

# FEHBP HIGH DEDUCTIBLE PLAN: HSA / HRA

## SUMMARY OF BENEFITS – 2008

### 1300/2600 80/60



	<b>IN NETWORK</b>	<b>OUT OF NETWORK</b>
Deductible – Family Deductible is Aggregate	Single \$1,300, Family \$2,600	Single \$4,000, Family \$8,000
Lifetime Maximum Benefits	Unlimited	Unlimited
Aggregate Annual Out-of-Pocket Max <i>(includes deductible)</i>	Single \$3,000 Family \$6,000	Single \$12,000, Family \$24,000

<b>PREVENTIVE HEALTH SERVICES*</b>		
Routine Health Screenings	100% After \$20 Copay*	60%
Well Child Care, Including Immunizations	100% After \$20 Copay*	60%
<b>PHYSICIAN SERVICES</b>		
Physician Office Visits	80%	60%
Maternity Care	80%	60%
Surgical Procedures	80%	60%
Inpatient Hospital Visits	80%	60%
Organ Transplantation <i>(Non-Experimental Transplants At An OSF Approved Facility)</i>	80%	60%
Radiation Therapy	80%	60%
Chemotherapy	80%	60%
Hemodialysis	80%	60%
<b>INPATIENT HOSPITAL SERVICES</b>		
All Inpatient Services (Pre-certification required)	80%	60%
<b>OUTPATIENT HOSPITAL SERVICES</b>		
Outpatient Surgery (Pre-certification required)	80%	60%
Outpatient Diagnostic X-ray and Laboratory Services	80%	60%
<b>OTHER COVERED SERVICES</b>		
Emergency Care <i>(Non-Emergency Not Covered/Copayment Waived If Admitted)</i>	80%	80%
Ambulance Transportation	80%	80%
Home Health	80%	60%
Skilled Nursing Facility <i>(Up To 45 In Network Days Per Year) (Up To 10 Out Of Network Days Per Year)</i>	80%	60%
Outpatient Rehabilitation <i>(Physical, Occupational &amp; Speech Therapies – \$5,000 Combined In &amp; Out of Network Maximum Per Year)</i>	80%	60%
Durable Medical Equipment <i>(\$10,000 Combined In &amp; Out of Network Maximum Benefit Per Year)</i>	80%	60%

\* Not subject to the deductible.

This document is intended As a Summary Only. Please Refer to the Explanation of Coverage and Benefit Schedule for Further Details.

**IN NETWORK**

**OUT OF NETWORK**

**MENTAL HEALTH**

Inpatient Mental Health Conditions (Pre-certification required)	<b>80%</b>	60%
Outpatient Mental Health Conditions	<b>80%</b>	60%

**SUBSTANCE ABUSE**

Inpatient Services (Pre-certification required)	<b>80%</b>	60%
Outpatient Services	<b>80%</b>	60%

**Important Points To Remember**

- Members are required to pre-certify all **in and out of network** inpatient hospitalizations (including maternity, transplant, mental health and substance abuse admissions), outpatient surgeries, durable medical equipment, home health care, skilled nursing & hospice. Failure to pre-certify will result in a penalty of \$500.
- Members are required to notify OSF HealthPlans within 48 hours of any emergency admission.
- Out of network coinsurance amounts are based on Usual, Customary, and Reasonable (UCR) fees. Member is responsible for out of network charges in excess of UCR fees.
- All benefits are subject to deductible and out-of-pocket maximum unless otherwise noted.
- Unmarried dependent children are covered through age 22.
- The most current participating provider directory is available on our website at [www.osfhealthplans.com](http://www.osfhealthplans.com).
- This plan is a faith based plan, any services objectionable to the Catholic church are not covered.

**For Questions About**

**Your Coverage  
Pre-certification**

OSF HealthPlans (309) 677-8222 or (800) 673-5222  
(309) 677-8236 or (800) 284-2273

**Mental Health/Substance Abuse**

or (800) 375-5716 in the Rockford area  
UBH (800) 420-5729

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You are encouraged to review the information in these marketing materials. THESE MARKETING MATERIALS ARE NOT LEGAL DOCUMENTS. For full benefit information please refer to your contract or certificate, or contact OSFHP at 1-800-673-5222. If any inconsistencies exist between these marketing materials and the applicable contract or certificate, the terms of the contract or certificate will control.