

CDPHP Universal Benefits, Inc.

Formerly Capital District Physicians' Health Plan, Inc. (CDPHP)



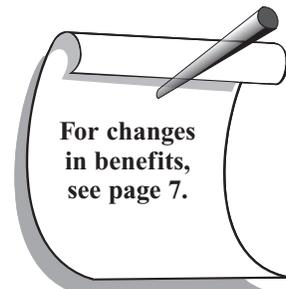
www.cdphp.com

2005

A Prepaid Comprehensive Medical Plan

Serving: Upstate, Hudson Valley, and Central New York

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



Enrollment codes for this Plan:
SG1 Self Only
SG2 Self and Family

Special Notice:

Codes QB1, QB2, PW1, and PW2 have been eliminated. If you were enrolled in one of these codes, you will be automatically transferred to SG1 or SG2, unless you make an Open Season change.



Authorized for distribution by the:



**United States
Office of Personnel Management**

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

RI 73-549



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT

WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

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

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

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

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

Sincerely,

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

Kay Coles James
Director



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



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

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

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

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

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

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

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

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

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

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

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

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

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

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

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

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

Table of Contents

| | |
|---|----|
| Introduction | 3 |
| Plain Language | 3 |
| Stop Health Care Fraud! | 4 |
| Preventing medical mistakes | 5 |
| Section 1. Facts about this prepaid plan | 6 |
| How we pay providers | 6 |
| Your Rights | 6 |
| Service Area | 6 |
| Section 2. How we change for 2005 | 7 |
| Program-wide changes | 7 |
| Changes to this Plan | 7 |
| Section 3. How you get care | 8 |
| Identification cards | 8 |
| Where you get covered care | 8 |
| • Plan providers | 8 |
| • Plan facilities | 8 |
| What you must do to get covered care | 8 |
| • Primary care | 8 |
| • Specialty care | 8 |
| • Hospital care | 9 |
| Circumstances beyond our control | 9 |
| Services requiring our prior approval | 9 |
| Section 4. Your costs for covered services | 10 |
| Copayments | 10 |
| Deductible | 10 |
| Coinsurance | 10 |
| Your catastrophic protection out-of-pocket maximum | 10 |
| Section 5. Benefits—OVERVIEW (<i>See page 7 for how our benefits changed this year and page 55 for a benefits summary.</i>) | 11 |
| Section 5(a) Medical services and supplies provided by physicians and other health care professionals . . . | 12 |
| Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals . | 20 |
| Section 5(c) Services provided by a hospital or other facility, and ambulance services | 23 |
| Section 5(d) Emergency services/accidents | 25 |
| Section 5(e) Mental health and substance abuse benefits | 27 |
| Section 5(f) Prescription drug benefits | 29 |
| Section 5(g) Special features | 31 |
| • Flexible benefits option | 31 |
| • Non-emergency care for full-time students out of the area | 31 |
| • Services for deaf and hearing impaired | 31 |

Table of Contents *continued*

| | |
|---|------------|
| • Childbirth Education Reimbursement Program | 31 |
| • Centers of excellence | 31 |
| Section 5(h) Dental benefits | 32 |
| Section 5(i) Non-FEHB benefits available to Plan members | 33 |
| Section 6. General exclusions – things we don’t cover | 34 |
| Section 7. Filing a claim for covered services | 35 |
| Section 8. The disputed claims process | 36 |
| Section 9. Coordinating benefits with other coverage | 38 |
| When you have other health coverage | 38 |
| What is Medicare? | 38 |
| • Should I enroll in Medicare? | 38 |
| • The Original Medicare Plan (Part A or Part B) | 39 |
| • Medicare Advantage | 41 |
| TRICARE and CHAMPVA | 41 |
| Workers’ Compensation | 42 |
| Medicaid | 42 |
| When other Government agencies are responsible for your care | 42 |
| When others are responsible for injuries | 42 |
| Section 10. Definitions of terms we use in this brochure | 43 |
| Section 11. FEHB Facts | 44 |
| Coverage information | 44 |
| • No pre-existing condition limitation | 44 |
| • Where you can get information about enrolling in the FEHB Program | 44 |
| • Types of coverage available for you and your family | 44 |
| • Children’s Equity Act | 44 |
| • When benefits and premiums start | 45 |
| • When you retire | 45 |
| When you lose benefits | 45 |
| • When FEHB coverage ends | 45 |
| • Spouse equity coverage | 46 |
| • Temporary Continuation of Coverage (TCC) | 46 |
| • Converting to individual coverage | 46 |
| • Getting a Certificate of Group Health Plan Coverage | 46 |
| Section 12. Two Federal Programs complement FEHB benefits | 47 |
| The Federal Flexible Spending Account Program— <i>FSAFEDS</i> | 47 |
| The Federal Long Term Care Insurance Program | 50 |
| Index | 51 |
| Summary of benefits for CDPHP UBI—2005 | 55 |
| 2005 Rate Information for CDPHP UBI | Back cover |

Introduction

This brochure describes the benefits of CDPHP Universal Benefits, Inc. (CDPHP UBI) under Capital District Physicians' Health Plan's contract (CS 2901) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for CDPHP UBI administrative offices is:

CDPHP UBI
Patroon Creek Corporate Center
1223 Washington Avenue
Albany, NY 12206

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2005, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2005, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; “we” means Capital District Physicians' Health Plan, Inc. (CDPHP).
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's “Rate Us” feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov. you may also write to OPM at the Office of Personnel Management, Insurance Services Program, Program Planning & Evaluation Group, 1900 E Street, NW Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud—Here are some things that you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at (518) 641-3228 and explain the situation.
 - If we do not resolve the issue:

**CALL—THE HEALTH CARE FRAUD HOTLINE
202-418-3300**

**OR WRITE TO:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100**

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

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

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

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

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
 - Exactly what will you be doing?
 - About how long will it take?
 - What will happen after surgery?
 - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- <http://www.ahrq.gov/consumer/pathqpack.html>. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this prepaid plan

This Plan is a prepaid comprehensive medical plan. We require you to see specific physicians, hospitals, and other providers that contract with us. You are encouraged to select a personal doctor within the Plan's network. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent CDPHP UBI provider directory.

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

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms. With the exception of emergency services, all services by non-participating practitioners and providers must be authorized in advance by CDPHP UBI. When you choose a non-participating provider, and the care has not been preauthorized by CDPHP UBI, you will pay all charges.

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

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- CDPHP Universal Benefits, Inc. (CDPHP UBI) is licensed under Article 43 in New York State.
- CDPHP UBI is an affiliate of Capital District Physicians' Health Plan, Inc. (CDPHP), a health plan that has been in existence for 20 years.
- CDPHP UBI is a non-profit health services corporation.

If you want more information about us, call 1-877-269-2134, or write to CDPHP UBI, Patroon Creek Corporate Center, 1223 Washington Ave., Albany, NY 12206. You may also contact us by fax at (518) 641-5005 or visit our Web site at www.cdphp.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is: Albany, Broome, Chenango, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Hamilton, Herkimer, Madison, Montgomery, Oneida, Orange, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Tioga, Ulster, Warren, and Washington counties.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

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

Section 2. How we change for 2005

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

Program-wide changes

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

Changes to this Plan

- Your share of the non-Postal premium will increase by 5.2% for Self Only and decrease by 3% for Self and Family for enrollment code SG. Enrollment codes PW and QB have been consolidated under enrollment code SG for 2005.
- Your share of the Postal premium will increase by 5.2% for Self Only and decrease by 13.5% for Self and Family for enrollment code SG. Enrollment codes PW and QB have been consolidated under enrollment code SG for 2005.
- The HMO plan will be replaced by a Prepaid comprehensive medical plan in 2005 and will eliminate the referral requirement for specialty services. Members must use a provider who participates with the CDPHP UBI network to obtain coverage except for emergency care or when the care has been preauthorized by CDPHP UBI. A listing is available from CDPHP UBI Member Services at 1-877-269-2134 or on Find-A-Doc at our Web site, www.cdphp.com.
- The primary/specialist office visit copay has increased to \$20.
- The inpatient hospital copay has changed to \$100 copay per day up to a maximum of \$500 per admission. For family coverage, inpatient copays are limited to two per calendar year. The copay will also apply to inpatient hospital rehabilitation, but is waived if the patient is admitted within one day of discharge.
- The copay for routine annual exam for patients over age 19 including routine screenings has increased to \$20 per visit.
- Physical, occupational, and speech short-term therapy are limited to one course each for two consecutive months for each specific diagnosis and related conditions per calendar year. The \$20 specialist office visit will apply.
- Coverage for cardiac rehabilitation is based on medical necessity. The \$20 office copay visit will apply.
- The copay for local professional ambulance will increase to \$50.
- The copay for diabetic supplies and insulin will increase to \$20 per item.
- The copay for diabetic durable medical equipment will increase to \$20 and must be preauthorized only if over \$500.
- The copay for hospital or ambulatory surgical center will increase to \$50 per day.
- The prescription drug copay has changed to \$10 generic, \$25 preferred brand, and \$40 non-preferred brand for a 30-day supply. The copay for a 90-day mail order plan has been changed to \$20 generic, \$50 preferred brand and \$80 non-preferred brand.
- The brochure has been clarified to include new preventive guidelines for children and adults. See page 13 and 14.

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 1-877-269-2134 or write to us at Patroon Creek Corporate Center, 1223 Washington Ave., Albany, NY 12206. You may also request replacement cards through our Web site at www.cdphp.com.

Where you get covered care

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

- **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 set by the National Committee for Quality Assurance (NCQA).

We list Plan providers in the CDPHP UBI provider directory, which we update periodically. The list is also available at Find-A-Doc on our Web site at www.cdphp.com.

- **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 CDPHP UBI provider directory, which we update periodically. The list is also available at Find-A-Doc on our Web site at www.cdphp.com.

What you must do to get covered care

It depends on the type of care you need. You can go to any participating provider you want, but we must approve some care in advance.

- **Primary care**

Because all covered services must be provided or arranged by CDPHP UBI participating providers, you are encouraged to select a personal doctor within the network to coordinate your care. Your primary care provider can be an internist, family practitioner, general practitioner, or pediatrician (for children). Alternate primary care providers are obstetricians and gynecologists.

- **Specialty care**

- Participating specialists are listed in our CDPHP UBI directory and in Find-A-Doc at our Web site at www.cdphp.com.
- No referral is necessary to visit a participating specialist.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
 - Reduce our service area and you enroll in another FEHB Plan, you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

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

Section 3. How you get care *continued*

• 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 1-877-269-2134. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Circumstances beyond our control

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

Services requiring our prior approval

For certain services, you or 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 pre-certification. It is your responsibility to make sure this review process is followed. Your physician or specialist must obtain prior approval for the following services: hospitalization or skilled nursing facility care, home health care, inpatient rehabilitation unit or facility services, prosthetic devices, some identified medications, durable medical equipment, home dialysis, and hospice care. Prior approval is also required for physical therapy, occupational therapy, speech therapy, mental health/substance abuse, GHT, and other services such as off-plan referrals.

Your physician contacts CDPHP's Resource Coordination Management Department with a description of the medical necessity of the request.

A nurse reviewer reviews the request. Clinical information is obtained to support the medical necessity of the request. Clinical information is reviewed against established criteria. Decisions are based on the appropriateness of care. Ultimate determinations are made by the Plan's Medical Director. Upon approval you and your provider are notified via telephone and mail. Services that do not receive prior approval will not be covered by the Plan.

Section 4. Your costs for covered services

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

Copayments

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

Example: When you see your primary care physician you pay a copayment of \$20 per office visit and when you go in the hospital, you pay \$100 per day, up to a maximum of \$500 per confinement.

Deductible

We do not have a deductible.

Coinsurance

Coinsurance is the percentage of our negotiated fee that you must pay for your care. Example: In our Plan, you pay 20 percent of our allowance for durable medical equipment.

Your catastrophic protection out-of-pocket maximum

We do not have a catastrophic protection out-of-pocket maximum.

Section 5. Benefits—OVERVIEW

(See page 8 for how our benefits changed this year and page 55 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 claim forms, claims filing advice, or more information about our benefits, contact us at (518) 641-3140 or 1-877-269-2134 or at our Web site at www.cdphp.com.

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| Section 5(a) | Medical services and supplies provided by physicians and other health care professionals | 12 |
| | Diagnostic and treatment services | 12 |
| | Lab, X-ray and other diagnostic tests | 13 |
| | Preventive care, adult | 13 |
| | Preventive care, children | 14 |
| | Maternity care | 14 |
| | Family planning | 15 |
| | Infertility services | 15 |
| | Allergy care | 15 |
| | Treatment therapies | 16 |
| | Physical and occupational therapies | 16 |
| | Speech therapy | 16 |
| | Hearing services (testing, treatment, and supplies) | 17 |
| | Vision services (testing, treatment, and supplies) | 17 |
| | Foot care | 17 |
| | Orthopedic and prosthetic devices | 17 |
| | Durable medical equipment (DME) | 18 |
| | Home health services | 18 |
| | Chiropractic | 18 |
| | Alternative treatments | 18 |
| | Educational classes and programs | 18 |
| Section 5(b) | Surgical and anesthesia services provided by physicians and other health care professionals | 20 |
| | Surgical procedures | 20 |
| | Reconstructive surgery | 21 |
| | Oral and maxillofacial surgery | 21 |
| | Organ/tissue transplants | 22 |
| | Anesthesia | 22 |
| Section 5(c) | Services provided by a hospital or other facility, and ambulance services | 23 |
| | Inpatient hospital | 23 |
| | Outpatient hospital or ambulatory surgical center | 24 |
| | Extended care benefits/Skilled nursing care facility benefits | 24 |
| | Hospice care | 24 |
| | Ambulance | 24 |
| Section 5(d) | Emergency services/accidents | 25 |
| | Emergency within our service area | 25 |
| | Emergency outside our service area | 26 |
| | Ambulance | 26 |
| Section 5(e) | Mental health and substance abuse benefits | 27 |
| Section 5(f) | Prescription drug benefits | 29 |
| | Covered medications and supplies | 30 |
| Section 5(g) | Special features | 31 |
| | Flexible benefits option | 31 |
| | Services for deaf and hearing impaired | 31 |
| | Centers of excellence | 31 |
| Section 5(h) | Dental benefits | 32 |
| | Accidental injury benefit | 32 |
| Section 5(i) | Non-FEHB benefits available to Plan members | 33 |
| | Summary of benefits for CDPHP UBI, Inc.—2005 | 55 |
| | 2005 Rate Information for CDPHP UBI, Inc. | Back cover |

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care. You pay all charges for non-participating providers.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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| Benefit Description | You pay |
|---|-----------------------|
| Diagnostic and treatment services | |
| Professional services of physicians • In physician's office | \$20 per office visit |
| Professional services of physicians • In an urgent care center | \$25 per visit |
| • During a hospital stay • In a skilled nursing facility | Nothing |
| • Office medical consultations • Second surgical opinion | \$20 per office visit |
| At home | \$20 per visit |
| <i>Not covered</i> • <i>Surgery primarily for cosmetic purposes</i> • <i>Homemaker services</i> | <i>All charges</i> |

Diagnostic and treatment services—continued on next page

| Lab, X-ray and other diagnostic tests | You pay |
|--|---|
| Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG | Nothing if you receive these services at a preferred facility; otherwise, \$20 per office visit |
| <ul style="list-style-type: none"> • Non-routine pap tests | \$20 per office visit |
| Preventive care, adult | |
| Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol—Once every five years • Colorectal Cancer Screening, including <ul style="list-style-type: none"> — Fecal occult blood test—every five years starting at age 50 — Sigmoidoscopy, screening—every five years starting at age 50 — Double contrast barium enema—every five years starting at age 50 — Colonoscopy—once every 10 years starting at age 50. | \$20 per office visit |
| Routine 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 <i>Diagnosis and Treatment</i> , above. | \$20 per office visit \$20 per office visit |
| Routine mammogram—covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one baseline during this five year period • From age 40 through 49, one every one to two calendar years • From age 50 to 70, annually • Over age 71, as indicated | Nothing |
| Routine immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster—once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and over | Nothing, office visit copay applies |
| <i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i> | <i>All charges</i> |

| Preventive care, children | You pay |
|--|--|
| <ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics | Nothing. |
| <ul style="list-style-type: none"> Well-child care charges for routine examinations, immunizations and care (up to age 22). Visits covered at 2 weeks, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, and 18 months, then annually to age 22. | Nothing for children to age 19. \$20 per visit age 19–22. |
| <ul style="list-style-type: none"> Examinations, such as: <ul style="list-style-type: none"> Eye exams through age 17 to determine the need for vision correction. Limited to one every 24 months. Ear exams through age 17 to determine the need for hearing correction Examinations done on the day of immunizations (up to age 22) | Nothing when performed during well child routine visits up to age 19. \$20 per office visit, otherwise. |
| Maternity care | |
| <p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> Prenatal care | \$20 per office visit for the initial diagnosis. You pay nothing thereafter. |
| <ul style="list-style-type: none"> Delivery Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> You do not need to precertify your normal delivery; see page 10 for other circumstances, such as extended stays for you or your baby. You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). | \$100 copay per day up to a maximum of \$500 per admission. The copayment does not apply to hospital inpatient charges for newborn nursery care. |
| <i>Not covered: Elective sonograms to determine fetal sex</i> | <i>All charges</i> |

| Family planning | You pay |
|---|---|
| <p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Genetic counseling when approved • Visits to insert or implant covered contraceptive devices | \$20 per office visit |
| <p>Note: We cover oral contraceptives under the prescription drug benefit</p> <ul style="list-style-type: none"> • Oral and transdermal contraceptives • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms | <p>\$25 per covered preferred brand name drug or device</p> <p>\$40 per non-preferred drug (30-day supply)</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> | <i>All charges</i> |
| Infertility services | |
| <p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - <i>intra-vaginal insemination (IVI)</i> - <i>intra-cervical insemination (ICI)</i> - <i>intrauterine insemination (IUI)</i> • Fertility drugs <p>Note: Members must be at least 21 years of age but no more than 44 years old to be covered for infertility services.</p> <p>Note: We cover fertility drugs under the prescription drug benefit for up to six cycles per lifetime.</p> | <p>\$20 per office visit</p> <p>\$100 copay per day up to a maximum of \$500 per admission. For family coverage, inpatient copays are limited to two per calendar year.</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>in vitro fertilization</i> - <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm</i> • <i>Leuprolide Acetate when used for cessation of ovulation.</i> • <i>Items such as ovulation predictor kits and home pregnancy testing kits.</i> • <i>IVIG when utilized for infertility or pregnancy loss.</i> | <i>All charges</i> |
| Allergy care | |
| Testing and treatment | \$20 per office visit |
| Allergy injection Allergy serum | Nothing |
| <i>Not covered: provocative food testing and sublingual allergy desensitization</i> | <i>All charges</i> |

| Treatment therapies | You pay |
|--|---|
| <ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 22.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis—Hemodialysis and peritoneal dialysis | \$20 per office visit |
| <p>Intravenous (IV)/Infusion Therapy—Home IV and antibiotic therapy</p> | \$20 per office visit if received as an outpatient. Covered in full if part of home health care. |
| <ul style="list-style-type: none"> • Growth hormone therapy (GHT) <p>Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p> | \$20 per office visit |
| Physical and occupational therapies | |
| <p>Physical and occupational therapy are limited to one course each for two consecutive months for each specific diagnosis and related conditions per calendar year:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <ul style="list-style-type: none"> • Medically necessary cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction. | <p>\$20 per office visit</p> <p>\$20 per outpatient visit</p> <p>Nothing per visit during covered inpatient admission</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> • <i>Continuous ECG monitoring and Thallium stress tests.</i> • <i>Services for chronic or maintenance phase of cardiac rehabilitation.</i> | <i>All charges</i> |
| Speech therapy | |
| <p>Speech therapy is limited to one course for two consecutive months for each specific diagnosis and related conditions per calendar year.</p> | <p>\$20 per office visit</p> <p>\$20 per outpatient visit</p> <p>Nothing during covered inpatient admission</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Care beyond treatment period.</i> | <i>All charges</i> |

| Hearing services (testing, treatment, and supplies) | You pay |
|---|-----------------------|
| <ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) | \$20 per office visit |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> • <i>Hearing aids, testing and examinations for them</i> | <i>All charges</i> |
| Vision services (testing, treatment, and supplies) | |
| <ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) | \$20 per office visit |
| <ul style="list-style-type: none"> • Eye exam to determine the need for vision correction for children through age 17 (see <i>Preventive care, children</i>) • Eye refractions once every 24 months • Eye exercises and orthoptics when approved | \$20 per office visit |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses</i> • <i>Radial keratotomy and other refractive surgery</i> | <i>All charges</i> |
| Foot care | |
| <p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p> | \$20 per office visit |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> | <i>All charges</i> |

| Orthopedic and prosthetic devices | You pay |
|--|---------------------------------------|
| <ul style="list-style-type: none"> Artificial limbs and eyes Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy | 20% of charges. Must be preauthorized |
| <ul style="list-style-type: none"> Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device. | Nothing |
| <ul style="list-style-type: none"> Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. Approved lumbosacral supports | 20% of charges. Must be preauthorized |
| <ul style="list-style-type: none"> Hair prosthesis. CDPHP provides benefits for the purchase of one medically necessary cranial prosthesis, wig or toupee per lifetime per member for replacement of hair loss as a result of injury, disease or treatment of a disease. You pay 20 percent of charges. Coverage is limited to a maximum amount of \$200 per prosthesis, wig or toupee. This limitation is applied to the balance remaining after the member's payment of the 20 percent coinsurance. | 20% of charges. |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Orthopedic and corrective shoes</i> <i>Arch supports</i> <i>Foot orthotics</i> <i>Heel pads and heel cups</i> <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> <i>Prosthetic replacements provided less than 3 years after the last one we covered unless medically indicated</i> <i>Stump hose</i> | <i>All charges</i> |
| Durable medical equipment (DME) | |
| <p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> Hospital beds Wheelchairs Crutches Walkers | 20% of charges. Must be preauthorized |
| <ul style="list-style-type: none"> Blood glucose monitors Insulin pumps <p>Your Plan physician will call us for authorization of this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment.</p> | \$20 per item, must be preauthorized |
| <p><i>Not covered: Motorized wheelchairs.</i></p> | <i>All charges</i> |

| Home health services | You pay |
|---|-----------------------|
| <ul style="list-style-type: none"> Home health care ordered by a Plan physician, approved by the Plan's medical director, and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. | Nothing |
| <ul style="list-style-type: none"> Services include oxygen therapy, intravenous therapy and medications. | 20% of charges. |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> <i>Rest cures</i> | <i>All charges</i> |
| Chiropractic | |
| <ul style="list-style-type: none"> Medically necessary care for spinal manipulation. | \$20 per office visit |
| Alternative treatments | |
| <ul style="list-style-type: none"> No benefit | <i>All charges</i> |
| Educational classes and programs | |
| <p>Coverage is limited to:</p> <ul style="list-style-type: none"> Smoking Cessation—Provided at no cost to you through CDPHP UBI's wellness program. Peak Asthma Performance—Members are encouraged to call toll-free for telephonic education about asthma. Members who participate may receive a semi-annual newsletter and materials including a peak flow meter, a video on asthma, a daily diary, and medication spacer. PressureWise—An interactive program for members identified as hypertensive. Members attending program receive a blood pressure monitor and information on taking their blood pressure at home. | Nothing |

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care. You pay all charges for non-participating providers.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

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| Benefit Description | You pay |
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| Surgical procedures | |
| <p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) | \$20 per office visit |
| <ul style="list-style-type: none"> • Surgical treatment of morbid obesity—a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; and there is documented failure of a non-surgical attempt. • Insertion of internal prosthetic devices. See 5(a)—Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization (e.g; Tubal ligation, Vasectomy) • Surgically implanted contraceptive and intrauterine devices (IUDs). Note: Devices are covered under 5(a) Prescription drug coverage. • Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done.</p> | \$20 per office visit; nothing for hospital visit |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care.</i> | <i>All charges</i> |

| Reconstructive surgery | You pay |
|---|--|
| <ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance on the other breast; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p> | <p>\$20 per office visit; nothing for hospital visit</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery—any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> | <p><i>All charges</i></p> |
| Oral and maxillofacial surgery | |
| <p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate, or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. | <p>\$20 per office visit; nothing for hospital visit</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> • <i>Dental work related to TMJ.</i> | <p><i>All charges</i></p> |

| Organ/tissue transplants | You pay |
|--|--|
| <p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single–Double • Pancreas • Allogeneic donor bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas when medically necessary. • National Transplant Program (NTP)—CDPHP UBI facilitates organ transplants at a CDPHP UBI approved transplant center. <p>Limited Benefits—Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute—or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p> | <p>\$20 per office visit; nothing at hospital visit.</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> | <p><i>All charges</i></p> |
| Anesthesia | |
| <p>Professional services provided in—</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center | <p>Nothing</p> |
| <p>Professional services provided in—</p> <ul style="list-style-type: none"> • Office | <p>\$20 per office visit</p> |

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility. You pay all charges for non-participating providers.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

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| Benefit Description | You pay |
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| Inpatient hospital | |
| Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. | \$100 copay per day up to a maximum of \$500 per admission. For family coverage, inpatient copays are limited to two per calendar year. The copayment does not apply to hospital inpatient charges for newborn nursery care. |
| Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • 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 • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home. | Nothing |
| <i>Not covered:</i> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care except when medically necessary in the hospital when ordered and approved by a CDPHP UBI participating physician | <i>All charges</i> |

| Outpatient hospital or ambulatory surgical center | You pay |
|--|--------------------|
| <ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services | \$50 per day |
| <ul style="list-style-type: none"> • Medical supplies, including oxygen | 20% of charges |
| <ul style="list-style-type: none"> • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p> | \$20 per day |
| <ul style="list-style-type: none"> • <i>Not covered: Blood and blood derivatives not replaced by the member. Storage of blood and blood derivatives, except in the case of autologous blood donations required for a scheduled surgical procedure.</i> | <i>All charges</i> |
| Extended care benefits/skilled nursing care facility benefits | |
| Skilled nursing facility (SNF): up to 90 days in lieu of hospitalization. | Nothing |
| <i>Not covered: Custodial care</i> | <i>All charges</i> |
| Hospice care | |
| Up to 210 days combined inpatient and outpatient | Nothing |
| <i>Not covered: Independent nursing, homemaker services</i> | <i>All charges</i> |
| Ambulance | |
| <ul style="list-style-type: none"> • Local professional ambulance service when medically appropriate | Nothing |
| <i>Not covered: Transportation for convenience.</i> | <i>All charges</i> |

Section 5(d). Emergency services/accidents

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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What is a medical emergency?

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

What to do in case of emergency:

You should go directly to the emergency room, call 911 or the appropriate emergency response number, or call an ambulance if the situation is a medical emergency as defined above.

Emergencies within our service area: If you are unsure whether your condition is an emergency, contact your primary care physician for assistance and guidance. However, if you believe you need immediate medical attention, follow the emergency procedures.

Emergencies outside our service area: If you have an emergency outside of CDPHP’s service area, simply go to the nearest hospital emergency room. If you are required to pay for services at the time of treatment, please request an itemized bill. Send the bill along with your name and member ID number to CDPHP’s Member Services Department, Patroon Creek Corporate Center, 1223 Washington Ave., Albany, NY 12206.

If you are not admitted to the hospital for further services or care, you will be responsible for a \$50 copayment. If you are admitted immediately, the emergency room copayment is waived and the hospital services will cost you \$100 copay per day up to a maximum of \$500 per admission.

After receiving emergency medical care, be sure your primary care physician is notified within forty-eight (48) hours, unless it is not reasonably possible to do so. He or she will need to know what services were provided before scheduling any of your follow-up care. All follow-up care must be provided or directed by a Plan physician. Examples of follow-up care are removal of stitches, cast removal, and X-rays.

| Benefit Description | You pay |
|---|---|
| Emergency within our service area | |
| • Emergency care at a doctor’s office | \$20 per visit |
| • Emergency care at an urgent care center | \$25 per visit |
| • Emergency care as an outpatient or inpatient at a hospital, including doctors’ services | \$50 per visit. \$100 per day if admitted, up to a maximum of \$500 per confinement, limited to two copayments per family per calendar year. |
| <i>Not covered: Elective care or non-emergency care</i> | <i>All charges</i> |

| Emergency outside our service area | You pay |
|---|---|
| <ul style="list-style-type: none"> Emergency care at a doctor's office | \$20 per visit |
| <ul style="list-style-type: none"> Emergency care at an urgent care center | \$25 per visit |
| <ul style="list-style-type: none"> Emergency care as an outpatient or inpatient at a hospital, including doctors' services | \$50 per visit. \$100 per day if admitted, up to a maximum of \$500 per confinement, limited to two copayments per family per calendar year. |
| Ambulance | |
| <ul style="list-style-type: none"> Local professional ambulance service when medically appropriate. Air ambulance if medically appropriate. Note: See 5(c) for non-emergency service. | \$50 per trip |
| <i>Not covered: Non-emergency or routine transport.</i> | <i>All charges</i> |

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

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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. Participating providers must provide all care.

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| Benefit Description | You pay |
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| Mental health and substance abuse benefits | |
| <p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p> | Your cost sharing responsibilities are no greater than for other illness or conditions. |
| <ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management | \$20 per visit |
| <ul style="list-style-type: none"> • Diagnostic tests | \$20 per visit or test |
| <ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment | \$20 outpatient \$100 copay per day up to a maximum of \$500 per admission. For family coverage, inpatient copays are limited to two per calendar year. |
| <p><i>Not covered: Services we have not approved</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another</i></p> | <i>All charges.</i> |

Mental health and substance abuse benefits—Continued on next page

Mental Health and substance abuse benefits *(Continued)*

Preauthorization

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

Mental Health Care

You have direct access to in-network mental health care. A direct access toll-free telephone number, 1-800-700-4824, to ValueOptions, will connect you to a qualified mental health clinician who will assist and arrange for treatment. For your convenience, the telephone number for mental health services is imprinted on your CDPHP UBI ID card.

Alcohol/Substance Abuse Benefits

You have access to alcohol and substance abuse care. These benefits are coordinated by St. Peter's Addiction Recovery Center (SPARC). CDPHP UBI members can contact SPARC directly at 1-800-427-9025.

Limitation

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

Section 5(f). Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A Plan physician or Plan dentist 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. Approved maintenance prescriptions can be refilled through the mail at two copayments for a 90-day supply.
- **We use a formulary.** A formulary is a list of prescription drugs covered by CDPHP UBI based on their efficacy and cost in providing effective patient care. We cover non-formulary drugs prescribed by a Plan doctor at a higher copayment. Coverage is available for both formulary drugs and non formulary drugs.
- **These are the dispensing limitations.** Prescriptions filled at a participating pharmacy are limited to a 30-day supply. Maintenance prescriptions are filled up to a 90-day supply by mail order. Only certain maintenance prescriptions are available via mail order to insure quality, proper dosage, and medical appropriateness. Prescription refills received prior to the next scheduled refill date will not be filled.

There are different copayments for generic and brand name prescriptions. A generic will be dispensed whenever possible. If there is no generic equivalent available, you will still be responsible for the brand name copayment.

- **Why use generic drugs?** Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your plan less money than brand name drugs.
- **When you do have to file a claim.** You do not have to submit claims.

Plan members called to active duty (or members in time of national emergency) who need to obtain prescribed medications should call our Member Services Department at 1-877-269-2134.

Prescription drug benefits begin on the next page.

| Benefit Description | You pay |
|---|---|
| <p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as <i>Not covered</i>. • Self-administered injectable drugs • Implanted time-release medications. There will be no refund of any portion of the copay if the medication is removed before the end of the expected life. • Drugs for sexual dysfunction within applicable limits • Contraceptive drugs and devices • Smoking cessation prescriptions up to a 12-week supply • Contraceptive drugs and devices • Nutritional supplements for the therapeutic treatment of phenylketonuria (PKU). • Infertility prescriptions available for members between 21 and 44 years of age. • Intravenous fluids and medication for home use. • Prescription drugs for certain inherited disease of amino acid and organic acid metabolism shall include modified sold food products that are low protein or which contain modified protein which are medically necessary for up to 12 months. Benefit limit of \$2,500. | <p>\$10 generic/\$25 preferred brand/\$40 non-preferred brand for a 30-day supply.</p> <p>\$20 generic/\$50 preferred brand/\$80 non-preferred brand for a 90-day supply by mail order</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p> |
| <ul style="list-style-type: none"> • Insulin, oral agents to control blood sugar, needles, test strips, lancets, and visual reading and urine test strips. • Disposable needles and syringes for the administration of covered medications. • Durable medical equipment for insulin dependent persons, preauthorization needed only if over \$500. | <p>\$20 per item</p> <p>20 percent</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Vitamins, nutrients, and food supplements that can be purchased without a prescription</i> • <i>Nonprescription medicines</i> • <i>Weight loss prescriptions</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> | <p><i>All charges</i></p> |

Section 5(g). Special Features

| Feature | Description |
|--|---|
| Flexible benefits option | <p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. |
| Non-emergency care for full-time students out-of-the area | <p>If you are away at school and need medical care (non-preventive) for an illness or injury, coverage is available. When a medical situation develops, call 1-800-274-2332 prior to seeking care and request that CDPHP UBI authorize coverage of necessary treatment by a practitioner in the area.</p> |
| Services for deaf and hearing impaired | <p>The telephone system also includes a TDD system. Members may call 1-877-261-1164 for services.</p> |
| Childbirth Education Reimbursement Program | <p>CDPHP UBI will reimburse expectant mothers 50 percent of the cost, up to \$30 per year, for participating in and completing childbirth education classes. Once you complete the class, send the receipt and certificate of completion to CDPHP UBI, Patroon Creek Corporate Center, 1223 Washington Ave., Albany, NY 12206, for reimbursement.</p> |
| Centers of excellence | <p>CDPHP facilitates care at approved transplant centers for medically necessary, non-experimental treatment.</p> |

Section 5(h). Dental benefits

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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| Accidental injury benefit | You pay |
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| 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 | \$20 per visit |

Dental benefits

We have no other dental benefits.

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

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.**

| | |
|---|---|
| <p>“The Road to Good Health” Wellness Workshops</p> | <p>Through a series of wellness workshops, you can learn how the combined power of good nutrition, regular exercise, and stress management can help you move toward optimal health and well-being. A schedule of wellness programs appears on our Web site, www.cdphp.com, and in <i>SmartMoves</i>, CDPHP’s quarterly member newsletter. All wellness programs are free to members.</p> |
| <p>Complementary and Alternative Medicine (CAM) Program</p> | <p>CDPHP will be offering at no charge, an easy way to research and obtain reputable, top-quality Complementary and Alternative Medicine (CAM) services and products. The program is being provided to CDPHP members through a partnership with American WholeHealth, Inc., a nationwide group of more than 28,000 credentialed practitioners of acupuncture, massage, chiropractic, and other CAM disciplines. The CAM program features discounts on a wide variety of non-covered services, including: vitamins, massage therapy, fitness centers, spas, personal trainers, Tai Chi classes, health magazine subscriptions, and more. Members may access it by logging in through CDPHP’s secure Web site function, Online Health™ using member ID and PIN. Areas that can be navigated include:</p> <ul style="list-style-type: none"> • Healing Centers—Look up home remedies to supplement the care your physician provides. • Reference Library—Learn about dozens of different natural therapies. • Healing Kitchen—Review healthy recipes and nutrition information. • News and Perspectives—Read updates from the medical literature. • Expert Opinions—See how the experts answer frequently asked questions. • Find A Practitioner—Locate a participating massage therapist, acupuncturist, or holistic practitioner near you. |
| <p>Disease Management Programs</p> | <ul style="list-style-type: none"> • Smoking Cessation—Classes provided at no cost to you through CDPHP’s wellness program. • Peak Asthma Performance—Members are encouraged to call a toll-free number to CDPHP’s Wellness Line for telephonic education. They may receive a semi-annual newsletter about asthma and a kit including a peak flow meter, a video on asthma, a daily diary, and a medication spacer. • Pressure Wise—An interactive program for members identified as hypertensive. Members attending the program receive a blood pressure monitor and information on taking their blood pressure at home. |

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 and we agree, as discussed under *Services Requiring Our Prior Approval* on page 9.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs, or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies required for obtaining or continuing employment or insurance, attending schools or camp, or travel; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment 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. Your facility will file on the UB-92 form. For claims questions and assistance, call us at (518) 641-3140 or 1-877-269-2134.

When you must file a claim—such as for services you receive outside the Plan's service area—submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to: CDPHP Universal Benefits, Inc.
Patroon Creek Corporate Center
1223 Washington Avenue
Albany, NY 12206

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

| Step | Description |
|------|-------------|
|------|-------------|

- | | |
|----------|--|
| 1 | Ask us in writing to reconsider our initial decision. You must: <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: CDPHP UBI, Patroon Creek Corporate Center, 1223 Washington Ave., Albany, NY 12206; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. |
| 2 | We have 30 days from the date we receive your request to: <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial—go to step 4; orAsk you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3. |
| 3 | You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p> |
| 4 | If you do not agree with our decision, you may ask OPM to review it. <p>You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, DC 20415-3630</p> |

Section 8. The disputed claims process *continued*

Send OPM the following information:

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

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

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

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

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

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

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

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

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

- (a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at (518) 641-3140 or 1-877-269-2134 and we will expedite our review; or
- (b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 2 at (202) 606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

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

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

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

•What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

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

•Should I enroll in Medicare

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

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

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

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various 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.

Section 9. Coordinating benefits with other coverage *continued*

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

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

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

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at (518) 641-3140 or 1-877-269-2134 or see our Web site at www.cdphp.com.

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

Section 9. Coordinating benefits with other coverage *continued*

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

| Primary Payer Chart | | |
|--|--|------------------------------------|
| A. When you—or your covered spouse—are age 65 or over and have Medicare and you... | Then the primary payer for the individual with Medicare is... | |
| | Medicare | This Plan |
| 1) Have FEHB coverage on your own or through your spouse who is also an active employee | | ✓ |
| 2) Have FEHB coverage through your spouse who is an annuitant | ✓ | |
| 3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above | ✓ | |
| 4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and... • You have FEHB coverage on your own or through your spouse who is also an active employee | | ✓ |
| • You have FEHB coverage through your spouse who is an annuitant | ✓ | |
| 5) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) | ✓ | |
| 6) Are enrolled in Part B only, regardless of your employment status | ✓ for Part B services | ✓ for other services |
| 7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty | ✓* | |
| B. When you or a covered family member... | | |
| 1) Have Medicare solely based on end stage renal disease (ESRD) and... • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period) | | ✓ |
| • It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD | ✓ | |
| 2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and... • This Plan was the primary payer before eligibility due to ESRD | | ✓ for 30-month coordination period |
| • Medicare was the primary payer before eligibility due to ESRD | ✓ | |
| C. When either you or your spouse are eligible for Medicare solely due to disability and you... | | |
| Have FEHB coverage on your own or through your spouse who is also an active employee | | ✓ |
| Have FEHB coverage on your own as an annuitant or through a family member who is also an annuitant | ✓ | |
| D. Are covered under the FEHB Spouse Equity provision as a former spouse | | |
| | ✓ | |

*Worker's Compensation is primary for claims related to your condition under Worker's Compensation.

Section 9. Coordinating benefits with other coverage *continued*

Medicare Advantage

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

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

This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage plan (called Medicare Choice) and also remain enrolled in our FEHB plan. In this case, we do not waive cost-sharing for your FEHB coverage.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

TRICARE and CHAMPVA

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

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

Section 9. Coordinating benefits with other coverage *continued*

Workers' Compensation

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

| | |
|---|--|
| Calendar year | January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year. |
| Coinsurance | Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 12. |
| Copayment | A copayment is a fixed amount of money you pay when you receive covered services. See page 12. |
| Covered services | Care we provide benefits for, as described in this brochure. |
| Custodial care | Custodial care is care that does not have a direct medical benefit such as house cleaning, preparing meals, personal hygiene. Custodial care that lasts 90 days or longer is sometimes known as long-term care. |
| Deductible | A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before the plan starts paying for those services. Note: We do not have a deductible. |
| Experimental or investigational services | A procedure that is not approved by the Federal Food and Drug Administration and/or the National Institute of Health Technology Assessment. |
| Group health coverage | Medical benefits such as hospital, surgical, and preventive care that are purchased on an employer-sponsored basis. |
| Medical necessity | A service or treatment which is appropriate and consistent with the diagnosis and accepted standards in the medical community. |
| Plan allowance | Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance by the average community charges. Our providers accept the allowances as payment in full. |
| Us/We | Us and We refer to CDPHP Universal Benefits, Inc., an affiliate of Capital District Physicians' Health Plan, Inc. (CDPHP). |
| You | You refers to the enrollee and each covered family member. |

Section 11. FEHB facts

Coverage information

- **No pre-existing condition limitation** We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Where you can get information about enrolling in the FEHB Program** See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:
 - When you may change your enrollment;
 - How you can cover your family members;
 - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
 - When your enrollment ends; and
 - When the next open season for enrollment begins.We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

- **Children's Equity Act** OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

Section 11. FEHB facts *continued*

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in a prepaid plan that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in a prepaid plan that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

• **When benefits and Premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2005 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2004 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

• **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

• **When FEHB coverage ends**

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

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

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

Section 11. FEHB facts *continued*

- **Spouse equity coverage**

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

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

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

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

- **Converting to individual coverage**

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

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

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

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

- **Getting a Certificate of Group Health Plan Coverage**

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

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12. Two Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

The Federal Flexible Spending Account Program—*FSAFEDS*

• What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

Health Care Flexible Spending Account (HCFSA)

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

Dependent Care Flexible Spending Account (DCFSA)

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

• Enroll during Open Season

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

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

What is SHPS?

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

Section 12. Two Federal Programs complement FEHB benefits *continued*

Who is eligible to enroll?

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

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

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

• How much should I contribute to my FSA?

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

The [FSAFEDS Calculator](http://www.FSAFEDS.com) at www.FSAFEDS.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

• What can my HCFSAs pay for?

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 12 and detailed throughout this brochure. Your HCFSAs will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under this plan, typical out-of-pocket expenses include: inpatient hospital copayments, coinsurance for durable medical equipment, office visit copays, prescription drug copays, dental services, and eyeglasses.

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

• Tax savings with an FSA

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

Section 12. Two Federal Programs complement FEHB benefits *continued*

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

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

• Tax credits and deductions

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

Health care expenses

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

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

Dependent care expenses

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

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

Section 12. Two Federal Programs complement FEHB benefits *continued*

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

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

- **Contact us**

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

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

The Federal Long Term Care Insurance Program

It's important protection

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

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

To find out more and to request an application

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

Index

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

- Accidental injury 17, 21, 32
Allergy tests 15
Allogeneic (donor) bone marrow
 transplant 22
Alternative treatments 19
Ambulance 23, 24, 26
Anesthesia 5, 20
Autologous bone marrow
 transplant 16, 22
Biopsy 20
Blood and blood plasma 24
Casts 23, 24
Catastrophic protection
 out-of-pocket maximum 53
Changes for 2005 7
Chemotherapy 16
Chiropractic 19
Cholesterol tests 13
Claims 8, 11, 35, 36, 40, 45, 47
Coinsurance 6, 8, 35, 43, 48
Colorectal cancer screening 13
Congenital anomalies 20, 21
Contraceptive drugs and
 devices 15, 30
Covered charges 39
Crutches 18
Deductible 6, 10, 48
Definitions 12, 20, 23, 25, 27,
 29, 42, 43, 52
Dental care 32, 52
Diagnostic services 12, 23, 27, 52
Disputed claims review 31
Donor expenses 22
Dressings 23
Durable medical equipment 18
Educational classes and programs 19
Effective date of enrollment 9
Emergency 6, 25, 26, 34, 35, 52
Experimental or investigational 34
Eyeglasses 17
Family planning 15
Fraud 3, 4
General exclusions 34
General Exclusions 11
Hearing services 17
Home health services 19
Hospice care 24
Hospital 5, 6, 8, 9, 18,
 20, 21, 22, 23, 24, 25, 27,
 35, 39, 41, 42, 52
Immunizations 6, 13
Infertility 15
Inpatient hospital benefits 35
Insulin 30
Magnetic Resonance Imagings
 (MRIs) 13
Mammograms 13
Maternity benefits 14
Medicaid 42
Medically necessary 12, 14, 16, 20,
 23, 25, 27, 29, 32, 34
Medicare 27, 38, 40
 Medicare + Choice 41
 Original Medicare 39, 41
 Medicare Advantage 41
Members
 Associate 54
 Family 44
 Plan 8, 33
Mental Health/Substance Abuse
 Benefits 27
Newborn care 14
Nurse
 Licensed Practical Nurse (LPN) 19
 Nurse Anesthetist (NA) 23
Occupational therapy 16
Ocular injury 17
Office visits 6, 10
Oral and maxillofacial surgical 21
Out-of-pocket expenses 38
Oxygen 18, 19, 23, 24
Pap test 13
Physician 18, 20
Precertification 37
Prescription drugs 35, 41, 52
Preventive care, adult 13
Preventive care, children 14
Preventive services 6
Prior approval 36, 37
Prosthetic devices 20
Psychologist 27
Radiation therapy 16
Room and board 23
Second surgical opinion 12
Skilled nursing facility care 9, 12,
 22, 24
Smoking cessation 19
Social worker 27
Speech therapy 16
Splints 23
Subrogation 42
Substance abuse 52
Surgery 5, 14, 16, 17
 Anesthesia 24
 Oral 21
 Outpatient 24
 Reconstructive 20, 21
Syringes 30
Temporary Continuation of
 Coverage (TCC) 45
Transplants 16, 22
Treatment therapies 16
Vision care 52
Vision services 17
Wheelchairs 18
Workers Compensation 42
X-rays 13, 23, 24

NOTES:

NOTES:

NOTES:

Summary of benefits for the Capital District Physicians' Health Plan, Inc. 2004

- **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: <ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office | Office visit copay: \$20 primary care; \$20 specialist | 12 |
| Services provided by a hospital: <ul style="list-style-type: none"> • Inpatient • Outpatient | \$100 copay per day up to a maximum of \$500 per admission. For family coverage, inpatient copays are limited to two per calendar year. \$20 per visit | 23 24 |
| Emergency benefits <ul style="list-style-type: none"> • In-area • Out-of-area | \$50 per visit to hospital emergency room; \$25 per visit to urgent care center \$50 per visit to hospital emergency room | 25 26 |
| Mental health and substance abuse treatment | Regular cost sharing | 27 |
| Prescription drugs | \$10 generic/\$25 preferred brand/\$40 non-preferred brand for a 30-day supply. \$20 generic/\$50 preferred brand/\$80 non-preferred brand for a 90-day supply by mail order | 29 |
| Dental care | \$20 per visit for accidental injury benefit | 32 |
| Vision Care | \$20 per visit for one refraction every twenty-four (24) months | 17 |
| Special features Flexible benefits option Non-emergency medical care for full-time students attending school out of the area Services for deaf and hearing impaired Childbirth Education Reimbursement Program Centers of Excellence for transplants/heart surgery | | 31 |
| Protection against catastrophic costs (your out-of-pocket maximum) | We do not have an out-of-pocket maximum. | 10 |

2005 Rate Information for CDPHP UBI

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

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

| | | Non-Postal Premium | | | | Postal Premium | |
|--------------------|------|--------------------|------------|-------------|------------|----------------|------------|
| | | Biweekly | | Monthly | | Biweekly | |
| Type of Enrollment | Code | Gov't Share | Your Share | Gov't Share | Your Share | USPS Share | Your Share |

| | | | | | | | |
|-----------------|-----|----------|----------|----------|----------|----------|----------|
| Self Only | SG1 | \$116.50 | \$ 38.83 | \$252.41 | \$ 84.14 | \$137.86 | \$ 17.47 |
| Self and Family | SG2 | \$293.58 | \$ 97.86 | \$636.09 | \$212.03 | \$347.40 | \$ 44.04 |