

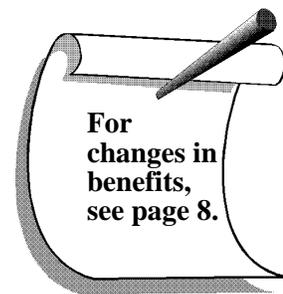
UnitedHealthcare of Georgia, Inc.

www.myuhc.com/groups/fehbp

2007

A Health Maintenance Organization

Serving: The following metropolitan areas-Atlanta, and Athens, Georgia



Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.

Enrollment codes for **Atlanta and Athens, GA:**

GN1 High Option – Self Only

GN2 High Option – Self and Family

Special notice: This Plan is offered for the first time under the Federal Employees Health Benefits Program during the 2007 Open Season



Authorized for distribution by the:



**United States
Office of Personnel Management**
Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

**Important Notice from UnitedHealthcare of Georgia, Inc. About
Our Prescription Drug Coverage and Medicare**

OPM has determined that UnitedHealthcare of Georgia, Inc.'s prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

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

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

Please be advised

If you lose or drop your FEHB coverage and 63 days or longer without a prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

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

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Introduction

This brochure describes the benefits of UnitedHealthcare of Georgia, Inc. under our contract (CS 2909) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for our administrative offices is:

UnitedHealthcare's Federal Employees Health Benefits (FEHB) Program

6095 Marshalee Drive

Suite 200

Elkridge, MD 21075

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, 2007, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007, 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 UnitedHealthcare of Georgia, Inc.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

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

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at xxx/xxx-xxxx 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, DC20415-1100

- 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); o
 - 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.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.

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

3. Get the results of any test or procedure.

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

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

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

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

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

Want more information on patient safety?

Ø www.ahrq.gov/consumer/pathqpack.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

Ø www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

Ø 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.

Ø www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

Ø www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Ø www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1 Facts about this HMO plan

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

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

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

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

General Features of our High Option

- This is a Direct Access HMO; you do not need to have referrals for services from your Primary Care Physician (PCP);
- We have a wide service area of participating providers you must use to access care.
- You will not have to routinely file claims for medical services;
- We have a 24-hour Customer Service Department available at 1-877-835-9861.

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.

UnitedHealthcare of Georgia, Inc. is a health maintenance organization.

You do not need to select a Primary Care Physician (PCP) and you do not need to get written referrals to see a participating specialist for medical services. The provider must be participating for services to be covered. You must call United Behavioral Health at 1-877-835-9861 24 hours a day, seven days a week to obtain authorization for services to use Mental Health/Substance Abuse benefits. Woman may see a Plan gynecologist for their routine examinations.

The Plan's provider directory lists primary care doctors with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. The directory is updated on a regular basis and is available at the time of enrollment or upon calling the Customer Service Department at 1-877-835-9861 24 hours a day, seven days a week. When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or participation of any one doctor, hospital, or other provider, cannot be guaranteed.

The Plan will provide benefits for covered services only when the services are medically necessary to prevent, diagnose or treat your illness or condition. Payment of claims for prosthetic devices or durable medical equipment, when the item cost is more than \$1000 requires prior notification.

Your rights

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

- UnitedHealthcare of Georgia, Inc has been in existence since 1992
- UnitedHealthcare of Georgia, Inc. is a for-profit organization

If you want more information about us, call 1-877-835-9861 24 hours a day, seven days a week., or write to UnitedHealthcare's, Federal Employees Health Benefits (FEHB) Program at 6095 Marshalee Drive, Suite 200, Elkridge, MD 21075. You may also visit our Web site at www.myuhc.com/groups/fehbp.

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:

Atlanta and Athens, Georgia (Enrollment code GN1 and GN2):

Georgia:

Counties of:

Atlanta area consisting of the following counties: Dawson, Cherokee, Forsyth, Cobb, Gwinnett, De Kalb, Walton, Morgan, Putnam, Jasper, Newton, Paulding, Henry, Spalding, Coweta, Rockdale, Fayette, Fulton, Douglas, Haralson, Carroll, Clayton, Heard and Butts.

Athens area consisting of the following counties: Elbert, Banks, Madison, Hall, Jackson, Barrow, Clarke, Oconee, and Oglethorpe

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 We are a new plan for 2007

This Plan is new to the FEHB Program. We are being offered for the first time during the 2007 Open Season.

Section 3. How you get care

Identification cards	<p>We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.</p> <p>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 1-877-835-9861 24 hours a day, seven days a week or write to us at UnitedHealthcare's, Federal Employees Health Benefits (FEHB) Program at 6095 Marshalee Drive, Suite 200, Elkridge, MD 21075. You may also print temporary cards or request replacement cards through our Web site: www.myuhc.com/groups/fehbp.</p>
Where you get covered care	<p>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.</p>
<ul style="list-style-type: none">• Plan providers	<p>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.</p> <p>We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site www.myuhc.com/groups/fehbp.</p>
<ul style="list-style-type: none">• Plan facilities	<p>Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site www.myuhc.com/groups/fehbp.</p>
What you must do to get covered care	<p>You do not need to select a primary care physician and you do not need to get written referrals to see a contracted specialist for medical services. The provider must be participating for services to be covered. You must call United Behavioral Health at 1-877-835-9861 24 hours a day, seven days a week to obtain authorization for services to use mental health/substance abuse benefits. Prior authorization for prosthetic devices or durable medical equipment is required when the item costs more than \$1000 or for Growth Hormone Therapy (GHT). The Plan will provide benefits for covered services only when the services are medically necessary to prevent, diagnose or treat your illness or condition.</p>
<ul style="list-style-type: none">• Primary care	<p>Your primary care physician (PCP) can be a family practitioner, internist, or pediatrician. Your PCP will provide most of your care.</p>
<ul style="list-style-type: none">• Specialty care	<p>You do not need to have a referral to see a participating specialist.</p> <p>If you need the care of a specialist, you may select a specialist from our provider directory and contact that provider to verify participation with the Plan, or call your PCP who will assist you in locating an appropriate participating provider. If your current specialist is a Plan contracted doctor, you may continue to see that doctor without a written referral unless the provider is a mental health/substance abuse specialist. You must call Customer Service at 1-877-835-9861 to obtain authorization for services to use mental health/substance abuse benefits.</p> <p>Here are some other things you should know about specialty care:</p>

- If you are seeing a specialist when you enroll in our Plan, check with the specialist or verify in our provider directory that the specialist is participating with the Plan. If the specialist is contracted with the Plan, you may continue to see the provider. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
 - Reduce our service area and you enroll in another FEHB Plan,

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

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

• **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our Customer Service Department immediately at 1-877-835-9861 24 hours a day, seven days a week. If you are new to the FEHB Program, we will arrange for you to receive care and reimburse you for your covered expenses while you are in the hospital beginning on the effective date of your coverage.

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 cases, 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

You do not need to have a referral to see a participating specialist. For certain services, however, you or your physician must obtain prior approval from us. We call this review and approval process prior authorization. You or your physician must obtain prior authorization for some services such as, but not limited to the following:

- Mental health and substance abuse benefits. See page 37.

- Orthopedic and prosthetic devices over \$1,000. See page 23.
- Durable medical equipment over \$1,000. See page 24.
- Growth hormone therapy (GHT). See page 21.

Section 4 Your costs for covered services

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

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

Example: When you see your primary care physician you pay a copayment of \$15 per Primary Care Physician's office visit and when you go in the hospital, you pay \$200 per day up to \$600 per admission.

Deductible We do not have a deductible.

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

Example: In our Plan, you pay no copayment for durable medical equipment, benefits limited to \$2,500 per calendar year.

Your catastrophic protection out-of-pocket maximum After your total \$1,000 per person or \$2,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

- Orthopedic devices
- Prosthetic Devices
- Durable Medical Equipment
- Medical supplies (excluding diabetic supplies)
- Growth Hormones
- Hospital Emergency Room
- Office visit, Emergency Room & Urgent Care copays
- Pharmacy Copays
- Refractive Eye Exams

Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

Carryover If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

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Section 5 High Option Benefits Overview

This Plan offers a High Option. Our benefit package is described in Section 5. Make sure that you review the benefits carefully.

The High Option Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about High Option benefits, contact us at 1-877-835-9861 24 hours a day, seven days a week or at our Web site at www.myuhc.com/groups/fehbp.

Our benefit package offers the following unique features:

High Option Benefits	You pay
Medical services provided by physicians:	
Diagnostic and treatment services provided in the office	\$15 per visit to your Primary Care Physician (PCP) \$30 per specialist visit
Services provided by a hospital:	
• Inpatient	\$200 per day up to \$600 per admission copay
• Outpatient Services	Nothing
• Outpatient Surgical	\$50 per visit
Emergency benefits:	
• In or out-of-area	\$100 per visit
Mental health and substance abuse treatment:	Regular cost sharing
Prescription drugs:	
• Plan retail pharmacy and Specialty Pharmaceuticals	Tier 1: \$7
	Tier 2: \$25
	Tier 3: \$40
• Plan mail order or retail for up to a 90-day fill	Tier 1: \$21
	Tier 2: \$75.00
	Tier 3: \$120.00
Dental care:	Please refer to page 44 for a description of our non-FEHB dental benefit.
Vision care:	\$30 copayment for eye refraction exam every other year
Special features:	Flexible Benefits Option, Care 24, Transplant Centers of Excellence, Cancer Resource Services, Healthy Pregnancy Program, Health and Wellness Programs

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- **A facility copay applies to services that appear in this section but are performed in a hospital, an ambulatory surgical center or the outpatient department of a hospital. See *Section 5(c) Services provided by a hospital or other facility, and ambulance services* for more information.**
- We have no deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • Office medical consultations • Second surgical opinion 	\$15 per visit to your Primary Care Physician (PCP) \$30 per specialist visit st
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility 	Nothing
At home	Nothing
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing

Benefit Description	You pay
Preventive care, adult	
Routine physical every year which includes: Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening , including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 	\$15 per visit to your Primary Care Physician (PCP) \$30 per specialist visit
Routine Pap test Note: You do not pay a separate copay for a Pap test performed during your routine annual physical; see <i>Diagnostic and treatment services</i> , above.	\$15 per visit to your Primary Care Physician (PCP) \$30 per specialist visit
Routine Pap test Note: You do not pay a separate copay for a Pap test performed during your routine annual physical; see <i>Diagnostic and treatment services</i> .	\$15 per visit to your Primary Care Physician (PCP) \$30 per specialist visit
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	\$15 per visit to your Primary Care Physician (PCP) \$30 per specialist visit
Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC), such as: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older 	\$15 per visit to your Primary Care Physician (PCP) \$30 per specialist visit
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>

Benefit Description	You pay
Preventive care, children	
<ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics 	\$15 per visit to your Primary Care Physician (PCP) \$30 per specialist visit
<ul style="list-style-type: none"> Well-child care charges for routine examinations, immunizations and care (up to age 22) Examinations, such as: <ul style="list-style-type: none"> Eye exams through age 17 to determine the need for vision correction Hearing exams through age 17 to determine the need for hearing correction Examinations done on the day of immunizations (up to age 22) 	\$15 per visit to your Primary Care Physician (PCP) \$30 per specialist visit
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> Prenatal care 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 32 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. Surgical benefits, not maternity benefits, apply to a circumcision. We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	\$30 per specialist office visit for initial visit only
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex.</i></p>	<p><i>All charges.</i></p>

Benefit Description	You pay
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms • Genetic counseling <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$15 per visit to your Primary Care Physician (PCP)</p> <p>\$30 per specialist visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> 	<p><i>All charges.</i></p>
Infertility services	
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: • intravaginal insemination (IVI) • intracervical insemination (ICI) • intrauterine insemination (IUI) 	<p>\$15 per visit to your Primary Care Physician (PCP)</p> <p>\$30 per specialist visit</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> - in vitro fertilization - <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • Services and supplies related to ART procedures • Cost of donor sperm • Cost of donor egg <p>Fertility drugs</p>	<p><i>All charges.</i></p>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	<p>\$15 per visit to your Primary Care Physician (PCP)</p> <p>\$30 per specialist visit</p>
<p>Allergy serum</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 	<p><i>All charges.</i></p>

Benefit Description	You pay
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 28.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: We only cover GHT when prior authorization is obtained for the treatment by your participating provider who notifies the Plan that the GHT is medically necessary. Prior authorization is required for GHT before you begin treatment; otherwise, we will only cover GHT services from the date your provider submits the information. If your provider does not obtain prior authorization or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>\$15 per visit to your Primary Care Physician (PCP)</p> <p>\$30 per specialist visit</p>
Physical and occupational therapies	
<p>Up to two consecutive months per condition per year of visits for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 36 sessions.</p>	<p>\$30 per specialist office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<p><i>All charges.</i></p>

Benefit Description	You pay
Speech therapy	
Up to two consecutive months per condition per year	\$30 per specialist office visit
Not covered: Exercise Programs	<i>All charges</i>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	\$30 per specialist 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"> • Diagnosis and treatment of diseases of the eye 	\$30 per specialist office visit
<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) 	\$30 per specialist office visit
<ul style="list-style-type: none"> • Eye refraction exams (to provide a written lens prescription) one every other year 	\$30 per specialist office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses and contact fittings, except as shown above</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges.</i>
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	\$30 per specialist 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>

Benefit Description	You pay
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Orthopedic devices such as braces; medical supplies including colostomy supplies; dressings; catheters and related supplies. • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. <p>Note: Plan prior authorization required for items that cost \$1,000 or more. Benefits for orthopedic and prosthetic devices are limited to \$2,500 per calendar year excluding prosthetic arms and legs.</p> <p>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.</p>	<p>Nothing up to \$2,500 then 100%</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • Orthopedic and corrective shoes • Arch supports • Foot orthotics • Heel pads and heel cups • Lumbosacral supports • Corsets, trusses, elastic stockings, support hose, and other supportive devices • Prosthetic replacements provided less than 3 years after the last one we covered 	<p><i>All charges</i></p>
Durable medical equipment (DME)	
<p>We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and 	<p>Nothing up to \$2,500 then 100%</p>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	
<ul style="list-style-type: none"> Insulin pumps. <p>Note: Plan prior authorization is required for items that cost \$1,000 or more. Repairs and replacements are covered if needed due to a change in the member’s medical condition. Benefits for durable medical equipment are limited to \$2,500 per Policy year.</p>	Nothing up to \$2,500 then 100%
<i>Not covered: Motorized wheelchairs</i>	<i>All charges.</i>
Home health services	
<ul style="list-style-type: none"> Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. Services include oxygen therapy, intravenous therapy and medications. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Nursing care requested by, or for the convenience of, the patient or the patient’s family; Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative. <p>Services for primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.</p>	<i>All charges.</i>
Chiropractic	
<ul style="list-style-type: none"> Diagnosis and related services for the manipulation of the spine and extremities to remove nerve interference or its effects. Limited to one treatment per day up to 24 visits per calendar year.Note: The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column. 	\$30 per specialist office visit
Alternative treatments	
Acupuncture – by a doctor of medicine or osteopathy for: anesthesia, pain relief	\$30 per specialist office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Naturopathic services Hypnotherapy <p>Biofeedback</p>	<i>All charges.</i>

Benefit Description	You pay
Educational classes and programs	
Coverage is limited to: <ul style="list-style-type: none"> • Smoking cessation • Diabetes self management 	\$15 per visit to your Primary Care Physician (PCP) \$30 per specialist visit

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have not deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(a) for charges associated with an office visit and Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).**
- **YOUR PHYSICIAN MUST OBTAIN PRIOR AUTHORIZATION OF SOME SURGICAL PROCEDURES.** Please refer to the prior authorization information shown in Section 3 to be sure which services require prior authorization and identify which surgeries require prior authorization.

Benefit Description	You pay
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 <i>Reconstructive surgery</i>) • Surgical treatment of morbid obesity (bariatric surgery) • Eligible members must be age 18 or over; and <p>Individuals must weigh 100 pounds or 100% over his or her normal weight according to current underwriting standards. Insertion of internal prosthetic devices . See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information</p> <ul style="list-style-type: none"> • Insertion of internal prosthetic devices . See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns 	<p>Nothing for surgery subject to the applicable office visit and facility charge copayments; see sections 5(a) and 5(c)</p>

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
<p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>Nothing for surgery subject to the applicable office visit and facility charge copayments; see sections 5(a) and 5(c)</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • Reversal of voluntary sterilization <p>Routine treatment of conditions of the foot; see Foot care</p>	<p><i>All Charges.</i></p>
Reconstructive surgery	
<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; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>Nothing for surgery subject to the applicable office visit and facility charge copayments; see sections 5(a) and 5(c)</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>

Benefit Description	You pay
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; • Dental care necessary to release pain in treatment of temporomandibular joint pain dysfunction; • 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>Nothing for surgery subject to the applicable office visit and facility charge copayments; see sections 5(a) and 5(c)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<p><i>All charges.</i></p>
Organ/tissue transplants	
<p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Kidney/Pancreas • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and the pancreas 	<p>Nothing for surgery subject to the applicable office visit and facility charge copayments; see sections 5(a) and 5(c)</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnosis. The medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia 	<p>Nothing for surgery subject to the applicable office visit and facility charge copayments; see sections 5(a) and 5(c)</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) Blood or marrow stem cell transplants for: <ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced forms of myelodysplastic syndromes - Advanced neuroblastoma - Infantile malignant osteopetrosis - Kostmann’s syndrome - Leukocyte adhesion deficiencies - Mucopolipidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome variants) - Myeloproliferative disorders - Sickle cell anemia - Thalassemia major (homozygous beta-thalassemia) - X-linked lymphoproliferative syndrome 	<p>Nothing for surgery subject to the applicable office visit and facility charge copayments; see sections 5(a) and 5(c)</p>
<ul style="list-style-type: none"> • Autologous transplants for: <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Amyloidosis - Ependymoblastoma 	<p>Nothing for surgery subject to the applicable office visit and facility charge copayments; see sections 5(a) and 5(c)</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> - Ewing’s sarcoma - Medulloblastoma - Pineoblastoma <p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocol’s for:</p> <ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma • Nonmyeloablative allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced forms of myelodysplastic syndromes - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myeloproliferative disorders - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas 	<p>Nothing for surgery subject to the applicable office visit and facility charge copayments; see sections 5(a) and 5(c)</p>
<ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - Breast cancer - Epithelial ovarian cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple sclerosis 	<p>Nothing for surgery subject to the applicable office visit and facility charge copayments; see sections 5(a) and 5(c)</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> - Systemic lupus erythematosus - Systemic sclerosis <p>National Transplant Program (NTP) – United Resource Network (URN) used for organ tissue transplants</p> <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><i>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</i></p>	<p>Nothing for surgery subject to the applicable office visit and facility charge copayments; see sections 5(a) and 5(c)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered • All services related to non-covered transplants • All services associated with complications resulting from the removal of an organ from a non-member 	<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 • Office 	<p>Nothing</p>

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).**
- **YOUR PHYSICIAN MUST OBTAIN PRIOR AUTHORIZATION OF SOME HOSPITAL STAYS.** Please refer to the prior notification information shown in Section 3 to be sure which services require prior authorization.

Benefit Description	You pay
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. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	\$200 per day up to \$600 per admission
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen 	Nothing
<ul style="list-style-type: none"> • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • Non-covered facilities, such as nursing homes, schools 	<i>All Charges</i>

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
<ul style="list-style-type: none"> Personal comfort items, such as telephone, television, barber services, guest meals and beds <p>Private nursing care except when medically necessary</p>	<i>All Charges</i>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> Operating, recovery, and other treatment rooms Prescribed drugs and medicines Diagnostic laboratory tests, X-rays , and pathology services Administration of blood, blood plasma, and other biologicals Pre-surgical testing Dressings, casts , and sterile tray services Medical supplies, including oxygen Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	\$50 per outpatient surgical facility charge
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges.</i>
Extended care benefits/Skilled nursing care facility benefits	
<ul style="list-style-type: none"> Room and board in a semi-private room General nursing Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor. Benefits up to 60 days when full-time skilled nursing care is necessary and confinement is medically appropriate 	Nothing
<i>Not covered: Custodial care</i>	<i>All Charges.</i>
Hospice care	
<p>Hospice care benefits are limited to 360 days per lifetime and include:</p> <ul style="list-style-type: none"> Inpatient care Outpatient care Family counseling Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. 	Nothing

Hospice care - continued on next page

Benefit Description	You pay
Hospice care (cont.)	
<p>Note: These services are provided under the direction of the Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.</p>	Nothing
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<i>All Charges</i>
Ambulance	
<ul style="list-style-type: none"> • Non-emergency local professional ambulance service when medically appropriate with a network provider and when ordered or authorized by a Plan doctor. • Air ambulance, when medically necessary 	Nothing

Section 5(d) Emergency services/accidents

Important things you should keep in mind about these benefits:

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

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within or outside our service area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact your local emergency system (e.g. 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 48 hours. It is your responsibility to ensure the Plan has been timely notified.

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

Benefits are available for care from non-participating providers in a medical emergency only if delay in reaching a contracted provider would result in death, disability or significant jeopardy to your condition. To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Benefit Description	You pay
Emergency within or outside our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office 	\$15 per visit to your Primary Care Physician (PCP) \$30 per specialist visit
<ul style="list-style-type: none"> • Emergency care at an urgent care center 	\$50 per visit
<ul style="list-style-type: none"> • Emergency care as an outpatient at a hospital , including doctors’ services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	\$100 per visit
Not covered: <ul style="list-style-type: none"> • Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers 	<i>All Charges.</i>

Emergency within or outside our service area - continued on next page

Benefit Description	You pay
Emergency within or outside our service area (cont.)	
<ul style="list-style-type: none"> • Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area • Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area 	<i>All Charges.</i>
Ambulance	
<ul style="list-style-type: none"> • Professional ambulance service when medically appropriate. • Air ambulance when medically appropriate. <p>Note: See Section 5(c) for non-emergency service.</p>	Nothing
<i>Not covered: Air ambulance</i>	<i>All Charges.</i>

Section 5(e) Mental health and substance abuse benefits

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no deductible.
- **A facility copay applies to services that appear in this section but are performed in a hospital, an ambulatory surgical center or the outpatient department of a hospital. See Section 5(c) Services provided by a hospital or other facility, and ambulance services for more information.**
- 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 OBTAIN PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay
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>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$15 per visit to your Primary Care Physician (PCP)</p> <p>\$30 per specialist visit</p> <p>Nothing per outpatient hospital visit</p>
<p>Diagnostic tests</p> <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 	<p>\$15 per visit to your Primary Care Physician (PCP)</p> <p>\$30 per specialist visit</p> <p>Nothing per outpatient hospital visit</p> <p>\$15 per visit to your Primary Care Physician (PCP)</p> <p>\$30 per specialist visit</p> <p>Nothing per outpatient hospital visit</p>
<p><i>Not covered: Services we have not approved.</i></p>	<p><i>All Charges.</i></p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay
Mental health and substance abuse benefits (cont.)	
<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>	<p><i>All Charges.</i></p>
Preauthorization	<p>To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes. Call Customer Service at 1-877-835-9861 24 hours a day, seven days a week before obtaining care to obtain prior authorization before utilizing services or for a list of participating providers.</p>
Limitation	<p>We may limit your benefits if you do not obtain a treatment plan and obtain prior authorization.</p>

Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescription medications, as described in the chart beginning on the next page.
- 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.
- We have no deductible.
- Certain medications require your physician to obtain prior authorization to us in order for these to be payable under the Pharmacy Plan. The Pharmacy Plan requires prior authorization for these prescription medications to make sure that they are being prescribed and used according to FDA-approved indications and dosing schedules. If your pharmacist tells you that your prescription medication requires prior authorization, ask your pharmacist or physician to call the Customer Services Department at 1-877-835-9861 for further instructions. You will find valuable information about our Prescription Drug List, as well as information about prior authorization on our website, www.myuhc.com/groups/fehbp.
- 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.

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy, or by mail for maintenance medication. Maintenance medications are those medications anticipated to be required for six months or longer, to treat a chronic condition such as high blood pressure, asthma, or diabetes. The maintenance drug list by drug classification is available on our web site, www.myuhc.com/groups/fehbp. To locate the name of a Plan pharmacy near you, call our Customer Services Department at 1-877-835-9861, or visit our website, www.myuhc.com/groups/fehbp.
- **We use a Prescription Drug List (PDL).** This is a list that identifies those prescription medications that are preferred by the Plan for use. You are covered for all prescription medications written in accordance with FDA guidelines for a particular therapeutic indication whether or not the medication appears on our PDL, except for prescription medications, or classes of medications listed under “Not Covered” in this section of the brochure. The PDL consists of three Tiers which contain a mixture of generic and brand name medications. These medications are placed on the PDL based upon safety, efficacy and cost. A team of clinical reviewers, including physicians and pharmacists, determine the placement of medication on a Tier based on clinical, economical and health care value. This team also periodically reviews and modifies the placement of medications on the PDL and it may change during the course of the year including January, May and September.

The PDL is a tool that can help you identify opportunities to lower your out-of-pocket costs when your doctor prescribes medications for you. Tier 1 is your lowest copayment option. For the lowest out-of-pocket expense, you should always consider Tier 1 medications if you and your physician decide they are appropriate for your treatment. Tier 2 is your middle copayment option. If you are currently taking a medication in Tier 2, ask your physician whether there are Tier 1 alternatives that may be appropriate for your treatment. Tier 3 is your highest copayment option. Sometimes there are alternatives available in Tier 1 or Tier 2. If you are currently taking a medication in Tier 3, ask your physician whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment.

In rare cases, you will pay the full copayment amount for a medication when the actual cost of that medication is less than the discounted ingredient cost of the drug. This means if the medication you have filled costs \$6, you may have to pay the full copayment of \$7 if it is a Tier 1 medication. This only occurs at a minimum of retail pharmacies, and is based upon our network contracting policies. You will never pay more than the appropriate copayment for a medication.

You will find the most up-to-date Prescription Drug List (PDL) on our website, www.myuhc.com/groups/fehbp. You may also call our Customer Services Department at 1-877-835-9861 and ask for a copy of our Prescription Drug List (PDL).

- **These are the dispensing limitations.** Prescription medications prescribed by a contracted or referral doctor and obtained at a contracted pharmacy will be dispensed for up to a 31-day supply or 100-unit supply, whichever is less unless limited by drug manufacturer’s packaging; 240 milliliters of liquid (8 oz.); 60 grams of ointment, creams, or topical preparation; or one commercially prepared unit (e.g. one in haler or one vial ophthalmic medication) of non-maintenance prescription medications at a Plan pharmacy. Prescriptions for covered maintenance medications may be filled up to a consecutive 90-day supply at a Plan retail pharmacy, or through the mail by Medco, Inc. The maintenance drug list by drug classification is available on our web site, www.myuhc.com/groups/fehbp.
- **Quantity Level Limits.** Certain medications may be subject to quantity level limits (QLL) based upon the manufacturer’s package size, FDA-approved dosing guidelines as defined in the product package insert and/or the medical literature or guidelines that support the use of higher dosages than the FDA-recommended dosage.
- **Quantity Per Duration.** A prescription can be refilled when you have used 75 percent of the medication. This process is called Quantity per Duration, or QD. For example, a prescription that was filled for a 31-day supply can be refilled after 23 days. The Plan will give special consideration to filling prescription medications for members covered under the FEHB if:
 - You are called to active duty, or
 - You are officially called off-site as a result of a national or other emergency.

In order to fill the prescription for the two reasons listed above, your physician may need to request prior authorization from the Plan.

- **Specialty Pharmacy Program.** Prescriptions for Specialty medications must be filled for a maximum of a 30-day supply. You will need to use a participating specialty pharmacy to receive in-network coverage for your specialty medication. To locate a participating specialty pharmacy, call our Specialty Pharmacy Referral Line at 1-866-429-8177, 24 hours a day, seven days a week.
- **Half Tablet Program.** With certain medications, you may elect to join the voluntary Half Tablet Program. This Program allows you to save money in copayments by electing a double strength medication, receiving half the quantity, and splitting the tablet in half. If you take advantage of this Program, you will pay half a copayment at retail or mail-order. Your provider must write the prescription for the increased dosage, with the instructions to “take a half tablet”. A free tablet splitter is provided. For more information on this Program please visit our Frequently Asked Questions at www.halftablet.com or call 1-877-471-1860.
- **Why use Tier 1 drugs?** Medications in Tier 1 offer the best health care value and are available at the lowest copayment. Tier 2 medications are available at a higher copayment and Tier 3 medications are available at the highest copayment level. This approach helps to assure access to a wide range of medications and control health care costs for you.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin, with a copayment charge applied every 2 vials • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction • Oral and injectable contraceptive drugs 	Tier 1- \$ 7 Tier 2- \$ 25 Tier 3- \$ 40 Note: If you choose to fill a Tier 2 or Tier 3 drug when there is a Tier 1 alternative available, you will pay the \$7 (Tier 1 copay) plus the difference between the negotiated rate for the medication dispensed and the Tier 1 medication. If the prescribing physician indicates “dispense as written” you will be responsible for the applicable Tier 2 or Tier 3 copay only. You will not have to pay the difference between the negotiated rate for the medication dispensed and the Tier 1 medication.

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
<p>Note: Intravenous fluids and medications for home use, implantable drugs, and some injectable drugs are covered under <i>Medical services and supplies Section (5a)</i> or <i>Surgical and anesthesia services Section (5b)</i>.</p>	<p>Tier 1- \$ 7 Tier 2- \$ 25 Tier 3- \$ 40</p> <p>Note: If you choose to fill a Tier 2 or Tier 3 drug when there is a Tier 1 alternative available, you will pay the \$7 (Tier 1 copay) plus the difference between the negotiated rate for the medication dispensed and the Tier 1 medication. If the prescribing physician indicates “dispense as written” you will be responsible for the applicable Tier 2 or Tier 3 copay only. You will not have to pay the difference between the negotiated rate for the medication dispensed and the Tier 1 medication.</p>
<ul style="list-style-type: none"> • Diabetic supplies limited to insulin syringes, needles, glucose test tape, Benedict’s solution or equivalents and acetone test tablets. • Implanted contraceptive drugs and devices such as Norplant 	<p>Nothing up to \$2,500 then 100%</p>
<p>This Plan’s specialty program includes medications that treat rare, unusual, or complex diseases such as Anemia, Growth Hormone Deficiency, Hepatitis C, Infertility, Multiple Sclerosis, Neutropenia, and Rheumatoid Arthritis.</p> <ul style="list-style-type: none"> • You must use a participating specialty pharmacy to receive coverage for your specialty medication. To locate a participating specialty pharmacy, call our Specialty Pharmacy Referral Line at 1-866-429-8177, 24 hours a day, seven days a week. • Note: Beginning January 1, 2007, members will be provided a transition period where they will be forgiven for up to the first two fills on this program at a non- participating specialty pharmacy. If you use a non- participating pharmacy, you will pay 100% of the cost at the pharmacy, and you will have to submit a claim for reimbursement to the plan. At a non-participating pharmacy, you will pay your copayment plus the difference between the participating and non participating pharmacy costs. 	<p>Plan specialty pharmacy:</p> <p>Tier 1- \$ 7 Tier 2- \$ 25 Tier 3- \$ 40</p> <p>Note: You will only receive a 30-day supply of a specialty medication per fill.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Drugs and supplies for cosmetic purposes • Drugs to enhance athletic performance • Fertility drugs • Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies • Vitamins, nutrients and food supplements even if a physician prescribes or administers them 	<p><i>All Charges.</i></p>

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
<ul style="list-style-type: none"> • Nonprescription medicines • Medical supplies such as dressings and antiseptics • Appetite suppressants • <p><i>Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed; any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug; Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent.</i></p>	<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. For example:</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 is solely ours, and we may withdraw it at any time and resume regular contract benefits. <p>Note: Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</p>
Care24	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-877-835-9861 24 hours a day, seven days a week and talk with a registered nurse with an average of 15 years of experience who will discuss treatment options and answer your health questions. Members may learn self-care for minor illnesses and injuries; understand diagnosed conditions; manage chronic diseases; discover and evaluate possible benefits and risks of various treatment options; learn about specific medications; prepare questions for doctor visits; develop and maintain healthful living habits; and connect with community support groups.</p>
Transplant Centers of Excellence	<p>United Resource Network (URN) provides you access to one of the nation's leading transplant networks, managing more than 10,000 referrals each year. Centers of Excellence are selected through a process of quality measurement and cover all phases of patient health care from evaluation, pre-transplant, transplant, post-transplant and 12-month follow-up health care. Contact URN at 1-877-835-9861 24 hours a day, seven days a week to discuss information about transplants and physicians.</p>
Cancer Resource Services	<p>Cancer is one of the most prevalent conditions in medicine. Cancer Resource Services (CRS) provides unparalleled clinical and economic value in managing complex cancers-providing patients with access to expertise at leading cancer centers throughout the country. Call 1-877-835-9861 24 hours a day, seven days a week, to discuss information about cancer centers and physicians.</p>
Health Pregnancy Program	<p>With our Healthy Pregnancy Program, UnitedHealthcare enrollees receive personal support through all stages of pregnancy and delivery. Some features of the program include a pregnancy assessment to identify special needs, identification of pregnancy risk factors, a 24-hour toll-free phone number to experienced nurses and customized maternity educational materials. To enroll in the Healthy Pregnancy Program, simply call toll-free at 1-877-835-9861 24 hours a day, seven days a week; or visit www.healthy-pregnancy.com.</p>
Health and Wellness Educational Information	<p>You can find healthy living article and general information on www.myuhc.com/groups/fehbp. Health and wellness topic categories include the following and much more:</p> <ul style="list-style-type: none"> • Addiction • Family • Fitness and Nutrition • Healthy Aging • Healthy Pregnancy • Preventive Medicine • Relationships

Section 5(h) Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- Plan dentists must provide or arrange your care.
- We have no deductible.
- **We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.**
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Accidental injury benefit	
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.	Nothing

Dental benefits

Please refer to page 44 for a description of our non-FEHB dental benefit.

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. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums.

PPO Dental Plan

UnitedHealthcare provides a PPO Basic Dental plan to our Federal members enrolled in this plan. There is no additional premium for this benefit that includes many restorative procedures as well as comprehensive preventive benefits. Enrollment is automatic when you enroll in this UnitedHealthcare FEHB health plan. See the 2007 Federal Employees Health Benefits Summary, visit us on the web at www.myuhc.com/groups/fehbp, or contact Customer Service at 1-877-835-9861 for benefit information or to locate providers.

UnitedHealth Wellness SM

As a comprehensive portfolio of wellness programs and services offered through UnitedHealthcare, UnitedHealth Wellness can help improve your total health and well-being. UnitedHealth Wellness is not insurance. Instead, it is our commitment to bring you more ways than ever to stay healthy. We are pleased to offer you the following portfolio of wellness programs and services:

myRenewellSM

myRenewell is designed to help individuals find health and wellness services, discounted products and information all in one place. myRenewell has a unique, balanced approach toward well-being that is not limited to physical health. You will have access to comprehensive information that relates to the five areas of total well-being: Physical, Intellectual, Social, Spiritual and Emotional. myRenewell includes several interactive online tools and resources:

- Surveys – Reports on the five areas of total well-being
- Library – 20,000 scientific articles on a variety of subjects
- Marketplace – Discounts on fitness clubs, nutrition counseling, weight management and more
- Pathways – Guidance on reaching personal health and well-being goals
- Quizzes, Calculators, Assessments – Health and wellness testing and evaluation
- Journaling – A helpful tool in tracking healthy changes

UnitedHealth AlliesSM

UnitedHealth Allies provides typical savings of up to 50 percent on certain health care services not covered by your medical, dental or vision plan, including complementary care/alternative medicine, cosmetic dentistry, laser eye vision correction, hearing services and long-term care services.

Online Personal Health Manager

Available on myuhc.com, the online Personal Health Manager helps you manage your health information all in one place.

- Securely record your current health status or conditions.
- Provide access to only those people you approve.
- Document your medical contacts.
- Create an emergency medical wallet card.
- Store information from doctor visits and print reports.

Online Health Assessment, and Personalized Report

Available through **myuhc.com**, the Health Assessment is an online confidential survey that helps assess your overall current state of health. After taking the 20-minute Health Assessment, you immediately receive a Personalized Report with your results. You then can begin taking steps to achieve a healthier lifestyle through using the online Health Improvement Programs, based on your Personalized Report's suggested improvement areas. You also have the option to speak with a consultative nurse about your results.

Online Health Improvement Programs

With UnitedHealthcare's online Health Improvement Programs, you can choose from a variety of six-week programs designed to help you make lifestyle changes at your own pace. Whether your objective is to lose weight, gain energy or improve your overall health, all Health Improvement Programs are based on sound medical and behavioral research.

Section 6 General exclusions – things we don't cover

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

We do not cover the following:

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

Section 7 Filing a claim for covered services

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

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 1-877-835-9861 24 hours a day, seven days a week .

When you must file a claim – such as for services you received 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: UnitedHealthcare, P.O. Box 740800, Atlanta, GA 30374-0800.

Prescription drugs

Submit your claims to: Medco Health, P.O. Box 14711, Lexington, KY 40512.

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 benefits for 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 required by Section 3.

- 1** Ask us in writing to reconsider our initial decision. You must:
 - a) Write to us within 6 months from the date of our decision; and
 - b) Send your request to us at: UnitedHealthcare's, Federal Employees Health Benefits (FEHB) Program Appeals, P.O. Box 30573, Salt Lake City, Utah 84130-0573; and
 - c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
 - d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

- 2** We have 30 days from the date we receive your request to:
 - a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
 - b) Write to you and maintain our denial - go to step 4; or
 - c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

- 3** You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

- 4** If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group III, 1900 E Street, NW, Washington, DC 20415-3630.

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 1-877-835-9861 24 hours a day, seven days a week 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 III at 202/606-0755 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 any other 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; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.

Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• Should I enroll in Medicare?

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

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

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

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

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

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

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

Claims process when you have the Original Medicare Plan – You probably will not need 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 1-877-835-9861 24 hours a day, seven days a week or see our Web site at www.myuhc.com/groups/fehbp.

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

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs) in some areas of the country. 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 and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments or coinsurance for your FEHB plan. For more information on our Medicare Advantage plan, please contact 1-800-504-4848 to see if this program is available in your area.

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

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

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

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

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you?	The primary payer for the individual with Medicare is?	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• 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) and you are not covered under FEHB through your spouse under #1 above	✓	
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 a covered family member are eligible for Medicare solely due to disability and you?		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

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

**TRICARE and
CHAMPVA**

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

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

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.

Primary Payer Chart

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	Services that are non-health related, such as daily living activities, or services which are health related but do not seek to cure, or services which do not require a trained medical professional. Custodial care that lasts 90 days or more 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 we start paying benefits for those services. See page 12.
Experimental or investigational service	<p>UnitedHealthcare of Georgia, Inc. determines “Medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, diagnostic procedures, drug therapies, or devices to be experimental or investigational when one of the following applied (at the time it makes a determination regarding coverage in a particular case):</p> <ul style="list-style-type: none">• Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service as appropriate for the proposed use;• Subject to review and approval by any Institutional Review Board for the proposed use;• The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 Clinical Trial set forth in the FDA regulations, regardless of when the trial is actually subject to FDA oversight;• Not demonstrated through the prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition, illness or diagnosis for which its use is proposed.
Medical necessity	Services which are reasonably necessary in the exercise of good medical practice in accordance with professional standards accepted in the United States for the treatment of an active illness or injury. We determine medical necessity.
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 as follows: UnitedHealthcare’s Plan allowance is based upon an internally-developed fee schedule. Each CPT, HCPC or ADA procedure code is assigned a regional rate, based on your physician’s or health care practitioner’s office address. This rate includes your copayment or coinsurance amount. Participating physicians or health care practitioners accept this rate, including your copayment or coinsurance amount, as payment in full.
Us/We	Us and We refer to UnitedHealthcare of Georgia, Inc.
You	You refers to the enrollee and each covered family member.

Section 11 FEHB Facts

Coverage information

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

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

Types of coverage available for you and your family

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

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

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

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

Children's Equity Act

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

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

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

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

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2007 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 2006 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.)

Upon divorce

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. However, you may be eligible for your own FEHB coverage under either 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 Three Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Long Term Care Insurance Program (FLTCIP)**, helps cover long term care costs, which are not covered under the FEHB.

Second, the **Federal Flexible Spending Account 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.

Third, the new **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, offers a variety of dental plans and vision plans to anyone who is eligible to enroll in the Federal Employees Health Benefits Program. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents. Premiums are on an enrollee-pay-all basis.

The Federal Long Term Care Insurance Program – *FLTCIP*

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.** 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. 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 about your benefits. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.
- **To request an Information Kit and application.** Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum election of \$5,000.

- **Health Care FSA (HCFSA)**-Pays for eligible health care expenses for you and your dependents which are not covered or reimbursed by the FEHBP coverage or other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)**-Designated for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents which are not covered or reimbursed, by FEHBP or FEDVIP coverage or other insurance.
- **Dependent Care FSA (DCFSA)**-Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

What expenses can I pay with an FSAFEDS account?

For the HCFSA-Health plan copayments, deductibles, over-the-counter medications and products, sunscreen, eyeglasses, contacts, other vision and dental expenses (but not insurance premiums).

For the LEX HCFSA-Dental and vision care expenses including eligible over-the-counter medicines and products related to dental and vision care (but not insurance premiums).

For the DCFSA-Daycare expenses (including summer camp) for your child(ren) under age 13, dependent care expenses for dependents unable to care for themselves.

AND MUCH MORE! Visit www.FSAFEDS.com

Who is eligible to enroll?

Most Federal employees in the Executive branch and many in non-Executive branch agencies are eligible. For specifics on eligibility, visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., EST. TTY: 1-800-952-0450.

When can I enroll?

If you wish to participate, you must make an election to enroll each year by visiting www.FSAFEDS.com or calling the number above during the FEHB Open Season or within 60 days of employment (for new employees).

Even if you enrolled for 2006, you must make a new election to continue participating in 2007. Enrollment DOES NOT carry over from year to year.

Who is SHPS?

SHPS is the Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is BENEFEDES?

BENEFEDES is the name of the voluntary benefits portal hired by OPM to work with the FSAFEDS Program to set up payroll deductions for FSAFEDS allotments.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (**FEDVIP**) is a new program, separate and different from the FEHB Program established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004.

OPM has contracted with several insurance carriers to make supplemental dental and vision benefits available to eligible Federal and USPS employees, annuitants, and their eligible family members.

Dental Insurance

Dental plans will provide a comprehensive range of services, including the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays
- Class B (Intermediate) services, which include restorative procedures such as fillings, pre-fabricated stainless steel crowns, periodontal scaling, tooth extractions and denture adjustments.

- Class C (Major) services which include Endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (orthodontic) services with a 24-month waiting period

Please review the dental plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

Vision Insurance

Vision plans will provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on **LASIK** surgery may also be available.

Please review the vision plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

What plans are available?

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

Premiums

The premiums will vary by plan and by enrollment type (self, self plus one, or self and family). There is no government contribution to the premiums. If you are an active employee, your premiums will be taken from your salary on a pre-tax basis when your salary is sufficient to make the premium withholding. If you are an annuitant, premiums will be withheld from your monthly annuity check when your annuity is sufficient. Pre-tax premiums are not available to annuitants. For information on each plan's specific premiums, visit www.opm.gov/insure/dentalvision.

Who is eligible to enroll?

Federal and Postal Service employees eligible for FEHB coverage (whether or not enrolled) and annuitants (regardless of FEHB status) are eligible to enroll in a dental plan and/or a vision plan.

Enrollment types available

- Self-only, which covers only the enrolled employee or annuitant;
- Self plus one, which covers the enrolled employee or annuitant plus one eligible family member specified by the enrollee; and
- Self and family, which covers the enrolled employee or annuitant and all eligible family members.

Which family members are eligible to enroll?

Eligible family members include your spouse, unmarried dependent children under age 22, and unmarried dependent children age 22 or over incapable of self-support because of a mental or physical disability that existed before age 22.

When can I enroll?

Eligible employees and annuitants can enroll in a dental and/or vision plan during this open season—November 13 to December 11, 2006. You can enroll, disenroll, or change your enrollment during subsequent annual open season, or because of a qualified life event. New employees will have 60 days from their first eligibility date to enroll.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. BENEFEDS is a secure enrollment website sponsored by OPM, where you enter your name, personal information like address, and Social Security Number, the agency you work for (or retirement plan that pays your annuity), and the dental and/or vision plan you select. For those without access to a computer, call 1-877-888-FEDS (TTY number: 1-877-TTY-5680). If you do not have access to a computer or a phone, contact your employing office or retirement system for guidance on how to enroll.

You cannot enroll in a **FEDVIP** plan using the Health Benefits Election Form (SF2908) or through an agency self-service system, such as Employee Express, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

When will coverage be effective?

The new Program will be effective December 31, 2006. Coverage for those who enroll during this year's open season (November 13-December 11, 2006) will be effective December 31, 2006. Coverage for any other enrollments will be effective on/or after December 31, 2006.

How does this coverage work with my FEHB plan's dental or vision coverage?

Some FEHB plans already cover some dental and vision services. When you are covered by more than one health/dental plan, federal law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered expenses.

Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFED.com you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Summary of benefits for the High Option of the UnitedHealthcare of Georgia, Inc.- 2007

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

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	\$15 per visit to your Primary Care Physician (PCP) \$30 per specialist visit	16
Services provided by a hospital:		
• Inpatient	\$200 per day up to \$600 per admission copay	32
• Outpatient Services	Nothing	33
• Outpatient Surgical	\$50 per visit	
Emergency benefits:		
• In or out-of-area	\$100 per emergency room visit.	35
Mental health and substance abuse treatment:	Regular cost sharing	37
Prescription drugs:		39
• Plan retail pharmacy and Specialty Pharmaceuticals	Tier 1: \$7 Tier 2: \$25 Tier 3: \$40	39
• Plan mail order for up to a 90-day fill	Tier 1: \$21.00 Tier 2: \$75.00 Tier 3: \$120.00	39
Dental care:	Please refer to page 44 for a description of our non-FEHB dental benefit.	43
Vision care:	\$30 copayment for eye refraction exam	22
Special features:	Flexible Benefits Option, Care 24, Transplant Centers of Excellence, Cancer Resource Services, Healthy Pregnancy Program, Health and Wellness Programs	42
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$1,000/ Self Only or \$2,000 for Self and Family enrollment per year Some costs do not count toward this protection	12

2007 Rate Information for - UnitedHealthcare of Georgia, Inc.

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

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

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

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

Georgia: Atlanta/Athens

High Option Self Only	GN1	\$129.93	\$43.31	\$281.51	\$93.84	\$153.75	\$19.49
High Option Self and Family	GN2	\$306.51	\$102.17	\$664.10	\$221.37	\$362.70	\$45.98