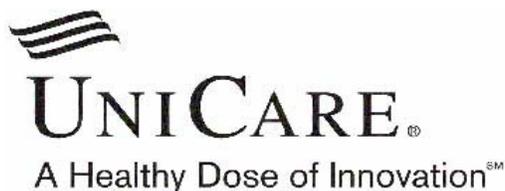


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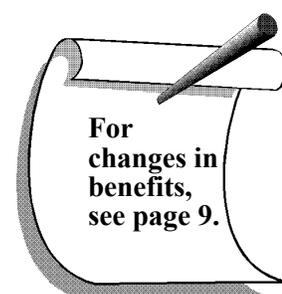


2009

A Health Maintenance Organization (High or Standard Option) and a High Deductible Health Plan (HDHP) Option

Serving: Chicagoland area

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 8 for requirements.



Enrollment codes for this Plan:

171 HMO High Option – Self Only

172 HMO High Option – Self and Family

174 HMO Standard Option – Self Only

175 HMO Standard Option - Self and Family

721 HDHP Option – Self Only

722 HDHP Option – Self and Family



Authorized for distribution by the:



**United States
Office of Personnel Management**

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

RI 73-029

**Important Notice from UniCare About
Our Prescription Drug Coverage and Medicare**

OPM has determined that UniCare's prescription drug coverage is, on average, comparable to Medicare Part D's prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. 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 UniCare will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB program.

Please be advised

- If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug 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 most other people pay. You may also have to wait until the next open enrollment period 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 UniCare HMO (UniCare Health Plans/UHP) and UniCare HDHP (UniCare Health Insurance Company of the Midwest/UHICM) and both entities will be referred to as "UniCare" under our contract (CS 2877) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for UniCare's administrative offices is:

UniCare
Sears Tower
233 South Wacker Drive, 39th Floor
Chicago, Illinois 60606-6309

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, 2009 unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, and changes are summarized on page 9. 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 UniCare.
- 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 fehbwebcomments@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:

- Do not give 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 312/234-8855 or 888/234-8855 (outside of the SBC local calling area) and explain the situation.
 - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW, Room 6400

Washington, DC 20415-1100

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

Preventing medical mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- 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.
- Contact your doctor or pharmacist if you have any questions.

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.

Visit these websites for more information on patient safety:

- www.ahrq.gov/path/beactive.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.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about the HMO and HDHP Plans

General features of our Health Maintenance Organization (HMO) coverage

We offer High Option or Standard Option HMO coverage. The HMO coverage requires 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, coinsurance, and deductibles 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 Deductible Health Plan (HDHP)

The HDHP option provides comprehensive coverage for high-cost medical events and provides a tax-advantaged way to help build savings for future medical expenses. HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans. Our HDHP allows you to seek care from participating or non-participating providers. When you seek care from within our participating provider network (in-network), your deductible and coinsurance for covered care is lower than for out-of-network services.

Preventive care services

In-network preventive care is paid as first dollar coverage. You do not have to meet the annual deductible before you get benefits.

Annual deductible

The annual deductible is \$1,500 under Self only and \$3,000 under Self and Family coverage for in-network services. The annual deductible is \$3,000 under Self only and \$6,000 under Self and Family enrollment for covered out-of-network care. You must satisfy the annual deductible before Plan benefits are paid for care except for certain preventive care services.

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, not received VA benefits within the last three months, not covered by your own or your spouse's flexible spending account (FSA) and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will contribute \$60 of the health plan premium under Self only enrollment or \$120 of the health plan premium under Self and Family enrollment to your HSA for that month. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. In addition, your HSA dollars earn tax-free interest.

- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement. The annual HRA credit is \$720 under Self only enrollment or \$1,440 under Self and Family enrollment. We may pro-rate this amount for mid-year enrollment. Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.
- You cannot contribute to an HRA.
- You can use the HRA to pay for eligible out-of-pocket expenses only for individuals covered under the Plan.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual in-network out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed \$3,000 for Self Only enrollment, or \$6,000 for Family coverage. Your annual out-of-network out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed \$6,000 for Self Only enrollment, or \$12,000 for Family coverage.

Health education resources and accounts management tools

Health Education Resources

We publish an e-newsletter to keep you informed on a variety of issues related to your good health. Visit our Website at www.unicare.com for information on:

- General health topics
- Links to health care news
- Cancer and other specific diseases
- Drugs/medication interactions
- Kids' health
- Patient safety information
- Several helpful website links

HSA and HRA Account Management Tools

For each HSA and HRA account holder we maintain a complete claims payment history online through www.unicare.com.

Your balances will also be shown on your explanation of benefits (EOB) form.

You will receive an EOB after every claim.

If you have an **HSA**

- You will receive a statement outlining your account balance and activity for the month.
- You may also access your account online at www.unicare.com.

If you have an **HRA**

- Your HRA balance will be available online through www.unicare.com.
- Your balance will also be shown on your EOB form.

How we pay contracted 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 deductibles, copayments or coinsurance for in-network services..

Your Rights

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

- **Compliance and licensing requirements** - The National Committee for Quality Assurance (NCQA) has awarded UniCare's HMO (UniCare Health Plans of the Midwest, Inc.) an accreditation status of Commendable for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement. NCQA, an independent, not-for-profit organization, evaluates a health plan's administration and delivery system—physicians, hospitals, other providers and administrative services—in order to continuously improve health care benefits for its members. The current accreditation is for the three year period of April 15, 2008 – April 15, 2011.

UniCare's utilization management and health call center have been awarded Health Utilization Management Accreditation from the Utilization Review Accreditation Commission (URAC) since 1993. UniCare is licensed to provide medical management in all states of the United States that require licensure. UniCare services a wide-variety of clients including health plans, government agencies, and large, private employers.

- **Years in existence** - UniCare HMO is a health benefits product offered by UniCare Health Plans of the Midwest, Inc. (referred to as "UniCare"). UniCare Health Plans of the Midwest, Inc., and its parent, UniCare Illinois Services, Inc., an Illinois corporation, are separately formed and capitalized subsidiaries of Wellpoint, Inc., a Delaware corporation, and are part of the Wellpoint Inc. family of companies.

UniCare Health Insurance Company of the Midwest (IL Residents) and UniCare Life & Health Insurance Company (Non-IL Residents) which underwrites the HDHP plan are also subsidiaries of Wellpoint, Inc. In 1995, UniCare became the brand name for most of the WellPoint businesses operated outside of California. WellPoint acquired the group health and life business of Massachusetts Mutual Life Insurance Company ® in 1996, and in 1997 acquired the group health and related life business of John Hancock Mutual Life Insurance Company ®. In early 2000, WellPoint acquired Rush Prudential Health Plans in Illinois. WellPoint, Inc. was formed when WellPoint Health Networks Inc. and Anthem, Inc. merged in 2004. Company Headquarters: 120 Monument Circle; Indianapolis, Indiana 46204.

- **Profit status** - WellPoint serves approximately 34 million medical members nationwide. WellPoint is included in the S&P 500 index. Trading Symbol: NYSE: WLP

If you want more information about us, call 312/234-8855 or 888/234-8855 (outside the SBC local calling area), or write to the address on your ID card. You may also visit our Web site at www.unicare.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. Our Service Area is the Chicago Metropolitan area and includes the Illinois counties of Cook, DuPage, Kane, Kankakee, Kendall, Lake, McHenry and Will and the Indiana counties of Lake and Porter. This is where our providers practice.

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 as indicated in Section 5(d) of this brochure. We will not pay for any other health care services.

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

Section 2. How we change for 2009

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

Changes to our High Option only

- Your share of the non-Postal premium will increase for Self Only or Self and Family coverage. Please refer to the rates on back cover of this brochure.

Changes to our Standard Option only

- Your share of the non-Postal premium will increase for Self Only or Self and Family coverage. Please refer to the rates on the back cover of this brochure.

Changes to our High Deductible Health Plan only

- Your share of the non-Postal premium did not change for Self Only and for Self and Family. Please refer to the rates that appear on the back cover of this brochure.

Changes to our High Option, Standard Option and HDHP Option

- In addition to the routine mammography screening, the Plan will cover a complete clinical breast exam for the purposes of early detection and prevention of breast cancer for women at least 20 years of age but less than 40 years of age at least once each 3 years. Women age 40 and older are annually entitled to a complete clinical breast exam. This benefit also includes breast ultrasound when medically necessary. See page 19 under High or Standard Option. See page 55 under the HDHP Option.
- We cover Human Papillomavirus Vaccination (HPV) as a child or adult immunization. See page 19 under High or Standard Option. See pages 55 and 56 under the HDHP Option.
- We will provide benefits for amino acid based elemental formulas when medically necessary for diagnosis and treatment of eosinophilic disorders and short bowel syndrome. See page 26 under High or Standard Option. See page 63 under the HDHP Option.

Section 3. How you get care

- Identification cards** We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.
- If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 312/234-8855 or 888/234-8855 (outside of the SBC local calling area), or write to us at the address on your ID card.
- Where you get covered care** You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance.
- **Plan providers** Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.
- We list Plan providers in the provider directory, which we update periodically. The list is on our Web site at www.unicare.com. A hard copy will be provided upon request.
- **Plan facilities** Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is on our Web site at www.unicare.com. A hard copy will be provided upon request.
- What you must do to get covered care** It depends on the type of care you need. First, you and each family member must choose a primary care physician (PCP) under the HMO option. This decision is important since your primary care physician provides or arranges for most of your health care. To select a Primary Care Physician, call us at 312/234/8855 or 888/234-8855 (outside of the SBC local calling area).
- **Primary care** Your primary care physician can be a family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.
- If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one
- **Specialty care** Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, female members may see an obstetrician/gynecologist (OB/GYN), also know as a “woman’s principal health care provider”, who is in the Plan’s network and has been designated by the member, without a referral. Although a woman may directly see her “woman’s principal health care provider,” a referral arrangement must exist between that provider and her PCP so her care can be coordinated. This will also eliminate any potential billing issues. Female members must call the Plan’s Customer Services Department for assistance in designating a provider where the referral arrangement exists.
- Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your 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 HMO 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 hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 312/234/8855 or 888/234-8855 (outside of the SBC local calling area). If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services 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 case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

How to get approval for...

- **Your hospital stay** Under the HMO coverage, your primary care physician will contact us to precertify an elective hospital admission (including maternity care). Under the HDHP coverage, you are ultimately responsible for ensuring that we have precertified an elective hospital admission.
- **How to pre-certify an admission** Under the HMO, your primary care physician is responsible for all verifications with the review organization. Under the HDHP, a covered person or their provider must obtain prior verification from the review organization for admission to a hospital or freestanding medical facility in the above listed instances. A review organization means a team of medical specialists who evaluate and certify a covered person's need for certain medical care or clinical treatment, services and supplies. To pre-certify benefits please call the toll-free Customer Service number on your ID card.
- **What happens when you do not follow the pre-certification rules when using out-of-network facilities** Under the HMO, out-of-network facilities are not applicable. Under the HDHP, if you do not obtain pre-certification for your hospital admission, we will apply a \$500 penalty to covered inpatient hospital admission charges. The pre-certification penalty does not apply to the out-of-pocket maximum.

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process pre-certification. Your or your physician must obtain preauthorization for services such as the following:

- Surgical procedures that must be performed in an ambulatory surgery unit or a hospital operating room, or if the procedure requires anesthesia;
- Inpatient hospital and skilled nursing facility admissions;
- 23 hour hospital observations;
- Organ tissue transplants;
- Skilled nursing facility care;
- Home health care;
- Durable medical equipment and prosthetic devices;
- Certain prescription drugs such as human growth hormones or drugs to treat sexual dysfunction;
- Temporomandibular joint dysfunction treatment;
- Mental health and substance abuse care.
- Certain diagnostic services under the HDHP option such as but not limited to (please call the toll free number on your ID card for a more detail on these services):
 - CT/CAT and MRI scans (except those of the head, neck, brain and face);
 - Nuclear cardiac (heart scans);
 - PET scans.

Section 4. Your costs for covered services

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

Cost-sharing Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance and copayments) for the covered care you receive.

Copayments A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. For example, you have a \$15 office visit copayment for visits to your primary doctor or specialist under the High Option coverage. The office visit copayment under the Standard Option coverage is \$20 per visit to the primary care physician and \$35 per visit to a specialist.

Deductible A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- For the High and Standard Options, you must satisfy a deductible for durable medical equipment, and orthopedic and prosthetic devices of \$100 Self and \$300 Family.
- For the High Deductible Health Plan, we have an In-Network deductible of \$1,500 Self Only enrollment and \$3,000 for Self and Family enrollment and an Out-of-Network deductible of \$3,000 for Self Only and \$6,000 for Self and Family for most covered expenses with the exception of In-network Preventive Care, which is covered at 100%.

Note: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

Coinsurance Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: In our High and Standard Options, you pay 20% of our allowance for durable medical equipment, and orthopedic and prosthetic devices after you have satisfied the durable medical equipment, and orthopedic and prosthetic devices deductible (\$100 Self/ \$300 Family).

Example: In our High Deductible Health Plan you typically pay 10% of the Plan allowance for in-network services and 30% of the Plan allowance for out-of-network services.

Differences between our Plan allowance and the bill Our Network Providers agree to accept a contracted plan allowance. If you use a Network Provider, you will not have to pay the difference between our contracted plan allowance and the billed amount for the covered services you received, if the billed amount is greater than our plan allowance. Non-Network Providers do not agree to accept a contracted plan allowance for their services. You will be required to pay the difference between our plan allowance and the billed amount.

Your catastrophic protection out-of-pocket maximum

For the High Option, after your total out-of-pocket expenses (copayments and coinsurance) exceed \$2,900 Self or \$7,000 Family enrollment, or for the Standard Option, after your total out-of-pocket expenses exceed \$3,000 Self or \$6,000 Family enrollment, in any calendar year, you do not have to pay any more for covered services in that calendar. However, expenses for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments/coinsurance for these services: prescription drugs, and expenses in excess of the Plan's limitations and maximums and amounts in excess of the Plan allowance.

For the High Deductible Health Plan, after your total Out-of-Pocket expenses exceed \$3,000 Self Only enrollment or \$6,000 for Self and Family enrollment for In-network benefits or \$6,000 for Self Only enrollment or \$12,000 for Self and Family enrollment for Out-of-Network benefits in any calendar year, you do not have to pay any more for covered services in that calendar year. However, certain expenses do not count toward your out-of-pocket maximums and you must continue to pay these expenses once you reach your out-of-pocket maximum expenses in excess of the Plan's benefit limitations or maximums and amounts in excess of the Plan allowance.

Note: Self-injectable drugs have a separate catastrophic protection out-of-pocket maximum of \$5,000 per calendar year under any Plan option.

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.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

Section 5. Benefits

See page 9 for how our benefits changed this year. Pages 107 and 108 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. High and Standard Option Benefits Overview

This Plan offers both a High and Standard HMO Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read *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 and Standard Option benefits, contact us at 312/234-8855 or 888/234-8855 (outside of the SBC local calling area) or at our Web site at www.unicare.com.

Each option offers the following unique features.

High Option

- \$15 office visit copayment for visits to your primary care physician or specialist
- \$250 copayment per inpatient hospital admission
- \$100 copay for outpatient surgery performed in a hospital or ambulatory surgery center
- You pay nothing for laboratory tests or radiological procedures
- You pay nothing for a physician's charge for surgery or anesthesia

Standard Option

- \$20 office visit copayment for visits to your primary care physician
- \$35 office visit copayment for visits to a specialist
- 10% coinsurance per inpatient hospital admission, outpatient hospital or ambulatory surgical center services
- You pay nothing for laboratory tests or radiological procedures
- You pay nothing for a physician's charge for surgery or anesthesia

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 when performed in an ambulatory surgical center or the outpatient department of a hospital.
- 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	
	High Option	Standard Option
Diagnostic and treatment services		
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • Office medical consultations • Second surgical opinions 	\$15 per office visit	\$20 per office visit to your primary care physician \$35 per office visit to a specialist
Professional services of physicians <ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	Nothing	Nothing
At home	\$15 per visit	\$35 per visit
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	Nothing

Benefit Description	You pay	
Preventive care, adult	High Option	Standard Option
Routine physical examination	\$15 per office visit	\$20 per office visit to your primary care physician \$35 per office visit to a specialist
Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol • Chlamydial Infection Screening • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Colonoscopy screening - every 10 years starting at age 50 	Nothing	Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing	Nothing
Routine Pap test	Nothing	Nothing
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one baseline mammogram during this five year period • From age 40 and older, one routine mammogram every calendar year • Breast Ultrasound when medically necessary following a mammogram 	Nothing	Nothing
Clinical breast exam - for the purposes of early detection and prevention of breast cancer for: <ul style="list-style-type: none"> • Women at least 20 but less than 40 years of age, at least once each 3 years • Women age 40 and older, annually 	Nothing	Nothing
• Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	Nothing	Nothing
<i>Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges</i>	<i>All charges</i>
Preventive care, children	High Option	Standard Option
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing	Nothing
• Well-child care charges for routine examinations and care (up to age 22) <ul style="list-style-type: none"> • Examinations, such as: <ul style="list-style-type: none"> - Eye exams through age 17 to determine the need for vision correction 	\$15 per office visit	\$20 per office visit to your primary care physician \$35 per office visit to a specialist

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - Ear exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22) 	\$15 per office visit	\$20 per office visit to your primary care physician \$35 per office visit to a specialist
Maternity care	High Option	Standard Option
Complete maternity (obstetrical) care, such as: <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"> • Your hospital admission must be precertified. 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 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). 	\$15 for initial maternity office visit and nothing for subsequent maternity office visits	\$20 for initial office visit to your primary care physician, or \$35 for initial office visit to a specialist and nothing for subsequent office visits
<i>Not covered: Routine sonograms to determine fetal age, size or sex.</i>	<i>All charges</i>	<i>All charges</i>
Family planning	High Option	Standard Option
A range of voluntary family planning services, limited to: <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 <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	\$15 per office visit	\$20 per office visit to your primary care physician \$35 per office visit to a specialist
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>
<ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling</i> 		

Benefit Description	You pay	
Infertility services	High Option	Standard Option
<p>Diagnosis and treatment of infertility (the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy) such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) • Fertility drugs • In vitro fertilization • Uterine embryo lavage • Embryo transfer • Gamete intrafallopian tube transfer • Zygote intrafallopian tube transfer • Low tubal ovum drugs <p>Coverage for procedures for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer shall be available only if:</p> <ul style="list-style-type: none"> • You are unable to attain or sustain a successful pregnancy through reasonable less costly medically appropriate infertility treatments covered under the plan. • You have not undergone four completed oocyte retrievals per your lifetime, except that if a live birth follows a complete oocyte retrieval, then two more completed oocyte retrievals will be covered; and • The procedures are performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization. <p>Note: We cover injectable fertility drugs under medical benefits when administered in the doctor’s office (not self-injected) subject to the office visit copay. Non-fertility self-injectables and oral fertility drugs are covered under the prescription drug benefit.</p>	<p>\$15 per office visit</p>	<p>\$20 per office visit to your primary care physician</p> <p>\$35 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Collection and storage of sperm, oocytes (eggs), or embryos for later use</i> • <i>Services and supplies in connection with the reversal of voluntary sterilization or sex change</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay	
Allergy care	High Option	Standard Option
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	\$15 per office visit	\$20 per office visit to your primary care physician \$35 per office visit to a specialist
<i>Not covered:</i> <ul style="list-style-type: none"> • Provocative food testing • Sublingual allergy desensitization 	<i>All charges</i>	<i>All charges</i>
Treatment therapies	High Option	Standard Option
<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 29.</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 <p>Note: Growth hormone therapy (GHT) is covered under the Prescription Drug Benefits (Section 5(f)) as a self-injectable drug.</p>	Nothing	Nothing
Physical and occupational therapies	High Option	Standard Option
<p>Sixty (60) visits per condition per calendar year for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <ul style="list-style-type: none"> • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to sixty (60) visits if determined to be medically necessary. 	Nothing	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
Speech therapy	High Option	Standard Option
Sixty (60) visits per condition per calendar year for the services of a qualified speech therapist	Nothing	Nothing
Hearing services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> Hearing testing only when necessitated by accidental injury Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> All other hearing testing Hearing aids, testing and examinations for them 	<i>All charges</i>	<i>All charges</i>
Vision services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> One eye refraction every 24 months for enrollees age 18 and older Eye exam to determine the need for vision correction for children through age 17 <p>Note: See <i>Preventive care, children</i>.</p>	\$15 per office visit	\$20 per office visit to your primary care physician \$35 per office visit to a specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Eyeglasses or contact lenses or the fitting of either Eye exercises and orthoptics Radial Keratotomy and other refractive surgery 	<i>All charges</i>	<i>All charges</i>
Foot care	High Option	Standard Option
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	\$15 per office visit	\$20 per office visit to your primary care physician \$35 per office visit to a specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery) 	<i>All charges</i>	<i>All charges</i>
Orthopedic and prosthetic devices	High Option	Standard Option
<ul style="list-style-type: none"> Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy External prosthetic devices, such as artificial limbs and eyes and lenses (following cataract removal) and stump hoses 	20% of the Plan allowance after you have satisfied a calendar year deductible of \$100 per Self Only enrollment or \$300 per Self and Family enrollment	20% of the Plan allowance after you have satisfied a calendar year deductible of \$100 per Self Only enrollment or \$300 per Self and Family enrollment

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> Internal prosthetic devices, such as artificial joints, pacemakers, insulin pumps and surgically implanted breast implant(s) following mastectomy. <p>Note: We pay internal prosthetic devices as hospital benefits, see Section 5(c) for payment information. See 5(b) for coverage of the surgery to insert the device. The internal prosthetic device must be medically necessary to restore bodily function and require a surgical incision (as opposed to an external prosthetic device).</p> <p>Note: Call us at 312/234-8855 or 888/234/8855 (if outside the SBC local calling area) as soon as your Plan physician prescribes these devices. We will arrange with a health care provider to rent or sell you these devices at discounted rates and will tell you more about this service when you call.</p>	<p>20% of the Plan allowance after you have satisfied a calendar year deductible of \$100 per Self Only enrollment or \$300 per Self and Family enrollment</p>	<p>20% of the Plan allowance after you have satisfied a calendar year deductible of \$100 per Self Only enrollment or \$300 per Self and Family enrollment</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Orthopedic and corrective shoes (unless permanently attached to an approved device)</i> <i>Arch supports</i> <i>Foot orthotics</i> <i>Braces</i> <i>Heel pads and heel cups</i> <i>Lumbosacral supports</i> <i>Cochlear implant devices</i> <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> <i>Prosthetic replacement provided less than 3 years after the last one we covered</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Durable medical equipment (DME)	High Option	Standard Option
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> Hospital beds; Wheelchairs; Crutches; Walkers; Blood glucose monitors 	<p>20% of the Plan allowance after you have satisfied a calendar year deductible of \$100 per Self Only enrollment or \$300 per Self and Family enrollment</p>	<p>20% of the Plan allowance after you have satisfied a calendar year deductible of \$100 per Self Only enrollment or \$300 per Self and Family enrollment</p>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	High Option	Standard Option
<p>Note: Call us at 312/234-8855 or 888/234/8855 (if outside the SBC local calling area) as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	20% of the Plan allowance after you have satisfied a calendar year deductible of \$100 per Self Only enrollment or \$300 per Self and Family enrollment	20% of the Plan allowance after you have satisfied a calendar year deductible of \$100 per Self Only enrollment or \$300 per Self and Family enrollment
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Cam walkers • Scooters • Blood pressure cuffs • Breast pumps • Personal comfort and convenience items and services, including but not limited to, telephones, televisions, air conditioners, exercise devices, food blenders, special clothing, therapeutic shoes, home mattresses, air filters, purifiers and similar items, dehumidifiers, whirlpools, automobile and home modifications 	<i>All charges</i>	<i>All charges</i>
Home health services	High Option	Standard Option
<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	10% of the Plan allowance
<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 • Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication 	<i>All charges</i>	<i>All charges</i>
Chiropractic	High Option	Standard Option
<ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application • Vertical alignment • Subluxation • Spinal column adjustments • Treatment of spinal column other than fractures or surgery 	\$15 per office visit	\$35 per office visit to a specialist

High and Standard Option

Benefit Description	You pay	
Amino acid based elemental formula	High Option	Standard Option
Coverage is limited to: <ul style="list-style-type: none"> • Amino acid based elemental formulas when medically necessary for diagnosis and treatment of eosinophilic disorders and short bowel syndrome 	Nothing	Nothing
Alternative treatments	High Option	Standard Option
No benefit	<i>All charges</i>	<i>All charges</i>
Educational classes and programs	High Option	Standard Option
Coverage is limited to: <ul style="list-style-type: none"> • Diabetes self management 	\$15 per visit if performed in a physician's office	\$20 per office visit to your primary care physician \$35 per visit to a specialist
<ul style="list-style-type: none"> • Smoking cessation classes in the service area. Members should call 312/234/7037 for times and locations. 	Nothing	Nothing

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.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay	
	High Option	Standard Option
<p>Surgical procedures</p> <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>) • 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>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>	Nothing	Nothing

Surgical procedures - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Surgical procedures (cont.)		
<ul style="list-style-type: none"> Surgical treatment of morbid obesity (bariatric surgery) - a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards. Eligible members must be age 18 or over and must have actively participated in non-surgical methods of weight reduction. To be eligible, the member must also have co-morbid conditions including, but not limited to, life threatening cardio-pulmonary problems, severe diabetes mellitus, cardiovascular disease or hypertension. For further details, call the member services number on your ID card, or on our website at www.unicare.com. 	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Reversal of voluntary sterilization</i> <i>Routine treatment of conditions of the foot; see Foot care</i> 	<i>All charges</i>	<i>All charges</i>
Reconstructive surgery	High Option	Standard Option
<ul style="list-style-type: none"> 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. Surgery to correct a functional deficit 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 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. <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>Note: Breast prostheses and surgical bras and replacements are covered under benefits for Prosthetic devices (Section 5 (a)).</p>	Nothing	Nothing
<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>All charges</i>	<i>All charges</i>

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Surgeries related to sex transformation</i> 	<i>All charges</i>	<i>All charges</i>
Oral and maxillofacial surgery	High Option	Standard Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	Nothing	Nothing
<ul style="list-style-type: none"> • Surgical treatment of temporomandibular joint (TMJ) pain dysfunction syndrome due to acute trauma or systemic disease <p>Note: We must approve your TMJ treatment plan in advance.</p>	50% of the Plan allowance for approved treatment of TMJ pain dysfunction syndrome	50% of the Plan allowance for approved treatment of TMJ pain dysfunction syndrome
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> • <i>Any dental care involved in the treatment of temporomandibular (TMJ) pain dysfunction syndrome</i> 	<i>All charges</i>	<i>All charges</i>
Organ/tissue transplants	High Option	Standard Option
<p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • 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 pancreas 	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses (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., myelogeneous) leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Hemoglobinopathy (i.e., Fanconi's, Thalessemia major) - Myelodysplasia/Myelodysplastic syndromes - Amyloidosis • 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 - Amyloidosis • Autologous tandem transplants for: <ul style="list-style-type: none"> - Recurrent germ cell tumors (including testicular cancer) - Multiple myeloma - De-novo myeloma <p>Blood or marrow stem cell transplants as follows:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced forms of myelodysplastic syndromes - Advanced neuroblastoma - Kostmann’s syndrome - Leukocyte adhesion deficiencies - Mucopolysaccharidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome variants) 	<p>Nothing</p>	<p>Nothing</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - Myeloproliferative disorders - Sickle cell anemia - X-linked lymphoproliferative syndrome - Infantile malignant osteopetrosis • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Ependymoblastoma - Ewing's sarcoma - Medulloblastoma - Pineoblastoma 	Nothing	Nothing
<p>Blood or marrow stem cell transplants covered only 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 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 - Chronic lymphocytic lymphoma/small lymphocytic lymphoma - Myelodysplasia/Myelodysplastic syndromes • 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 - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myeloproliferative disorders - Myelodysplasia/Myelodysplastic syndromes - Chronic lymphocytic lymphoma/small lymphocytic lymphoma/ (CLL/SLL) • Autologous transplants for <ul style="list-style-type: none"> - Chronic myelogenous leukemia 	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - Chronic lymphocytic lymphoma/small lymphocytic lymphoma(CLL/SLL) - Chronic lymphocytic leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Breast cancer - Epithelial ovarian cancer • National Transplant Program (NTP) <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<i>All charges</i>	<i>All charges</i>
Anesthesia	High Option	Standard Option
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient or outpatient) • Skilled nursing facility • Ambulatory surgical center • Office 	Nothing	Nothing

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.
- 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 GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay	
	High Option	Standard Option
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 • Private accommodations or private duty nursing care when a Plan doctor determines it is medically necessary. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	\$250 copayment per inpatient hospital admission	10% of the Plan allowance
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen 	Nothing	10% of the Plan allowance
<ul style="list-style-type: none"> • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	Nothing	10% of the Plan allowance
<i>Not covered:</i> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
	High Option	Standard Option
<p>Outpatient hospital or ambulatory surgical center</p> <ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma • 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>	\$100 copayment per outpatient surgery	10% of the Plan allowance
<i>Not covered: Blood and blood derivatives replaced by the member</i>	<i>All charges</i>	<i>All charges</i>
<p>Skilled nursing facility services</p> <p>We cover up to 120 days of skilled nursing facility care per calendar year when we determine that full-time skilled nursing care is medically necessary. You and your Plan doctor must obtain our prior approval. All necessary services are covered including:</p> <ul style="list-style-type: none"> • Skilled nursing facility room and board. This includes normal daily services and supplies furnished by the skilled nursing facility. • Other supplies and non-professional services furnished by the skilled nursing facility for medical care in it. <p>Skilled nursing facility services are eligible for coverage only if all of the following conditions are met.</p> <ul style="list-style-type: none"> • A participating doctor recommends the skilled nursing facility stay: <ul style="list-style-type: none"> - For recovery from a sickness or injury that caused a prior hospital stay, or from a related sickness or injury; or - In place of a hospital stay that would be required in the absence of these services and supplies for care and treatment of the person's sickness or injury. • The person is under the continuous care of a participating doctor. • A participating doctor certifies that the person needs 24-hour-a-day nursing care. 	Nothing	10% of the Plan allowance
<i>Not covered: Custodial care, rest cures, domiciliary or convalescent care</i>	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
Hospice care	High Option	Standard Option
<p>We cover support and palliative care for a terminally ill member in the home or hospice facility. Coverage is provided up to a maximum benefit of \$10,000 per period of care. Services include:</p> <ul style="list-style-type: none"> • Inpatient and outpatient care • Family counseling <p>Note: Covered hospice services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness with a life expectancy of approximately six (6) months or less.</p>	Nothing	10% of the Plan allowance
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges</i>	<i>All charges</i>
Ambulance	High Option	Standard Option
Local professional ambulance service ordered or authorized by a Plan doctor	Nothing	10% of the Plan allowance

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 our 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 the local emergency system (e.g. the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify us. You or a family member must notify us within 48 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that we have been timely notified.

If you need to be hospitalized in an Out-of-Network facility, we must be notified within 48 hours or on the first working day following admission, unless it was not reasonably possible to notify us within that time. If you are hospitalized in an Out-of-Network facility and Plan doctors believe care can be provided in a Plan hospital, we will transfer you to a Plan facility when medically feasible. We will cover any ambulance charges in full.

Benefits are available for care from Out-of-Network providers in a medical emergency only if delay in reaching a Plan 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.

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

If you need urgent or emergency medical care when you're away from home, you should call UniCare at 800/782-0180. Service is available 24 hours a day, 7 days a week. If your unexpected illness is not an emergency, you must call this number before seeking treatment. For life-threatening medical emergencies, you should seek treatment from the nearest medical facility and inform the hospital or physician that you are a member of UniCare. You should then contact the Plan at 800/782-0180 within 24 hours after medical care begins.

If you need to be hospitalized, you must notify us within 48 hours or on the first working day following your admission, unless it was not reasonably possible to do so within that time. If a Plan doctor believes care can be provided in a Plan hospital, we will transfer you to a Plan facility at our expense. We must approve all follow-up care recommended by a non-Plan provider or you must receive the follow-up care from a Plan provider.

Benefit Description	You pay	
Emergency within our service area	High Option	Standard Option
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care in a hospital emergency room <p>Note: We waive the ER copay if you are admitted to the hospital.</p> <p>Note: We pay reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.</p>	<p>\$15 per office visit</p> <p>\$50 per urgent care center visit</p> <p>\$100 per hospital emergency room visit</p>	<p>\$20 per office visit to your primary care physician</p> <p>\$35 per office visit to a specialist</p> <p>\$50 per urgent care center visit</p> <p>\$100 per hospital emergency room visit</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>	<i>All charges</i>
Emergency outside our service area	High Option	Standard Option
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • 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> <p>Note: We pay reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.</p>	<p>\$15 per office visit</p> <p>\$50 per urgent care center visit</p> <p>\$100 per hospital emergency room visit</p>	<p>\$20 per office visit to your primary care physician</p> <p>\$35 per office visit to a specialist</p> <p>\$50 per urgent care center visit</p> <p>\$100 per hospital emergency room visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges</i>	<i>All charges</i>
Ambulance	High Option	Standard Option
<p>Professional ambulance service when medically appropriate.</p> <p>Note: See 5(c) for non-emergency service.</p>	Nothing	10% of the Plan allowance per service
<i>Not covered: Air ambulance</i>	<i>All charges</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.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You Pay	
	High Option	Standard Option
<p>Mental health and substance abuse benefits</p> <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>	<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 • Diagnostic tests 	<p>\$15 per office visit</p>	<p>\$20 per office visit to your primary care physician</p> <p>\$35 per office visit to a specialist</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>\$250 copayment per inpatient hospital admission</p>	<p>10% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services we have not approved</i> • <i>Psychiatric evaluation or therapy on court order or as a condition of parole or probation unless determined by a Plan doctor to be necessary and appropriate</i> <p>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.</p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Preauthorization

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

You must contact UniCare at 800-746-6294 before seeking Mental Health or Substance Abuse treatment. UniCare will review your treatment needs. They will provide you and the provider with written authorization (certification letter) for your initial visit and any ongoing care.

Limitation

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

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

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

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

- **Who can write your prescription.** A licensed physician or a referral doctor must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy, or by mail for a maintenance medication. To obtain a list of Plan pharmacies call UniCare's Customer Services Department at 312/234-8855 or 888/234-8855 (outside the SBC local calling area). To order maintenance medications by mail, call UniCare's Customer Services Department to obtain the necessary forms. Complete or have your Plan doctor complete the prescription order form. Mail the Plan doctor's written prescription for up to a 90-day supply of the maintenance drug, along with the completed prescription order form and the appropriate copay amount to the mail order pharmacy provider. Additional refills may be obtained the same way provided the strength and dosage of the medication remain the same.
- **We use reference pricing.** The major difference from a traditional formulary based plan design is how our program classifies drugs and determines copayments. Reference pricing places drugs into common therapeutic drug categories such as diabetes and antihistamines. Each category has a reference price. The reference price is the average cost of a drug within a category of medications. It is dependent on a number of variables including, but not limited to, the actual cost of the drug, utilization patterns and other clinical considerations. The reference price is used to help determine member copayment levels. A list of prescription drugs and their respective therapeutic categories is available on UniCare's web site, www.unicare.com, or may be obtained by calling the UniCare customer service number located on your ID card.
- **There are 4 different copayment levels from Level 1 to Level 4.** Level 1 includes generic drugs that cost less than the reference price. For retail, your copayment is \$10 under High Option or \$15 under Standard Option per prescription unit or refill for Level 1 generic drugs. Level 2 includes brand name drugs that cost less than the reference price. For retail, your copayment is \$25 under High Option or \$30 under Standard Option per prescription unit or refill for Level 2 brand name drugs. Level 3 includes generic and/or brand name drugs that cost more than the reference price. For retail, your copayment is \$50 under High Option or \$60 under Standard Option per prescription unit or refill for Level 3 generic or brand name drugs. Level 4 includes self-injectables (not all insulin products are strictly level 4). Under both options, you pay 20% coinsurance per prescription drug or refill up to a maximum of \$200 per prescription or refill with an annual out-of-pocket maximum of \$5,000. **There may be dispensing limitations on some prescription drugs, such as a 30-day supply for retail and a 90-day supply for mail order and your pharmacist can advise you of these.**
- **Mail Order Program for maintenance medication.** You may obtain up to a 90-day supply of maintenance drugs from our mail order pharmacy program. You pay 2-times the applicable copay for a 90-day supply based on our dispensing limitations. Maintenance medications are drugs used on a continual basis for treatment of chronic health conditions such as high blood pressure, ulcers or diabetes and that are packaged and intended for self-administration by the patient. Additionally, you may obtain insulin and select oral contraceptives through the pharmacy mail order program.
 - To order maintenance medications by mail, call UniCare's Customer Services Department to obtain the necessary forms. Complete or have your Plan doctor complete the prescription order form. Mail the Plan doctor's written prescription for up to a 90-day supply of the maintenance drug, along with the completed prescription order form and the appropriate copay amount to the mail order pharmacy provider. Additional refills may be obtained the same way provided the strength and dosage of the medication remain the same. All drugs are not available by mail order. You cannot obtain antibiotics, cough syrup and self-injected drugs (except insulin) by mail.
 - Please note that we will only refill prescriptions within 12 months of the date of the initial prescription from your Plan doctor. Also, we will not refill a prescription less than 10 days prior to its completion.
 - Drugs to treat sexual dysfunction have dispensing limits and require prior approval. Please contact us for details.

- **Why use generic drugs?** Generic drugs are lower priced drugs that are the therapeutic equivalent to more expensive brand name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand name product. Generics cost less than the equivalent brand name product. The U.S. Food and Drug administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand name drugs.
- **When you do have to file a claim.** You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us. If you file a claim, please 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. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time. Please mail your claims to: UniCare HMO, P.O. Box 5597, Chicago, Illinois 60680-5597.

Benefit Description	You pay	
	High Option	Standard Option
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction • Oral contraceptive drugs and devices • Smoking cessation prescription drugs and medications including, but not limited to, nicotine patches and sprays <p>Note: Drugs for sexual dysfunction have pill limits and require preauthorization.</p>	<p>\$10 per generic prescription unit or refill that costs less than the reference price.</p> <p>\$25 per brand name prescription unit or refill that cost less than the prescription reference price.</p> <p>\$50 per generic or brand name prescription unit or refill that costs more than the reference price.</p> <p>Note: For mail order, you pay 2 times the per unit copay.</p>	<p>\$15 per generic prescription unit or refill that costs less than the reference price.</p> <p>\$30 per brand name prescription unit or refill that costs less than the prescription reference price.</p> <p>\$60 per generic or brand name prescription unit or refill that costs more than the reference price.</p> <p>Note: For mail order, you pay 2 times the per unit copay.</p>
<ul style="list-style-type: none"> • Self-injectable drugs • Self-injectable fertility drugs <p>Note: Fertility drugs administered in the doctor's office (not self-injected), intravenous fluids and medication for home use, implantable drugs, contraceptive devices, and injectable drugs that can only be administered by a physician are covered under Medical and Surgical Benefits.</p> <p>Drugs prescribed for sexual dysfunction have dispensing limitations. For complete details, please call UniCare's Customer Service.</p>	<p>20% of the cost of the prescription unit or refill up to \$200 maximum per prescription up to a \$5,000 out-of-pocket maximum per calendar year.</p>	<p>20% of the cost of the prescription unit or refill up to \$200 maximum per prescription up to a \$5,000 out-of-pocket maximum per calendar year.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines or medicines for which there is a non-prescription equivalent</i> • <i>Medical supplies such as dressings and antiseptics</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • <i>Replacement of lost or stolen medications or the replacement of medications damaged by improper storage</i> • <i>Drugs used for the purpose of weight loss or weight gain</i> • <i>Drugs consumed in an inpatient setting</i> 	<i>All charges</i>	<i>All charges</i>

Section 5(g). 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
- 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	High Option	Standard Option
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. Restorative services must be initiated within 60 days of the reported injury unless the member's medical condition is such that a delay in initiating treatment is required. The injury must be reported to the Plan as soon as reasonably possible after the accident.	Nothing	Nothing
Dental Benefits	High Option	Standard Option
We have no other dental benefits.	<i>All charges</i>	<i>All charges</i>

Section 5(h). Special features

Feature	Description
Feature	High Option
<p>Flexible benefits option</p>	<p>Under the flexible benefits option we determine the most effective way to provide services</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
<p>Services for deaf and hearing impaired</p>	<p>UniCare’s TDD (Telecommunication Device for the Deaf) machine is available to communicate with our hearing impaired members. Messages received by our TDD machine are returned and resolved quickly by a Customer Service Representative. The TDD telephone number is 312/234-7770.</p>

High Deductible Health Plan Benefits

See page 9 for how our benefits changed this year and page 109 for a benefits summary.

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Section 5. High Deductible Health Plan Benefits Overview

This Plan offers a High Deductible Health Plan (HDHP). The HDHP benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read *Important things you should keep in mind* at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 312/234/8855 or 888/234/8855 (outside of the local SBC calling area) or at our Web site at www.unicare.com.

Our HDHP option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your health care benefits.

The annual deductible under the HDHP is \$1,500 under Self only enrollment and \$3,000 under Self and Family enrollment. When you enroll in this HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility. Your full annual HRA credit will be available on your effective date of enrollment.

Preventive care services are not subject to an annual maximum. We do not apply the annual deductible to preventive care services that you receive within our network. You pay nothing for covered in-network preventive care services. For certain covered out-of-network preventive care services, you pay 70% of our allowable charges after you have satisfied the annual deductible. We cover well-child care and immunizations at 100% regardless of whether performed in-network or out-of-network. When you receive non-preventive medical care, you must meet the Plan's deductible before we provide benefits as described on page 57. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to grow.

This HDHP includes five key components: preventive care; traditional medical coverage health care that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

- **Preventive care** The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs, obesity weight loss programs, disease management and wellness programs. These services are covered at 100% per person per calendar year if you use a network provider and the services are described in Section 5 *Preventive care*. *You do not have to meet the deductible before using these services.*
- **Traditional medical coverage** After you have paid the Plan's deductible, we pay benefits under traditional medical coverage described in Section 5. The Plan typically pays 90% for in-network and 70% for out-of-network care.

Covered services include:

 - Medical services and supplies provided by physicians and other health care professionals
 - Surgical and anesthesia services provided by physicians and other health care professionals
 - Hospital services; other facility or ambulance services
 - Emergency services/accidents
 - Mental health and substance abuse benefits
 - Prescription drug benefits
- **Savings** Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see pages 50 - 54 for more details).

• **Health Savings Accounts (HSA)**

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else’s tax return, have not received VA benefits within the last three months or do not have other health insurance coverage other than another high deductible health plan. In 2009, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$60 per month for a Self Only enrollment or \$120 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is \$3,000 for Self Only enrollment or \$5,950 for Self and Family Enrollment. See maximum contribution information on page 51. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don’t deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

HSA features include:

- Your HSA is administered by JP Morgan Chase
- Your contributions to the HSA are tax deductible
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e, Employee Express, MyPay, etc.)
- Your HSA earns tax-free interest
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses)
- Your unused HSA funds and interest accumulate from year to year
- It’s portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- When you need it, funds up to the actual HSA balance are available.

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a HCFSA (such as FSAFEDS offers – see Section 12), this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you.

• **Health Reimbursement Arrangements (HRA)**

If you aren’t eligible for an HSA, for example you are enrolled in Medicare or have another health plan, we will administer and provide an HRA instead. You must notify us that you are ineligible for an HSA.

In 2009, we will give you an HRA credit of \$720 per year for a Self Only enrollment and \$1,440 per year for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don’t count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by UniCare.
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment.

- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP.
- Unused credits carryover from year to year.
- HRA credit does not earn interest.
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans.

An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements.

- **Catastrophic protection for out-of-pocket expenses**

Your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to \$3,000 per person or \$6,000 per family enrollment for in-network services or \$6,000 per person or \$12,000 per family enrollment for out-of-network services. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s allowable amount or benefit maximum). Refer to Section 4 Your catastrophic protection out-of-pocket maximum and HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.

- **Health education resources and account management tools**

HDHP Section 5(i) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA for you with JP Morgan Chase, this HDHP’s fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.)	UniCare is the HRA administrator.
Fees	Set-up fee of \$20 is paid by the HDHP. \$3 per month administrative fee charged by the fiduciary and is taken out of the account balance.	None.
Eligibility	You must: <ul style="list-style-type: none"> • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else’s tax return • Not have received VA benefits in the last three months • Complete and return all banking paperwork. 	You must enroll in this HDHP. Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.
Funding	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP. In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).	Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.
• Self Only enrollment	For 2009, a monthly premium pass through of \$60 will be made by the HDHP directly into your HSA each month.	For 2009, your HRA annual credit is \$720 (prorated for mid-year enrollment).
• Self and Family enrollment	For 2009, a monthly premium pass through of \$120 will be made by the HDHP directly into your HSA each month.	For 2009, your HRA annual credit is \$1,440 (prorated for mid-year enrollment)

<p>Contributions/credits</p>	<p>The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of \$3,000 for Self Only enrollment and \$5,950 for Self and Family enrollment.</p> <p>If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution.</p> <p>You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year.</p> <p>If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.</p> <p>You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP).</p> <p>HSAs earn tax-free interest (does not affect your annual maximum contribution).</p> <p>Catch-up contributions discussed on page 53.</p>	<p>The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.</p>
<ul style="list-style-type: none"> • Self Only enrollment 	<p>You may make an annual maximum contribution of \$2,280.</p>	<p>You cannot contribute to the HRA.</p>
<ul style="list-style-type: none"> • Self and Family enrollment 	<p>You may make an annual maximum contribution of \$4,510.</p>	<p>You cannot contribute to the HRA.</p>
<p>Access funds</p>	<p>You can access your HSA by the following methods:</p> <ul style="list-style-type: none"> • Debit card • Withdrawal form • Checks 	<p>For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through the HDHP. For expenses not covered by the HDHP, such as orthodontia, a reimbursement form will be sent to you upon your request.</p>

<p>Distributions/withdrawals</p> <ul style="list-style-type: none"> • Medical 	<p>You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses, including over-the-counter drugs.</p>	<p>You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP.</p> <p>Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan.</p> <p>See <i>Availability of funds</i> below for information on when funds are available in the HRA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses. Over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.</p>
<ul style="list-style-type: none"> • Non-medical 	<p>If you are under age 65, withdrawal of funds for non-medical expenses will create a 10% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds.</p> <p>When you turn age 65, distributions can be used for any reason without being subject to the 10% penalty, however they will be subject to ordinary income tax.</p>	<p>Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.</p>
<p>Availability of funds</p>	<p>Funds are not available for withdrawal until all the following steps are completed:</p> <ul style="list-style-type: none"> • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA. <p>The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you.</p>	<p>The entire amount of your HRA will be available to you upon your enrollment in the HDHP.</p>
<p>Account owner</p>	<p>FEHB enrollee</p>	<p>HDHP</p>
<p>Portable</p>	<p>You can take this account with you when you change plans, separate or retire.</p> <p>If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 50 for HSA eligibility.</p>	<p>If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA.</p> <p>If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.</p>
<p>Annual rollover</p>	<p>Yes, accumulates without a maximum cap.</p>	<p>Yes, accumulates without a maximum cap.</p>

If You Have an HSA

If you have an HSA

• **Contributions**

All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

If you enroll in an HDHP during Open Season and your effective date is after January 1st or you otherwise have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

• **Catch-up contributions**

If you are age 55 or older, the IRS permits you to make additional “catch-up” contributions to your HSA. The allowable catch-up contribution will be \$1,000 in 2009 and beyond. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury Web site at www.ustreas.gov/offices/public-affairs/hsa/.

• **If you die**

If you do not have a named beneficiary, if you are married, it becomes your spouse’s HSA; otherwise, it becomes part of your taxable estate.

• **Qualified expenses**

You can pay for “qualified medical expenses,” as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, over-the-counter drugs, LASIK surgery, and some nursing services.

When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS Web site at www.irs.gov and click on “Forms and Publications.” Note: Although over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

• **Non-qualified expenses**

You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.

• **Tracking your HSA balance**

You will receive a periodic statement that shows the “premium pass through”, withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.

• **Reimbursements from your HSA**

You can request reimbursement in any amount.

If You Have an HRA

- **Why an HRA is established** If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.

- **How an HRA differs** Please review the chart on page 50 which details the differences between an HRA and an HSA. The major differences are:
 - You cannot make contributions to an HRA
 - Funds are forfeited if you leave the HDHP
 - An HRA does not earn interest, and
 - HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include 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.

Section 5. Preventive care

Important things you should keep in mind about these benefits:

- You must use providers that are part of our network to receive the highest level of benefits.
- We pay covered in-network preventive care services at 100% per person per calendar year and do not apply the deductible. You pay 30% for covered out-of-network preventive care services, after the calendar year deductible unless otherwise indicated.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the deductible.*

Benefit Description	You pay
Preventive care, adult	
Routine examinations, screenings, and immunizations, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol • Chlamydial Infection Screening • 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 10 years starting at age 50 • Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) 	In-network: Nothing Out-of-network: 30% of the Plan allowance after the deductible
<ul style="list-style-type: none"> • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older 	In-network: Nothing Out-of-network: 30% of the Plan allowance after the deductible
<ul style="list-style-type: none"> • Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> - From age 35 through 39, one baseline mammogram during this five year period - From age 40 and older, one routine mammogram every calendar year • Breast ultrasound when medically necessary following a mammogram • Routine Pap test Note: The office visit is covered if the Pap test is received on the same day.	In-network: Nothing Out-of-network: 30% of the Plan allowance after the deductible
Clinical breast exam - for the purposes of early detection and prevention of breast cancer for: <ul style="list-style-type: none"> • Women at least 20 but less than 40 years of age, at least once each 3 years • Women age 40 and older, annually 	In-network: Nothing Out-of-network: 30% of the Plan allowance after the deductible
<i>Not covered: Physical exams and immunizations 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 and flu shots• Well-child care charges for routine examinations and care (up to age 7) and immunizations and flu shots (up to age 16)• Examinations done on the day of immunizations (up to age 16)• Eye exam through age 17 to determine the need for vision correction• Hearing exams through age 17 to determine the need for hearing correction	In-network: Nothing Out-of-network: Nothing (no deductible)

Section 5. Traditional medical coverage subject to the deductible

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.
- For information on preventive care services, please see Section 5. Preventive care.
- The In-network deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year and the Out-of-Network deductible is \$3,000 for Self Only enrollment and \$6,000 for Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your coinsurance and copayments for covered expenses.
- When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copays and deductibles total \$3,000 per person or \$6,000 per family enrollment for In-network benefits or \$6,000 per person or \$12,000 per family enrollment for Out-of-Network benefits in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket maximums and you must continue to pay these expenses once you reach your out-of-pocket maximum (expenses in excess of the Plan’s benefit maximum, amounts in excess of the Plan allowance and Prescription Drug copays for injectable drugs).
- In-network benefits apply only when you use a network provider. When a network provider is not available, out-of-network benefits apply.
- 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 After the calendar year deductible...
Deductible before Traditional medical coverage begins	
<p>The deductible applies to almost all benefits in this Section. In the You pay column, we say “No deductible” when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.</p>	<p>100% of allowable charges until you meet the deductible of \$1,500 per person or \$3,000 per family enrollment for In-network benefits or \$3,000 per person or \$6,000 per family for out-of-network benefits.</p>
<p>After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.</p>	<p>In-network: After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA or HRA, or you can pay for them out-of-pocket.</p> <p>Out-of-network: After you meet the deductible, you pay the indicated coinsurance based on our Plan allowance and any difference between our allowance and the billed amount.</p>

**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.
- The in-network deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year and the out-of-network deductible is \$3,000 for Self Only enrollment and \$6,000 for Family enrollment. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.
- 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 After the calendar year deductible...
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • Office medical consultations • Second surgical opinions • During a hospital stay • In a skilled nursing facility 	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance
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 	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance

Benefit Description	You pay After the calendar year deductible...
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 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 circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See <i>Hospital benefits</i> (Section 5c) and <i>Surgery benefits</i> (Section 5b). 	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance</p>
<i>Not covered: Routine sonograms to determine fetal age, size or sex</i>	<i>All charges</i>
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 <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling.</i> 	<i>All charges</i>
Infertility services	
<p>Diagnosis and treatment of infertility (the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy) such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) • Fertility drugs • In vitro fertilization • Uterine embryo lavage • Embryo transfer 	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance</p>

Infertility services - continued on next page
HDHP Section 5(a)

Benefit Description	You pay After the calendar year deductible...
Infertility services (cont.)	
<ul style="list-style-type: none"> • Gamete intrafallopian tube transfer • Zygote intrafallopian tube transfer • Low tubal ovum drugs <p>Coverage for procedures for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer shall be available only if:</p> <ul style="list-style-type: none"> • You are unable to attain or sustain a successful pregnancy through reasonable less costly medically appropriate infertility treatments covered under the plan. • You have not undergone four completed oocyte retrievals per your lifetime, except that if a live birth follows a complete oocyte retrieval, then two more completed oocyte retrievals will be covered; and • The procedures are performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization. <p>Note: We cover injectable fertility drugs under medical benefits when administered in the doctor’s office (not self-injected) subject to the office visit copay. Non-fertility self-injectables and oral fertility drugs are covered under the prescription drug benefit.</p>	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Collection and storage of sperm, oocytes (eggs), or embryos for later use</i> • <i>Services and supplies in connection with the reversal of voluntary sterilization or sex change</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg.</i> 	<p><i>All charges</i></p>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections • Allergy serum 	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing and sublingual allergy desensitization</i> 	<p><i>All charges</i></p>
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 67.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis 	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance</p>

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Treatment therapies (cont.)	
<ul style="list-style-type: none"> Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy <p>Note: Growth hormone therapy (GHT) is covered under the Prescription Drug Benefits (Section 5(f)) as a self-injectable drug.</p>	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance</p>
Physical and occupational therapies	
<p>Twenty four (24) visits per calendar year 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 twenty four (24) sessions.</p>	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance plus any amount in excess of our maximum payment of \$20. We will not pay more than \$20 per visit for out-of-network care.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Long-term rehabilitative therapy Exercise programs 	<p><i>All charges</i></p>
Speech therapy	
<p>Services of a qualified speech therapist that must be prescribed by a doctor due to an injury or illness</p>	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance</p>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> Hearing testing only when necessitated by accidental injury 	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> All other hearing testing Hearing aids, testing and examinations for them 	<p><i>All charges</i></p>
Vision services (testing, treatment, and supplies)	
<p><i>No benefits under the HDHP plan.</i></p> <p><i>Note: See section 5 "non-FEHB benefits available to plan members."</i></p>	<p><i>All charges</i></p>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery) 	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible...
Orthopedic and prosthetic devices	
<p>Limited to \$5,000 per person per calendar year:</p> <ul style="list-style-type: none"> • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • External prosthetic devices such as artificial limbs and eyes and lenses (following cataract removal) and stump hoses • Internal prosthetic devices, such as artificial joints, pacemakers, insulin pumps and surgically implanted breast implant(s) following a mastectomy • Wigs (for Alopecia resulting from chemotherapy only) limited to \$500 per person’s lifetime <p>Note: We pay internal prosthetic devices as hospital benefits, see Section 5(c) for payment information. See 5(b) for coverage of the surgery to insert the device. The internal prosthetic device must be medically necessary to restore bodily function and require a surgical incision (as opposed to an external prosthetic device).</p> <p>Note: Call us at 312/234-8855 or 888/234/8855 (if outside of the SBC local calling area) as soon as your Plan physician prescribes these devices. We will arrange with a health care provider to rent or sell you these devices at discounted rates and will tell you more about this service when you call.</p>	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes (unless permanently attached to an approved device)</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Braces</i> • <i>Heel pads and heel cups</i> • <i>Lumbrosacral supports</i> 	<p><i>All charges</i></p>
Durable medical equipment (DME)	
<p>Limited to \$5,000 per person per calendar year.</p> <p>We cover rental or purchase of durable medical equipment. At our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Hospital beds • Wheelchairs • Crutches • Walkers • Blood glucose monitors <p>Note: Call us at 312/234-8855 or 888/234/8855 (if outside the SBC local calling area) as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance</p>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible...
Durable medical equipment (DME) (cont.)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cam walkers</i> • <i>Scooters</i> • <i>Blood pressure cuffs</i> • <i>Breast pumps</i> 	<p><i>All charges</i></p>
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 up to 100 visits per calendar year. • Services include oxygen therapy, intravenous therapy and medications. 	<p>In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> • <i>Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.</i> 	<p><i>All charges</i></p>
Chiropractic	
<ul style="list-style-type: none"> • Manipulation of the spine • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application • Vertical alignment • Subluxation • Spinal column adjustments • Treatment of spinal column other than fractures or surgery 	<p>In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance</p>
Amino acid based elemental formula	
<ul style="list-style-type: none"> • Amino acid based elemental formulas when medically necessary for diagnosis and treatment of eosinophilic disorders and short bowel syndrome 	<p>In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance</p>
Alternative treatments	
<p><i>No benefit</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible...
Educational classes and programs	
Coverage is limited to: <ul style="list-style-type: none">• Diabetes self management	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance
<i>Not covered</i> <ul style="list-style-type: none">• <i>Smoking cessation</i>	<i>All charges</i>

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.
- The in-network deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year and the out-of-network deductible is \$3,000 for Self Only enrollment and \$6,000 for Family enrollment. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the pre-certification information shown in Section 3 to be sure which services require pre-certification and identify which surgeries require pre-certification.

Benefit Description	You pay After the calendar year deductible...
<p>Surgical procedures</p> <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>) • 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 • Surgical treatment of morbid obesity (bariatric surgery) – a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards. Eligible members must be age 18 or over and must have actively participated in non-surgical methods of weight reduction. To be eligible the member must also have co-morbid conditions including, but not limited to, life threatening cardio-pulmonary problems, severe diabetes mellitus, cardiovascular disease or hypertension. For further details, call the member services number on your ID card, or on our web site at www.UniCare.com. 	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance</p>

Surgical procedures - continued on next page
HDHP Section 5(b)

Benefit Description	You pay After the calendar year deductible...
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>In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<p><i>All charges</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> • 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. • Surgery to correct a functional deficit • 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 • 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. <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>Note: Breast prostheses and surgical bras and replacements are covered under benefits for Prosthetic devices (Section 5(a)).</p>	<p>In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and 	<p>In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance</p>

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...
Oral and maxillofacial surgery (cont.)	
<ul style="list-style-type: none"> Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance</p>
<ul style="list-style-type: none"> Surgical treatment of temporomandibular joint (TMJ) pain dysfunction syndrome due to acute trauma or systemic disease <p>Note: We must approve your TMJ treatment plan in advance.</p>	<p>50% of the Plan allowance for approved treatment of TMJ pain dysfunction syndrome for In-network or Out-of-network services</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Oral implants and transplants Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) Any dental care involved in the treatment of temporomandibular (TMJ) pain dysfunction syndrome 	<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 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 pancreas 	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses (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 Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) Advanced Hodgkin’s lymphoma Advanced non-Hodgkin’s lymphoma Chronic myleogenous leukemia Severe combined immunodeficiency Severe or very severe aplastic anemia 	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance</p>

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> - Hemoglobinopathy (i.e., Fanconi's, Thalessemia major) - Myelodysplasia/Myelodysplastic syndromes - Amyloidosis • 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 - Amyloidosis • Autologous tandem transplants for: <ul style="list-style-type: none"> - Recurrent germ cell tumors (including testicular cancer) - Multiple myeloma - De-novo myeloma <p>Blood or marrow stem cell transplants as follows:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced forms of myelodysplastic syndromes - Advanced neuroblastoma - Kostmann's syndrome - Leukocyte adhesion deficiencies - Mucopolysaccharidosis (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 - X-linked lymphoproliferative syndrome - Infantile malignant osteopetrosis • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Ependymoblastoma - Ewing's sarcoma - Medulloblastoma - Pineoblastoma 	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
<p>Blood or marrow stem cell transplants covered only 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 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 - Chronic lymphocytic lymphoma/small lymphocytic lymphoma - Myelodysplasia/Myelodysplastic syndromes • 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 - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myeloproliferative disorders - Myelodysplasia/Myelodysplastic syndromes - Chronic lymphocytic lymphoma/small lymphocytic lymphoma/ (CLL/SLL) • Autologous transplants for <ul style="list-style-type: none"> - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic lymphocytic leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Breast cancer - Epithelial ovarian cancer • National Transplant Program (NTP) <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance</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 	<p><i>All charges</i></p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<i>All charges</i>
Alternate benefits for human organ transplant	
<p>The following list represents human organ transplant benefits that are paid at 100% when you utilize Centers of Expertise:</p> <ul style="list-style-type: none"> • heart • heart-lung • lung • liver • pancreas • kidney-pancreas • bone-marrow <p>This benefit includes our Companion Travel Program that allows the member to choose a companion for emotional support. Reasonable transportation and lodging costs are covered for the member and a companion prior to the procedure and during the subsequent hospitalization to a maximum of \$10,000. You must call the Plan for preauthorization.</p>	Nothing (no deductible)
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>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance</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 .
- The in-network deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year and the out-of-network deductible is \$3,000 for Self Only enrollment and \$6,000 for Family enrollment. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.
- 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 GET PRE-CERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require pre-certification.

Benefit Description	You Pay After the calendar year deductible...
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; and • Private accommodations or private duty nursing care when a Plan doctor determines it is medically necessary. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen 	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance
<i>Not covered:</i> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools 	<i>All charges</i>

Inpatient hospital - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital (cont.)	
<ul style="list-style-type: none"> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> 	<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 • Blood and blood plasma • 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>	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance</p>
<i>Not covered: Blood and blood derivatives replaced by the member</i>	<i>All charges</i>
Skilled nursing care facility benefits	
<p>We cover up to 100 days of skilled nursing facility care per calendar year when we determine that full-time skilled nursing care is medically necessary. You and your Plan doctor must obtain our prior approval. All necessary services are covered including:</p> <ul style="list-style-type: none"> • Skilled nursing facility room and board. This includes normal daily services and supplies furnished by the skilled nursing facility. • Other supplies and non-professional services furnished by the skilled nursing facility for medical care in it. <p>Skilled nursing facility services are eligible for coverage only if all of the following conditions are met.</p> <ul style="list-style-type: none"> • A participating doctor recommends the skilled nursing facility stay: <ul style="list-style-type: none"> - For recovery from a sickness or injury that caused a prior hospital stay, or from a related sickness or injury; or - In place of a hospital stay that would be required in the absence of these services and supplies for care and treatment of the person's sickness or injury. • The person is under the continuous care of a participating doctor. • A participating doctor certifies that the person needs 24-hour-a-day nursing care. 	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance</p>
<i>Not covered: Custodial care, rest cures, domiciliary or convalescent care</i>	<i>All charges</i>

Benefit Description	You Pay After the calendar year deductible...
Hospice care	
<p>We cover support and palliative care for a terminally ill member in the home or hospice facility. Coverage is provided up to a maximum benefit of \$10,000 per lifetime. Services include:</p> <ul style="list-style-type: none"> • Inpatient and outpatient care • Family counseling <p>Note: Covered hospice services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness with a life expectancy of approximately six (6) months or less.</p>	<p>In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance</p>
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges</i>
Ambulance	
<p>Limited to a \$5,000 maximum per person per calendar year</p> <p>Local professional air and ground ambulance service when medically appropriate</p>	<p>In-network: 10% of the Plan allowance Out-of-network: 10% of the Plan allowance</p>

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.
- The in-network deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year and the out-of-network deductible is \$3,000 for Self Only enrollment and \$6,000 for Family enrollment. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.
- 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 our 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 the local emergency system (e.g. the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify us. You or a family member must notify us within 48 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that we have been timely notified.

If you need to be hospitalized in an Out-of-Network facility, we must be notified within 48 hours or on the first working day following admission, unless it was not reasonably possible to notify us within that time. If you are hospitalized in an Out-of-Network facility and Network doctors believe care can be provided in a Network hospital, we will transfer you to a Network facility when medically feasible. We will cover any ambulance charges in full.

Benefits are available for care from Out-of-Network providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

To be covered by this Plan, any follow-up care recommended by Out-of-Network providers must be approved by the Plan or provided by Network providers.

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

If you need urgent or emergency medical care when you're away from home, you should call UniCare at 800/782-0180. Service is available 24 hours a day, 7 days a week. If your unexpected illness is not an emergency, you must call this number before seeking treatment. For life-threatening medical emergencies, you should seek treatment from the nearest medical facility and inform the hospital or physician that you are a member of UniCare. You should then contact the Plan at 800/782-0180 within 24 hours after medical care begins.

If you need to be hospitalized, you must notify us within 48 hours or on the first working day following your admission, unless it was not reasonably possible to do so within that time. If a Network doctor believes care can be provided in a Network hospital, we will transfer you to a Network facility at our expense. We must approve all follow-up care recommended by a Out-of-Network provider or you must receive the follow-up care from a Network provider.

Benefit Description	You pay After the calendar year deductible...
Emergency within our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors’ services <p>Note: We pay reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.</p>	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 10% of the Plan allowance</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>
Emergency outside our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors’ services <p>Note: We pay reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.</p>	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 10% of the Plan allowance</p>
Ambulance	
<p>Limited to a \$5,000 maximum per person per calendar year</p> <p>Local professional air and ground ambulance service when medically appropriate</p>	<p>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 10% of the Plan allowance</p>

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 to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The in-network deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year and the out-of-network deductible is \$3,000 for Self Only enrollment and \$6,000 for Family enrollment. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible...
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> <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 • Diagnostic tests • 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>In-network: 10% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services we have not approved</i> • <i>Psychiatric evaluation or therapy on court order or as a condition of parole or probation unless determined by a Plan doctor to be necessary and appropriate</i> 	<p><i>All charges</i></p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits (cont.)	
<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>	<i>All charges</i>

Preauthorization To be eligible to receive these benefits you must obtain a treatment plan and follow the network authorization processes found on page 12.

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

Section 5(f). Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses or copayments for eligible prescriptions.
- 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 or a referral doctor must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy, or by mail for a maintenance medication. To obtain a list of Plan pharmacies call UniCare’s Customer Services Department at 312/234-8855 or 888/234-8855 (outside the SBC local calling area). To order maintenance medications by mail, call UniCare’s Customer Services Department to obtain the necessary forms. Complete or have your Plan doctor complete the prescription order form. Mail the Plan doctor’s written prescription for up to a 90-day supply of the maintenance drug, along with the completed prescription order form and the appropriate copay amount to the mail order pharmacy provider. Additional refills may be obtained the same way provided the strength and dosage of the medication remain the same.
- **We use reference pricing.** The major difference from a traditional formulary based plan design is how our program classifies drugs and determines copayments. Reference pricing places drugs into common therapeutic drug categories such as diabetes and antihistamines. Each category has a reference price. The reference price is the average cost of a drug within a category of medications. It is dependent on a number of variables including, but not limited to, the actual cost of the drug, utilization patterns and other clinical considerations. The reference price is used to help determine member copayment levels. There are 4 different copayment levels from Level 1 to Level 4. Please see the copayment levels listed below for the copayment amount you will pay. A list of prescription drugs and their respective therapeutic categories is available on UniCare’s website, www.unicare.com, or may be obtained by calling the UniCare customer service number located on your ID card.
- **There are 4 different copayment levels from Level 1 to Level 4.** Level 1 includes generic drugs that cost less than the reference price. The retail pharmacy copayment is \$10 copay per prescription or refill for Level 1 generic drugs. Level 2 includes brand name drugs that cost less than the reference price. The retail pharmacy copay is \$20 copay per prescription or refill for Level 2 brand name drugs. Level 3 includes generic and/or brand name drugs that cost more than the reference price. You pay a \$40 copay per prescription or refill for a Level 3 generic or brand name drug from a retail pharmacy. Level 4 is for self-injectables (not all insulin products are covered strictly level 4). You pay 20% coinsurance per prescription drug or refill up to a maximum of \$200 per prescription or refill. The out-of-pocket maximum for self-injectables is \$5,000 per calendar year. **There may be dispensing limits on Prescription Drugs, such as a 30 day supply for retail and a 90 day supply for mail order and your pharmacist can advise you of this.**
- **Mail Order for maintenance medication.** You may obtain up to a 90-day supply of maintenance drugs from our mail order pharmacy program. You pay 2-times the per unit copay. Maintenance medications are drugs used on a continual basis for treatment of chronic health conditions such as high blood pressure, ulcers or diabetes and that are packaged and intended for self-administration by the patient. Additionally, you may obtain insulin and select oral contraceptives through the pharmacy mail order program.
 - To order maintenance medications by mail, call UniCare’s Customer Services Department to obtain the necessary forms. Complete or have your Plan doctor complete the prescription order form. Mail the Plan doctor’s written prescription for up to a 90-day supply of the maintenance drug, along with the completed prescription order form and the appropriate copay amount to the mail order pharmacy provider. Additional refills may be obtained the same way provided the strength and dosage of the medication remain the same. All drugs are not available by mail order. You cannot obtain antibiotics, cough syrup and self-injected drugs (except insulin) by mail.

- Please note that we will only refill prescriptions within 12 months of the date of the initial prescription from your Plan doctor. Also, we will not refill a prescription less than 10 days prior to its completion.
- Drugs to treat sexual dysfunction have dispensing limits and require prior approval. Please contact us for details.
- **Out-of-Network Pharmacy.** For out-of-network, out-of-area emergencies, you pay the applicable copay above plus 30%.
- **Why use generic drugs?** Generic drugs are lower priced drugs that are the therapeutic equivalent to more expensive brand name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand name product. Generics cost less than the equivalent brand name product. The U.S. Food and Drug administration sets quality standard for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand name drugs.
- **When you do have to file a claim.** You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us. If you file a claim, please 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. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time. Please mail your claims to: UniCare, P.O. Box 5597, Chicago, Illinois 60680-5597

Benefit Description	You pay After the calendar year deductible
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction • Oral contraceptive drugs and devices • Smoking cessation prescription drugs and medications including, but not limited to, nicotine patches and sprays <p>Note: Drugs for sexual dysfunction have pill limits and require preauthorization</p>	<p>Retail:</p> <p>\$10 per generic prescription unit or refill that cost less than the reference price</p> <p>\$20 per brand name prescription unit or refill that cost less than the reference price</p> <p>\$40 per generic or brand name prescription unit or refill that cost more than the reference price</p> <p>Mail Order:</p> <p>\$20 per generic prescription unit or refill that cost less than the reference price</p> <p>\$40 per brand name prescription unit or refill that cost less than the reference price</p> <p>\$80 per generic or brand name prescription unit or refill that cost more than the reference price</p> <p>Out-of-network, out-of-area for emergencies: Applicable amount shown above plus 30% of the Plan allowance</p>
<ul style="list-style-type: none"> • Self-injectable drugs • Self-injectable fertility drugs <p>Note: Fertility drugs administered in the doctor's office (not self-injected), intravenous fluids and medication for home use, implantable drugs, contraceptive devices, and injectable drugs that can only be administered by a physician are covered under Medical and Surgical Benefits.</p> <p>Drugs prescribed for sexual dysfunction have dispensing limitations. For complete details, please call UNICARE's Customer Services.</p>	<p>20% of the cost of the prescription unit or refill up to \$200 maximum per prescription with a total Out-of-Pocket maximum of \$5,000 per calendar year</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible
Covered medications and supplies (cont.)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines or medicines for which there is a non-prescription equivalent</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Replacement of lost or stolen medications or the replacement of medications damaged by improper storage</i> • <i>Drugs used for the purpose of weight loss or weight gain</i> • <i>Drugs consumed in an inpatient setting</i> 	<p><i>All charges</i></p>

Section 5(g). 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.
- The in-network deductible is \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment each calendar year and the out-of-network deductible is \$3,000 for Self Only enrollment and \$6,000 for Family enrollment. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.
- 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 After the calendar year deductible...
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. Restorative services must be initiated within 60 days of the reported injury unless the member’s medical condition is such that a delay in initiating treatment is required. The injury must be reported to the Plan as soon as reasonably possible after the accident.	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance
Dental benefit	
<i>We have no other dental benefits.</i>	<i>All charges</i>

Section 5(h). Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option we determine the most effective way to provide services</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24 hour nurse line (MedCALL)	<p>Before you seek non-emergency care, you may want to call MedCALL. This service is a 24 hour telephone based health information, assessment, triage and referral service. This service is staffed by registered nurses. You may locate providers any time of the day or night. MedCALL nurses will also provide medical information, health event medical counseling, national and local resources for additional information, and triage to the appropriate level of care. See the back of your Member ID card for the number to call.</p>
Services for deaf and hearing impaired	<p>UNICARE’s TDD (Telecommunication Device for the Deaf) machine is available to communicate with our hearing impaired members. Messages received by our TDD machine are returned and resolved quickly by a Customer Service Representative. The TDD telephone number is 312/234-7770.</p>
High risk pregnancies (MATERNICALL)	<p>As soon as the pregnancy of a covered person is confirmed you may want to call the review organization. The review organization will evaluate the medical history of the covered person to identify risk factor early in the pregnancy. The review organization may be called by the covered person or her attending doctor at any time throughout the pregnancy to have questions answered. The Customer Service number to call is 1-800-392-8043.</p>
Centers of expertise	<p>Under our Alternate Human Organ Transplant program our Centers of Expertise provide members with access to a nationwide network of carefully selected, specialized transplant facilities. Our network includes some of the best transplant providers in the United States for members in need of heart, lung, heart/lung, liver, kidney/pancreas or bone marrow transplants. In some cases, we also offer Centers of Expertise for kidney transplants.</p>
Travel benefit for Centers of expertise	<p>Our Travel Companion Program allows the member to choose a companion for emotional support. Reasonable transportation and lodging costs are covered for the member and a companion prior to the procedure and during the subsequent hospitalization. Benefits are paid first dollar (100%) and not subject to the deductible, but are subject to a \$10,000 maximum.</p>

Section 5(i). Health education resources and account management tools

Special features	Description
<p>Health education resources</p>	<p>We publish an e-newsletter to keep you informed on a variety of issues related to your good health. Visit our Web site at www.unicare.com for information on:</p> <ul style="list-style-type: none"> • General health topics • Links to health care news • Cancer and other specific diseases • Drugs/medication interactions • Kids’ health • Patient safety information • and several helpful Web site links.
<p>Account management tools</p>	<p>For each HSA and HRA account holder, we maintain a complete claims payment history online through www.unicare.com.</p> <p>Your balance will also be shown on your explanation of benefits (EOB) form.</p> <p>You will receive an EOB after every claim.</p> <p>If you have an HSA,</p> <ul style="list-style-type: none"> • You will receive a statement outlining your account balance and activity for the month. • You may also access your account on-line at www.unicare.com. <p>If you have an HRA,</p> <ul style="list-style-type: none"> • Your HRA balance will be available online through www.unicare.com. • Your balance will also be shown on your EOB form.
<p>Consumer choice information</p>	<p>As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Directories are available online at www.unicare.com.</p> <p>Pricing information for medical care is available at www.unicare.com. Pricing information for prescription drugs is available at www.unicare.com.</p> <p>Link to online pharmacy through www.unicare.com.</p> <p>Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.unicare.com.</p>
<p>Care support</p>	<p>Patient safety information is available online at www.unicare.com</p>

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 maximum. For additional information contact the Plan at the numbers or website stated below.

Dental Benefits

As a UniCare member, you and your family are automatically eligible for participation in the UniCare Dental Network. By taking advantage of this non-FEHB benefit, you and your family will be able to choose a dental provider from an extensive network of participating, credentialed dental providers in the Chicagoland area. Also, you can realize discounts averaging around 20% on a wide range of preventive and specialty care services from participating dental providers, including orthodontists. After you enroll in UniCare we will send you an identification card that provides Dental information. You can either call 800-627-0004 or check our website at <http://www.unicare.com> to select a convenient dental office near you. Written inquiries or correspondence should be directed to P.O. Box 9201, Oxnard, CA 93031-9021. If you have questions, you may also contact UniCare Customer Services at 312/234-8855 or 888/234-8855 (outside of the SBC local calling area).

Vision Care

As a UniCare member, you and your family are entitled to discounts off the retail price on eye wear through UniCare's HealthyExtensions program and EyeMed Vision Care. You can receive discounts of up to 30% for eye wear. To find a location near you, please call toll free at 866/693-9372. You may also receive discounts of up to 50% on contact lenses using the HealthyExtensions program and TruVision. Contact TruVision at 877/765-2020. To participate in the HealthyExtensions program you must be a UniCare member. If you have questions you may also contact UniCare Customer Service at 312/234-8855 or 888/234-8855 (outside of the SBC local calling area).

HealthyExtensions

UniCare's HealthyExtensions program helps you and your family on your path toward a healthier lifestyle. You'll find discounts on an array of products, services, alternative health resources and independent practitioners. As a UniCare member, you are automatically eligible to receive these discounts.

Simply log on to www.unicare.com, click on "Discounts & Savings," then select "HealthyExtensions" and receive savings on:

- Fitness club memberships
- Weight loss programs
- Prescription glasses, contacts, sunglasses and LASIK
- Hearing products
- Teeth whitening
- Vitamins and supplements
- Pet insurance
- Child safety products
- Spa vacations and more!

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** and we agree as discussed under *Services requiring our prior approval* on page 12.

We do not cover the following:

- Care by out-of-Network providers in the HMO plan 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;
- 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, coinsurance, or deductible.

You will only need to file a claim when you receive services from out-of-network 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 312/234-8855 or 888/234-8855 (outside the SBC local calling area).

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:

UniCare
P.O. Box 4458
Chicago, IL 60680-4458

Prescription drugs

Submit your claims to:

UniCare
P.O. Box 9085
Claim Services
Oxnard , CA 93031-9085

Other supplies or services

In most cases you will not have to file a claim because our providers will handle the process for you. If you must file a claim for services such as durable medical equipment or prosthetic devices, use the procedure and address above.

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. Disagreements between you and the HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

- 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: UniCare, Attn: Appeals Department, 233 South Wacker Drive, Suite 3900, Chicago, IL 60606-6309; 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, Contracts Division 2, 1900 E Street, NW, Washington, DC 20415-3620.

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 312/234-8855 or 888/234-8855 (outside the SBC local calling area) 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 Contract Division 2 at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has 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.

If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

Claims process when you have the Original Medicare Plan – You will probably 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. To find out if you need to do something to file your claim, call us at 312/234-8855 or 888/234-8855 (outside the local SBC calling area) or see our web site at www.unicare.com.

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

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

- **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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

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		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) 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 #3 above	✓	
5) 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	✓	
6) 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 #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓ *	
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	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD (for the 30 month coordination period)		✓
• Medicare based on ESRD (after the 30 month coordination period)	✓	
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.

When you have Federal Employees Dental and Vision Insurance Plans (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, 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 BENEFEDS.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.

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 13.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 13.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Care that provides a level of routine maintenance for the purpose of meeting personal needs. This is care that can be provided by a layperson who does not have professional qualifications, skills, or training. Examples include help in walking, dressing, getting in to and out of bed, and help in functions of daily living. 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 14.
Experimental or investigational service	A procedure that is determined to be experimental or investigational based on Plan review of medical record, current reviews of medical literature and scientific evidence, results of current studies or clinical trials, research protocol, reports or opinions of authoritative medical bodies, and opinions of independent outside experts and approvals granted by regulatory bodies.
Medical necessity	Medical services provided for the diagnosis or the treatment of a sickness or injury or for the maintenance of a person's good health as specifically shown in the benefit schedules in this brochure. Also, the medical services are furnished by a provider with the appropriate training, experience, staff and facilities to furnish the service, and the established opinion, with the appropriate specialty of the United States medical profession, that the services are safe and effective for the intended use.
Us/We	Us and We refer to UniCare Health Plans of the Midwest, Inc. for the HMO and UniCare Health Insurance Company of the Midwest for the HDHP.
Plan allowance	<p>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 the reasonable and customary charges.</p> <p>With respect to physician charges, Reasonable and Customary for a covered expense is the lesser of:</p> <ul style="list-style-type: none">• the amount charged by the provider of services;• the amount that has been negotiated with the provider of services; or• the amount based on the percentage determined by us of the fee Medicare allows for the same or similar services on a national level.
You	You refers to the enrollee and/or each covered family member, as context permits.

High Deductible Health Plan (HDHP) Definitions

Calendar year deductible	A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them.
Catastrophic limit	Total out-of-pocket expenses including deductible and coinsurance after which is reached, benefits are payable at 100%.
Health Reimbursement Arrangement (HRA)	An employer funded account that reimburses employees for qualified medical care expenses, typically combined with a high-deductible health plan.
Health Savings Account (HSA)	A special account owned by an individual where contributions to the account are designed to pay for current and future medical expenses on a tax-free basis.
Premium contribution to HSA/HRA	A maximum that can be contributed to your HSA which is an annual combination of HDHP premium pass through and enrollee contribution funds which when combined do not exceed the amount of the deductible.

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 Benefits*, 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 2009 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 2008 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.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

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 for 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 Benefits 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 Benefits 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 protection 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 be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

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

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents, which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed 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 any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

Where can I get more information about 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. Annuitants are not eligible to enroll.

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

- **Health Care FSA (HCFSA)** – Pays for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.

- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed 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) formerly known as the Dependent Care FSA** – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

Where can I get more information about FSAFEDS?

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., Eastern time, TTY: 1800-952-0450.

The Federal Employees Dental and Vision Insurance Program – FEDVIP

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program has no pre-existing condition limitations. FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans provide a comprehensive range of services, including all 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, prefabricated 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 up to a 24 month waiting period.

Vision Insurance

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

Additional Information

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

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877-889-5680).

The Federal Long Term Care Insurance Program - FLTCIP

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. 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. 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. You must apply to know if you will be approved for enrollment. 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.

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Summary of benefits for the High Option of the UniCare HMO - 2009

- **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	Office visit copay: \$15	18
Services provided by a hospital:		
• Inpatient	Nothing after a \$250 inpatient hospital admission	33
• Outpatient	Nothing for Outpatient Surgery after a facility copay of \$100	34
Emergency benefits:		
• In-area or out-of area	\$100 per hospital emergency room visit	37
Mental health and substance abuse treatment:		
	Regular cost sharing	38
Prescription drugs:		
Retail Pharmacy	\$10 for Level 1; \$25 for Level 2; \$50 for Level 3; and 20% for Level 4 to a \$200 maximum per prescription and a separate Out-of-Pocket maximum of \$5,000 per calendar year	40
Mail order - up to a 90-day supply of maintenance medication	\$20 for Level 1; \$50 for Level 2; \$100 for Level 3; and 20% for Level 4 to a maximum of \$200 per prescription and a separate Out-of-Pocket maximum of \$5,000 per calendar year	44
Dental care:		
	No benefit	43
Vision care: One eye refraction every 24 months		
	Office visit copay: \$15	25
Special features:		
Flexible benefits option, TDD assistance		44
Protection against catastrophic costs (out-of-pocket maximum):		
Nothing after \$2,900/Self Only or \$7,000/Self and Family per calendar year		14
Some costs do not count toward this protection		

Summary of benefits for the Standard Option of the UniCare HMO - 2009

- 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.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$20 primary care; \$35 specialist	18
Services provided by a hospital:		
• Inpatient or outpatient	10% of the Plan allowance	33 - 34
Emergency benefits:		
• In-area or Out-of-area	\$100 per hospital emergency room visit	37
Mental health and substance abuse treatment:	Regular cost sharing	38
Prescription drugs:		
• Retail pharmacy	\$15 for Level 1; \$30 for Level 2; \$60 for Level 3; and 20% for Level 4 to a maximum of \$200 per prescription and a separate Out-of-Pocket maximum of \$5,000 per calendar year	40
• Mail order	\$30 for Level 1; \$60 for Level 2; \$120 for Level 3; and 20% for Level 4 up to a maximum of \$200 and a separate Out-of-Pocket maximum of \$5,000 per calendar year	40
Dental care:	No benefit	43
Vision care: One eye refraction every 24 months	Office visit copay: \$20 primary care; \$35 specialist	25
Special features: Flexible benefit option, TDD assistance		44
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$3,000/Self Only or \$6,000/Self and Family enrollment per calendar year Some costs do not count toward this protection	14

Summary of benefits for the HDHP of UniCare - 2009

Do not rely on this chart alone. All benefits 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.

In 2009 for each month you are eligible for the HSA, we will deposit \$60 per month for Self Only enrollment or \$120 per month for Self and Family enrollment to your HSA. For the Health Savings Account (HSA), you can use funds in your HSA to help pay your calendar year deductible of \$1,500 for Self Only or \$3,000 for Self and Family (In-network benefit) or \$3,000 for Self Only or \$6,000 for Self and Family (Out-of-network benefit). Once you satisfy your calendar year deductible, Traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of \$720 for Self Only and \$1,440 for Self and Family. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

HDHP Benefits	You pay After the calendar year deductible	Page
Medical preventive care	In-network: Nothing (no deductible applies) Out-of-network: 30% of the Plan allowance after the deductible	55
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance	58
Services provided by a hospital:		
• Inpatient or Outpatient	In-network: 10% of the Plan allowance Out-of-network: 30% of the Plan allowance	71-72
Emergency benefits:	10% of the Plan allowance	74
• In-area or Out-of-area		
Mental health and substance abuse treatment:	Regular cost sharing	76
Prescription drugs:		
• Retail pharmacy	In-network: \$10 for level 1; \$20 for level 2; \$40 for level 3; and 20% coinsurance for level 4 with a maximum of \$200 per prescription and a separate Out-of-Pocket maximum of \$5,000 per calendar year Out-of-Network Pharmacy: applicable copay plus 30%	78
• Mail order for maintenance medication	In-network: \$20 for level 1; \$40 for level 2; \$80 for level 3; and 20% coinsurance for level 4 with a maximum of \$200 per prescription and a separate Out-of-Pocket maximum of \$5,000 per calendar year Out-of-network pharmacy: applicable copay plus 30%	78
Special features: On-line resources and tools		82
Protection against catastrophic costs (annual out-of-pocket maximum):	In-network: Nothing after \$3,000 Self Only or \$6,000 Self and Family Out-of-network: Nothing after \$6,000 Self Only or \$12,000 Self and Family	14

2009 Rate Information for UniCare

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the Guide to Federal Benefits 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 Guide to Benefits *for Career United States Postal Service Employees*, RI 70-2, and to the rates shown below.

The rates shown below do not apply to *Postal Service Inspectors*, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

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 Guide to Federal Benefits.

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
High Option Self Only	171	\$155.66	\$75.13	\$337.26	\$162.79	\$179.45	\$51.34
High Option Self and Family	172	\$352.56	\$159.28	\$763.88	\$345.11	\$406.42	\$105.42
Standard Option Self Only	174	\$120.49	\$40.16	\$261.06	\$87.02	\$138.96	\$21.69
Standard Option Self and Family	175	\$267.21	\$89.07	\$578.96	\$192.98	\$308.18	\$48.10
HDHP Option Self Only	721	\$100.86	\$33.62	\$218.53	\$72.84	\$116.33	\$18.15
HDHP Option Self and Family	722	\$220.55	\$73.51	\$477.85	\$159.28	\$254.36	\$39.70