Inc. (ADVANTAGE Health Plan) under our contract (CS 2862) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means ADVANTAGE Health Plan.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

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 only pay the copayments and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. ADVANTAGE Health Plan pays almost all of its contracting medical groups and other physician networks on a capitation basis. Capitation is a method of payment in which an HMO pays a provider or provider network an agreed upon monthly fee for each member assigned to that provider or provider network.

Under capitation payment arrangements, the provider network is responsible for paying the physicians, hospitals and ancillary providers who provide the covered services to members. In some cases, the provider network pays the primary care physicians and specialty physicians on either a capitation basis or on a fee-for-services basis. "Fee-for-service" payment means that the physician bills the provider network for each service he/she provides, and the provider network pays an agreed upon rate for each service. Some hospital and ancillary providers are paid on a capitation payment basis, and others are paid on a fee-for-service basis. The provider networks may pay bonuses to, or withhold funds from, their contracted physicians based on how appropriately the physician has managed the utilization and costs of care for all his/her members.

If a member believes that his/her physician is refusing to authorize care when needed, or if it is taking too long to get approvals for specialty care or hospitalization, the member should contact Member Services at 1-800-553-8933 to discuss the concern. A Member Service Representative will assist in the evaluation of the concern and action.

ADVANTAGE Health Plan members may also contact a Member Service Representative to obtain additional information about provider payment arrangements and incentives.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

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

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

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

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

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

Specialty providers are generally limited to those participating within your PCP's network. The Provider Directory lists specialists by type of practice and by affiliated network.

If you want more information about us, call 1-800-553-8933, or write to ADVANTAGE Health Plan Member Services, P.O. Box 876, Carmel, IN 46082. You may also contact us by fax at 317-573-2839 or visit our website at www.sagamorehn.com.

Service Area

To enroll with us, you must live in or work in our service area. This is where our providers practice. Our service area includes the following counties: Allen, Boone, Clinton, Dekalb, Delaware, Elkhart, Gibson, Hamilton, Hancock, Hendricks, Henry, Howard, Huntington, Johnson, Kosciusko, Lake, Marion, Marshall, Morgan, Noble, Porter, Posey, Putnam, Shelby, St. Joseph, Vanderburgh, Wabash, Warrick, Wells and Whitley.

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 or urgently needed care. We will not pay for any other health care services.

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

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we had shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling 1-800-553-8933 **or** checking our website www.sagamorehn.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:

  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.

- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-553-8933.

Where you get covered care

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

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards. The Plan's Primary Care Physicians (PCPs) specialize in Family Practice, General Practice, Internal Medicine, and Pediatrics. The Plan's Specialists are practitioners who have furthered their training in specific areas of health care such as cardiology, surgery, dermatology, and oncology. The Plan arranges access to a broad range of participating providers through contracting with provider networks who directly contract with PCPs, specialists, hospitals and other facilities making up that provider network's delivery system.

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

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. When you select a PCP, you agree to utilize the physician's affiliated hospital or hospital services. When your physician authorizes inpatient or outpatient hospital services, you may contact us to obtain more information about the hospital, such as: hospital accreditation status, experience/volume in performing certain procedures, and comparable measures of quality and consumer satisfaction.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your PCP provides or arranges for most of your health care. At the time of enrollment, you are given a Provider Directory to select your PCP.

The ADVANTAGE Health Plan's Provider Directory lists primary care doctors with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular

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

- **Primary care**

Your PCP can be a Family Practice, General Practice, Internal Medicine or Pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

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

- **Specialty care**

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

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

Here are 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 PCP will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your PCP 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 PCP. Your PCP will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your PCP, who will arrange for you to see another specialist. You

may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

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

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

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

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

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-553-8933. If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the hospital benefit of the hospitalized person.

Circumstances beyond our control

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

Services requiring our prior approval

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

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

- Diagnostic procedures such as CAT Scans and MRIs
- Elective hospital admissions

- Transplants
- Outpatient surgical procedures

The Precertification Review process is initiated by a physician referral to the appropriate medical management department (most of the Plan's provider networks are delegated medical management and Precertification Review). A Registered Nurse applying nationally accepted clinical guidelines and criteria performs the review. Any referral not meeting medical necessity guidelines is referred to a physician consultant. Only a licensed physician will render a denial of the referral and only after consultation with the requesting physician. All denial letters include the principal reason for denial, specific details regarding your appeal rights, and how to obtain a copy of the actual clinical guidelines used during the review process. Precertification Review determinations are made within 2 business days of receiving all necessary information unless the request is urgent. Urgent precertification requests are completed within one business day of receipt. If procedures requiring Precertification are not appropriately reviewed, the services may be denied for coverage and may result in nonpayment by the Plan.

Section 4. Your costs for covered services

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

- **Copayments**	A copayment is a fixed amount of money you pay to the provider when you receive services. Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go in the hospital, you pay $100 per admission (limited to a maximum of two (2) copayments per member per year).
- **Deductible**	We do not have a deductible.
- **Coinsurance**	Coinsurance is the percentage of our negotiated fee that you must pay for your care. There is no deductible to meet. Example: In our Plan, you pay 50% of our allowance for corrective appliances and durable medical equipment.
Your out-of-pocket maximum	We do not have an out-of-pocket maximum.

Section 5. Benefits -- OVERVIEW

(See page 53 for a benefits summary.)

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

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • Primary care physician office visit • Specialist physician office visit	$10 per office visit
Professional services of physicians • In an urgent care center or emergency room • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Office medical consultations • Second surgical opinion	Nothing
At home (within the service area)	$25 per visit

Lab, X-ray and other diagnostic tests	You Pay
Tests, such as: • 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 during your office visit; otherwise,. $10 per office visit
Preventive care, adult	
Routine screenings, such as: • Routine physical exam • Blood lead level – One annually • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including ••Fecal occult blood test ••Sigmoidoscopy, screening – every five years starting at age 50 • Prostate Specific Antigen (PSA test) – one annually for men age 40 and older • Routine PAP test Note: The office visit is covered if pap test is received on the same day; see *Diagnostic and Treatment Services* above.	$10 per office visit

Preventive care, adult *(Continued)*	**You pay**
Routine mammogram –covered for women age 35 and older, as follows: • 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	$10 per office visit
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	$10 per office visit
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per office visit
• Examinations, such as: ••Eye exams through age 17 to determine the need for vision correction. ••Ear exams through age 17 to determine the need for hearing correction ••Examinations done on the day of immunizations (through age 22) • Well-child routine examinations, immunizations and care (through age 22)	$10 per office visit

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • Your normal delivery does not need to be percertified. • 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. • 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).	$10 per office visit
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*
Family planning	
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	$10 per office visit $100 per outpatient facility visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling, voluntary abortions	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: ••intra vaginal insemination (IVI) ••intra cervical insemination (ICI) ••intra uterine insemination (IUI)	50% coinsurance for each procedure
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* ••*in vitro fertilization* ••*embryo transfer and GIFT* • *Services and supplies related to excluded ART procedures* • *Injectable or oral fertility drugs* • *Cost of donor sperm*	*All charges.*
Allergy care	
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 26. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	$10 per office visit
• Growth hormone therapy (GHT) Note: – We will only cover GHT when we preauthorize the treatment. Call your Plan Physician for preauthorization. GHT must be medically necessary, and authorized by your Plan physician before you begin treatment. If you do not obtain authorization or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	50% of charges.
Rehabilitative therapies	
Physical therapy, occupational therapy and speech therapy -- • Up to two (2) consecutive months per condition for the services of each of the following: ••qualified physical therapists; ••speech therapists; and ••occupational therapists. •• chiropractors Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury, and if significant improvement can be expected within two (2) months. Note: Chiropractic services are limited to spinal manipulation only. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to three (3) month period	$10 per office visit
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges.*

Hearing services (testing, treatment, and supplies)	You pay
• First hearing aid testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per office visit
• First hearing aid only when necessitated by accidental injury	50% of charges
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them, except for accidental injury or preventive testing for children*	*All charges.*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	50% of charges
• Eye exam to determine the need for vision correction for children through age 17 (see preventive care) • Annual eye refractions	$10 per office visit
Not covered: • *Eyeglasses or contact lenses and, after age 17, examinations for them* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges.*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*

Orthopedic and prosthetic devices	You pay
• Artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device.	Nothing
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome	50% of charges
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, stump hose and other supportive devices* • *Prosthetic replacements provided less than two (2) years after the last one covered*	*All charges.*
Durable medical equipment (DME)	
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 items such as: • hospital beds; • wheelchairs; • crutches; • walkers; • blood glucose monitors; and • insulin pumps. Note: Call your Plan physician who will prescribe this equipment and direct you to a contracted supplier.	50% of charges

Durable medical equipment (DME) *(Continued)*	You Pay
Not covered: • *Motorized wheel chairs* • *Swimming pools and spas* • *Exercise equipment* • *Repair of DME when malfunction is directly a result of misuse or neglect*	*All charges.*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), dietician , or home health aide. • Services include oxygen therapy, intravenous therapy and medications. • Transparenteral Therapy (TPN) • Sleep Apnea Studies • Ventillator Management • Wound Care	$10 per office visit
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All charges.*
Educational classes and programs	
Coverage is limited to classes such as: • Smoking cessation if enrolled in an approved smoking cessation program. Approved prescription drugs are subject to the prescription copay. • Diabetes disease-management • Asthma disease management • Prenatal Program Note: You may call our health education department for a list of approved classes.	Nothing
Not covered: • *Over the counter smoking cessation aids* *More than one (1) smoking cessation class per calendar year and no more than three (3) classes per lifetime.*	All Charges

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

IMPORTANT

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

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

IMPORTANT

Benefit Description	You pay
Surgical procedures	
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Insertion of internal prostethic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information.	$10 per office visit

Surgical procedures *(Continued)*	**You Pay**
• Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds over his or her normal weight according to current underwriting standards; has a body mass index (BMI) over 40 kilograms/meter2; or has a BMI over 35 kilograms/meter2 and a high risk co-morbid condition. In addition the eligible members must be age 18 or over; has failed to lose a significant amount of weight or has regained weight despite compliance with a medically supervised, multidisciplinary, non-surgical program including low calorie or very low calorie diet, supervised exercise, behavioral modification and support and treatment of co-morbid condition; does not have a correctable cause for obesity; and is being treated in a surgical program with experience with obesity surgery including not only surgeons, but also a multidisciplinary team including all of the following: • Preoperative medical consultation and approval • Preoperative psychiatric consultation and approval • Nutritional counseling • Exercise counseling • Psychological counseling • Support group meetings • Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a). • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*

Reconstructive surgery	You Pay
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: ••the condition produced a major effect on the member's appearance and ••the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformaties; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; •• breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$10 per office visit
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation* • *Surgical procedures for body fat reduction, such as liposuction.*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$10 per office visit
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Dental work relating to TMJ*	*All charges.*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Kidney • Kidney/Pancreas • Liver • 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 Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-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. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	$10 per office visit
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered* • *Experimental and investigational transplants*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	Nothing
Professional services provided in – • Office	$10 per office visit

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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- No calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as: • semiprivate room accommodations; • specialized care units, such as intensive care or cardiac care units • general nursing care; and • meals and special diets. NOTE: • If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. • When your Plan physician determines it is medically necessary, the physician may prescribe private accommodations or private duty nursing care.	$100 per admission; copayment is limited to two (2) copayments per Member per calendar year

Inpatient hospital continued on next page.

Inpatient hospital *(Continued)*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	Nothing
Not covered: • *Custodial care* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Take-home prescription drugs* • *Hospitalization for dental procedures*	*All charges.*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: • We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$100 per admission
Not covered: blood and blood derivatives not replaced by the member	*All charges*

Extended care benefits/skilled nursing care facility benefits	You pay
Extended care benefit: Up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate and determined by your Plan physician and approved by the Plan. • Bed, board and general nursing care • Drugs, biologicals, supplies, equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by the Plan physician	Nothing
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care or homemaker services* • *Personal comfort items, such as telephone or television*	*All charges*
Hospice care	
Provided for a terminally ill member in accordance with a treatment plan developed before admission to the Hospice Care Program. The treatment plan must be approved by ADVANTAGE Health Plan or its designated agent. Note: Limited to services provided under the direction of a Plan physician who certifies that the patient is in the terminal stage of illness, with a life expectancy of approximately six months or less.	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

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

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

To be covered by this Plan, any follow-up care recommended by non-Plan physician must be approved by your Plan physician with a prior referral.

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

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

To be covered by this Plan, any follow-up care recommended by an emergency room physician must be approved by the Plan or provided by a Plan physician.

If you are required to pay for services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on pages 40-41.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center	$10 per office visit $10 per office visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$50 per visit
Note: Emergency Room copay is waived if member is admitted to the hospital.	
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center	$10 per office visit $10 per office visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$50 per visit
Note: Emergency Room copay is waived if member is admitted to the hospital.	
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*	*All charges.*
Ambulance	
Professional ambulance service when medically appropriate; including air ambulance transport. See 5(c) for non-emergency service.	Nothing

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

IMPORTANT

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

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

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

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

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per office visit

Mental health and substance abuse benefits - Continued on next page

Mental health and substance abuse benefits *(Continued)*	**You pay**
• Diagnostic tests	$10 per office visit
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment.	$100 per admission
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Preauthorization

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

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

Limitation

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

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

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

  Your health plan/employer has chosen a prescription drug program that has three different co-pay levels. This program allows you to pay a lower copay for covered drugs that are on the formulary. Covered drugs that are not on the formulary are still available to you but at a higher copay.

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

- **These are the dispensing limitations.** Prescription drugs prescribed by a plan or referral doctor and obtained at a plan pharmacy will be dispensed up to a 30-day supply; or one commercially prepared unit (i.e. one inhaler, one vial ophthalmic medication or insulin). You pay a $5 copay per prescription unit or refill for generic drugs or a $10 copay per prescription unit or refill for name brand drugs when generic substitution is not available. You pay a $25 copay for non-formulary drugs. When generic substitution is available, but you request the name brand drug or non-formulary drug, you pay the price difference and the required copay per prescription unit or refill as written. You will always pay the appropriate copayment or the actual cost of the drug, whichever is less.

  If your physician orders more than a 30 day supply of covered drugs, up to a 90 day supply, mail service is available. Initially you request your prescription information by completing a Pharmacare Mailer and enclosing your original written prescription. If you are currently taking a medication, you must call your physician's office and request a new prescription for the maximum day supply. You pay a $10 copay per generic, a $20 copay per name brand (when generic is not available), and $50 for non-formulary for up to a 90 day supply. When generic substitution is available, but you request the name brand or non-formulary drug, you pay the price difference and the required copay.

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

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below • Insulin • Insulin syringes and needles • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction are limited, contact the Plan for dose limitations, such as, Viagra quantity limited to 6 tabs/month • Oral and injectable contraceptive drugs and devices Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic. • We administer an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 1-800-553-8933.	$5 per Generic $10 per Name Brand $25 per Non-Formulary Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Medical supplies such as dressings and antiseptics* • *Drugs used for treating infertility* • *Drugs to enhance athletic performance* • *Experimental or investigational drugs* • *Diet Pills*	*All Charges*

Section 5 (g). Special Features

Feature	Description
Services for deaf and hearing impaired	Toll free 1-800-743-3333

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit	You Pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	$10 per office visit

Dental benefits

We have no other dental benefits.

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

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

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

Medical, hospital and drug benefits

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

When you must file a claim -- such as for out-of-area care -- 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 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: **ADVANTAGE Health Plan**
Attn: HMO Claims
P.O. Box 876
Carmel, IN 46082

Deadline for filing your claim

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

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: ADVANTAGE Health Plan, Appeals and Grievance Coordinator or Appeals Committee, 11555 North Meridian Street, Suite 240, Carmel, IN 46032; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, D.C. 20044-0436.

The disputed claims process (cont.)

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 different claims, 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 provide 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.

6 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. 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 1-800-553-8933 and we will expedite our review; or

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division III 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 are covered or a family member is covered 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.

· Original Medicare

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A.
- Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Managed Care is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan PCP, or precertified as required. We will not waive any of our copayments and coinsurance.

(Primary payer chart begins on next page.)

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

Please note, if your Plan physician does not participate in Medicare, you will have to file a claim with Medicare

- **Medicare Managed Care Plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do waive any of our copayments, coinsurance, or deductibles for your FEHB coverage.

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles.

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

- **Enrollment in Medicare Part B**

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

TRICARE

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

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency 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 benefits. You must use our providers.

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care.

Covered services

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

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.

Experimental or investigational services

ADVANTAGE Health Plan has available participating specialists, sub-specialists, and a referral center to assist with the review and determination of experimental treatment, procedures, drugs or devices. Your PCP must request an approval, before the service date, regarding the recommended treatment or services that is to be reviewed. A review with Technology Evaluation Center (TEC) is done to determine the feasibility of the recommended treatment. If a review of new technology is made on your behalf by your PCP, ADVANTAGE Health Plan will notify you of the determination for coverage within one business day following the determination. Review for urgent and emergent determinations will be communicated within 72 hours. For further information about the Medical Technology Assessment, please contact a Member Service Representative at 1-800-553-8933.

Medical necessity

Medical necessity means health services or supplies that are skilled care; are required for the treatment of illness or injury; are consistent with your symptoms or diagnosis; are appropriate treatments with regard to standards of accepted medical practice; are not primarily for your convenience, your family's convenience or the convenience of any health care provider; are not experimental, investigational or unproven; and do not exceed the level of care which is needed to provide a safe, adequate, and appropriate diagnosis of treatment.

A health service does not meet medical necessity if your symptoms or condition indicates that it would be safe to provide the service or supply in a less comprehensive setting. The fact that a physician or other health care provider has furnished, ordered, or approved a service or supply does not, alone, make that service or supply a medical necessity.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. We determine our allowance based on the lesser of the fee arrangement between ADVANTAGE Health Plan and the provider, or the billed charge. When covered services are provided by a Plan provider you are not responsible for charges above the allowance.

Us/We	Us and we refer to ADVANTAGE Health Plan.
You	You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans,* brochures for other plans, and other materials you need to make an informed decision about:

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

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

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

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 (TCC).

When you lose benefits

When FEHB coverage ends

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

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

Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get 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.

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.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure.

· Converting to individual coverage

You may convert to an individual policy if:

•• Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay your premium, you cannot convert;

•• You decided not to receive coverage under TCC or the spouse equity law; or

•• You are not eligible for coverage under TCC or the spouse equity law.

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

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

Getting a Certificate of Group Health Plan Coverage

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan.

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

Inspector General Advisory

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 317-580-8474 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE--202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

NOTES:

Summary of benefits for ADVANTAGE Health Plan - 2001

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

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $10 specialist	14
Services provided by a hospital:		
• Inpatient.....	$100 per admission; copayment is limited to two (2) copayments per member per year	27
• Outpatient.....	$100 per admission	28
Emergency benefits:		
• In-area	$50 per visit	31
• Out-of-area	$50 per visit	31
Mental health and substance abuse treatment	Regular cost sharing.	32
Prescription drugs.....	$5 Generic; $10 Brand Name; $25 Non-Formulary *Note: If there is no generic equivalent available, you will still have to pay the brand name copay.*	35
Dental Care.....	No benefit	37
Vision Care.....	$10 copay per visit for annual eye refraction	20
Special features: Services for deaf and hearing impaired		36

2001 Rate Information for ADVANTAGE Health Plan

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

Type of **Enrollment**	Code	***Non-Postal Premium*** **Biweekly** Gov't Share	Your Share	**Monthly** Gov't Share	Your Share	***Postal Premium*** **Biweekly** **USPS** Share	**Your** Share
Location Information							
High Option **Self Only**	**6Y1**	**$ 79.58**	**$ 26.53**	**$172.43**	**$ 57.48**	**$ 94.17**	**$ 11.94**
High Option Self & Family	**6Y2**	**$186.86**	**$ 62.29**	**$404.87**	**$134.96**	**$221.12**	**$ 28.03**