

# Federal Employees Health Benefit Program 2008 SUMMARY OF BENEFITS



Deductible	\$0
Lifetime Maximum Benefits	Unlimited
Annual Out of Pocket Maximum	Single \$1,500, Family \$3,000

SERVICES	BENEFITS		SPECIAL PROVISIONS
	Member Copayment	Then HMO Pays	
<b>PREVENTIVE HEALTH SERVICES</b>			
Routine Health Screenings	\$20	100%	
Well Child Care, Including Immunizations	\$20	100%	
Vision Examination*	\$20	100%	One Routine Exam Every 24 Months From Participating Provider
<b>PHYSICIAN SERVICES</b>			
Primary Care Physician Office Visits	\$20	100%	
Specialist Physician Office Visits	\$20	100%	
Gynecological Care Office Visits*	\$20	100%	
Maternity Care*	\$100	100%	One Copayment Per Delivery
Surgical Procedures	\$0	100%	
Inpatient Hospital Visits	\$0	100%	
Anesthesia	\$0	100%	
X-ray and Laboratory Services	\$0	100%	
Organ Transplantation	\$0	100%	Non-Experimental Transplants At An OSF HealthPlans Approved Facility
Radiation Therapy	\$0	100%	
Chemotherapy	\$0	100%	
Hemodialysis	\$0	100%	
<b>INPATIENT HOSPITAL SERVICES</b>			
All Inpatient Services	\$500 Per Admission	100%	
<b>OUTPATIENT HOSPITAL SERVICES</b>			
Outpatient Surgery	\$150	100%	One Copay Per Surgery
Outpatient Diagnostic X-ray and Laboratory Services	\$0	100%	
<b>OTHER COVERED SERVICES</b>			
Emergency Care*	\$100	100%	Non-emergency Not Covered: Copayment Waived if Admitted; Must Notify OSF HealthPlans Within 48 Hours
Ambulance Transportation	\$0	100%	If Emergency Or Pre-authorized
Home Health	\$0	100%	Up To 60 Visits Per Year
Skilled Nursing Facility	\$0	100%	Up To 45 Days Per Year
Physical and Occupational Therapy	\$20	100%	Up To 50 Visits Per Condition Per Year
Speech Therapy	\$20	100%	\$2,000 Maximum Benefit Per Person Per Year
Durable Medical Equipment**	20%	80%	\$10,000 Maximum Benefit Per Year

\*Does Not Require Primary Care Physician Referral

\*\*Copayments, and/or Coinsurance Do Not Apply Towards the Annual Maximum Out-of-Pocket

All Medical Care Must Be Preauthorized, Arranged Or Provided By Your OSF HealthPlans Primary Care Physician

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

SERVICES	BENEFITS		SPECIAL PROVISIONS
	Member Copayment	Then HMO Pays	
<b>MENTAL HEALTH</b>			
Inpatient Services	\$500 Per Admission	100%	
Outpatient Services	\$20	100%	
<b>SUBSTANCE ABUSE</b>			
Inpatient Services	\$500 Per Admission	100%	
Outpatient Services	\$20	100%	

**EXCLUSIONS:**

Non-covered benefits include, but are not limited to: non-emergency services not preauthorized, arranged, or provided by your OSF HealthPlans Primary Care Physician; investigational or experimental procedures; services not medically necessary; personal or convenience items; radial keratotomy; glasses or contact lenses; hearing examinations and hearing aids; custodial care; marital or employment physicals; cosmetic services or surgery; charges for missed appointments; reversal of sterilization; food supplements; medical or surgical treatment for reduction of weight; transexual surgery; over-the-counter drugs; dental services; foot or orthotics; abortions; and work related injury or illness.

*Please refer to the Explanation of Coverage (EOC) and Benefit Schedule for complete details on all limitations and exclusions.*

**IMPORTANT POINTS TO REMEMBER**

- You must select a Primary Care Physician for each family member at the time of enrollment. Each family member can have the same Primary Care Physician or each may select a different Primary Care Physician.
- College students or members on vacation or business travel are covered for emergency and urgent care outside the HMO service area.
- There is no annual deductible. For some services you will be required to pay a nominal copayment at the time service is received.
- In order to enroll in the HMO, you and your dependents must permanently reside within the HMO service area, or work within the HMO service area and reside in a contiguous county.
- All medical management is handled between OSF HealthPlans and the provider. Members are required to notify OSF HealthPlans within 48 hours of any emergency or urgent care.
- When the HMO is the secondary carrier, you must follow all the requirements of the HMO to receive secondary benefits.

<b>FOR QUESTIONS ABOUT</b>	
Your HMO Coverage.....	OSF HealthPlans (309-677-8222) or (800-673-5222) or TDD (888-817-0139)
Mental Health/Substance Abuse.....	United Behavioral Health (800-420-5729)

*\*Does Not Require Primary Care Physician Referral*

*\*\*Copayments, and/or Coinsurance Do Not Apply Towards the Annual Maximum Out-of-Pocket*

*All Medical Care Must Be Preauthorized, Arranged Or Provided By Your OSF HealthPlans Primary Care Physician*

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

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.