CDPHP Universal Benefits, Inc.®

www.cdphp.com

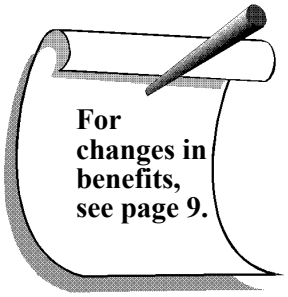
2009

A Prepaid Comprehensive Medical Plan (High and Standard Option) and a High Deductible Health Plan

Serving:

Upstate, Hudson Valley, and Central New York

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



Enrollment codes for this Plan

SG1 High Option - Self Only
SG2 High Option - Self and Family

SG4 Standard Option –Self Only
SG5 Standard Option –Self and Family

SX1 High Deductible Health Plan (HDHP) –Self Only
SX2 High Deductible Health Plan (HDHP) –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 73-549

Important Notice from CDPHP UBI About

Our Prescription Drug Coverage and Medicare

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

Medicare's Low Income Benefits

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

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

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

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Introduction

This brochure describes the benefits of CDPHP Universal Benefits, Inc. (CDPHP UBI) under Capital District Physicians' Health Plan's contracts (CS 2901 and CS2901-B) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for CDPHP UBI administrative offices is:

CDPHP UBI
500 Patroon Creek Blvd.
Albany, NY 12206

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 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 CDPHP UBI.
- 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 (518) 641-3228 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

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

Preventing medical mistakes

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

1.Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.

3.Get the results of any test or procedure.

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

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

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

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

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

Visit these Web sites for more information about patient safety.

- http://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.
- http://www.talkaboutrx.org. 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 CDPHP UBI

We offer two types of coverage. You may enroll in one of our prepaid comprehensive medical plans, either High Option or Standard Option, or you may enroll in our High Deductible Health Plan, with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA).

General Features of our High and Standard Options

We have Open Access benefits

The High and Standard Options offer Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

The High and Standard Options cover the same services and participating providers but differ in the out-of-pocket costs and premium rates.

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

Preventive care services

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

How we pay providers

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

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

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services under the Standard Plan. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed $4,000 for Self Only or $5,000 Self and Family enrollment for certain services.

General features of our High Deductible Health Plan (HDHP)

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans. FEHB Program HDHP's also offer health savings accounts or health reimbursement arrangements. Please see below for more information about these savings features.

Preventive care services

Certain preventive care services are covered at no charge to you and are not subject to deductible.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than 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 pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. 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 (HRA). 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.

Health education resources and account management tools

We have a Web site that contains links to a variety of general health news, tools that enable you to research treatments and options, and the ability to register for e-newsletters. Please refer to page 86.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services under the High Deductible Plan. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed $5,100 for Self Only enrollment, or $10,200 for Self and Family coverage for in-network services or $10,000 for Self Only enrollment and $20,000 Self and Family enrollment for out-of-network services in a calendar year.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. Under the HDHP, you have the flexibility of obtaining services without a referral for Plan providers. You may also obtain care from non-Plan providers for covered services; however, out-of-network benefits have higher out-of-pocket costs than in-network services, and you are responsible for all balances charged for covered services in excess of our allowable charge. You are also responsible for obtaining precertification for certain services. Please refer to Section 3, page 12.

Your Rights

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

- CDPHP Universal Benefits, Inc. (CDPHP UBI) is licensed under Article 43 in New York State.
- CDPHP UBI is an affiliate of Capital District Physicians' Health Plan, Inc. (CDPHP), a health plan that has been in existence for 24 years.
- CDPHP UBI is a not for profit health services corporation.

If you want more information about us, call (518) 641-3140 or 1-877-269-2134, or write to CDPHP UBI, 500 Patroon Creek Blvd., Albany, NY 12206. You may also visit our Web site at www.cdphp.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. This is where our providers practice. Our service area is: Albany, Broome, Chenango, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Hamilton, Herkimer, Madison, Montgomery, Oneida, Orange, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Tioga, Ulster, Warren, and Washington counties.

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

If you or a covered family member moves 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 moves, 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 only 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 High Option only

- Your share of the non-Postal premium will increase for Self Only and for Self and Family. See page 112.
- We added a $4,000 per calendar year out of pocket maximum benefit under the prescription drug benefit. See page 42.

Changes to Standard Option only

- Your share of the non-Postal premium will increase for Self Only and for Self and Family. See page 112.
- We added a $6,000 per calendar year out of pocket maximum benefit under the prescription drug benefit. See page 42.

Changes to both High and Standard Options

- We added a $400 per 30 day supply coinsurance limit on prescription drugs purchased at both retail and mail order pharmacies. See page 42.

Changes to our High Deductible Health Plan

- Your share of the non-Postal premium will increase for Self Only and for Self and Family. See page 112.

Changes to our High and Standard Options and High Deductible Health Plan

- We added a hearing aid and hearing aid repair benefit. See pages 24 and 64.

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 1-877-269-2134 or write to us at 500 Patroon Creek Blvd., Albany, NY 12206. You may also request replacement cards through our Web site at www.cdphp.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance, if you use our point-of-service program, you can also get care from non-Plan providers but it will cost you more. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards set by the National Committee for Quality Assurance (NCQA).

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

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the CDPHP UBI provider directory, which we update periodically. The list is also available at Find-A-Doc on our Web site at www.cdphp.com.

What you must do to get covered care

It depends on the type of care you need. You can go to any participating provider you want, but we must approve some care in advance for the High and Standard Options. If you enroll in the HDHP, you can also get care from non-Plan providers, but it will cost you more and we must approve some care in advance.

- **Primary care**

You are encouraged to select a personal doctor within the network to coordinate your care, but you are not required to notify us of your selection. Your primary care provider can be an internist, family practitioner, general practitioner, or pediatrician (for children). Alternate primary care providers are obstetricians and gynecologists.

- **Specialty care**

  - Participating specialists are listed in our CDPHP UBI directory and in Find-A-Doc at our Web site at www.cdphp.com.
  - No referral is necessary to visit a participating specialist.
  - If you have a chronic and disabling condition and lose access to your specialist because we:

    - Terminate our contract with your specialist for other than cause; or
    - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
    - Reduce our service area and you enroll in another FEHB Plan,

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

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

- **Hospital care**

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

If you are 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 518-641-3100. 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 cases, 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**

You or your physician must notify CDPHP UBI's Resource Coordination Department at 1-800-274-2332 when your physician recommends hospitalization. We call this review process precertification. It is your responsibility to make sure this review process if followed.

This requirement does not apply to admissions for emergency care or admissions for the delivery of a baby except for scheduled cesarean sections, however, we suggest that you contact CDPHP UBI within 48 hours of an emergency admission or maternity admission or as soon as reasonably possible.

- **How to precertify an admission**

You or your physician must obtain prior approval for the following services:

- Inpatient hospital admissions (non-emergency, 72 hours prior to admission)
- Inpatient acute mental health services
- Inpatient chemical abuse and dependency treatment services
- Skilled Nursing Facility care
- Inpatient rehabilitation or facility services

You or your physician should contact CDPHP Resource Coordination Department at 1-800-274-2332 with a request for services. If necessary your physician may be contacted by a nurse reviewer to obtain clinical information to support the medical necessity of the request. Clinical information is reviewed against established criteria. Decisions are based on the appropriateness of care. The Plan's Medical Director makes determinations. Upon approval you and the provider are notified via telephone and mail.

- **Maternity care**

The requirement does not apply to admissions for the delivery of a baby except for scheduled cesarean sections, however, we suggest that you contact CDPHP UBI within 48 hours of a maternity admission or as soon as reasonably possible.

What happens when you do not follow the precertification rules when using non-network facilities

If no one contacts us, we will decide whether the service was medically necessary. If we determine that the service was medically necessary, we will reduce our normal allowance by 50 percent, not to exceed $500 for each service. If we determine that it was not medically necessary, we will not pay benefits.

Within the exception of emergency care, you must obtain prior authorization for providers and facilities that do not participate with us if you enroll in the High or Standard Option. The number to call is 1-800-274-2332.

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.

Other services requiring our prior approval

For certain services, you or your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process pre-certification. It is your responsibility to make sure this review process is followed. In addition to inpatient services, you or your physician must obtain prior approval for the following services:

- Home health care and home infusion therapy
- Prosthetic devices, orthotic devices and durable medical equipment over $500 and all rentals
- Cardiac rehabilitation beyond 36 visits
- Speech therapy after the first visit
- Organ transplants and related services

You or your physician may contact CDPHP's Resource Coordination Department at 1-800-274-2332 with a request for services. If necessary your physician may be contacted by a nurse reviewer to obtain clinical information to support the medical necessity of the request. Clinical information is reviewed against established criteria. Decisions are based on the appropriateness of care. The Plan's Medical Director makes determinations. Upon approval you and your provider are notified via telephone and mail.

If no one contacts us, we will decide whether the service was medically necessary. If we determine that the service was medically necessary, we will reduce our normal allowance by 50% not to exceed $500 for each service. If we determine that it was not medically necessary, we will not pay benefits.

Prior approval is also required for the following services:

Mental health services – You must contact the behavioral health contractor, United Behavioral Health, at 1-888-320-9584 (TDD 1-800-486-7914) for information or pre-certification before you access mental health services.

Substance abuse – You must contact the behavioral health contractor, United Behavioral Health, at 1-888-320-9584 (TDD 1-800-486-7914) for information or pre-certification before you access substance abuse services.

Certain Prescription drugs – You or your physician must obtain prior approval for coverage of certain prescription drugs. The request for services can be made by contacting CDPHP's Pharmacy Department by mail, fax (518-641-3208), or by calling 1-877-269-2134. The prior approval request must contain clinical information that is reviewed against established criteria for medical necessity. If necessary your physician may be contacted by a pharmacist to obtain clinical information to support the request. The Plan's Medical Director makes final determinations.

Prescription drugs listed on CDPHP UBI's specialty pharmacy list must be obtained from CDPHP UBI's participating specialty pharmacy vendor(s), for up to a 30-day supply, upon approval from CDPHP UBI. You may contact our Member Services Department at (518) 641-3140 or 1-877-269-2134 or consult our web site at www.cdphp.com to determine whether a prescription is listed on CDPHP UBI's specialty drug list.

Non-participating provider services – With the exception of emergency care, you must obtain prior authorization for providers and facilities that do not participate with us if you are in the High or Standard Option. The number to call is 1-800-274-2332.

If no one contacted us for prior approval, we will not pay for these services.

Section 4. Your costs for covered services

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

Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: For the High Option when you see your primary care physician you pay a copayment of $20 per office visit and when you go in the hospital, you pay $100 per day, up to a maximum of $500 per confinement.
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.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services before we start paying benefits for them. There is no deductible for the High and Standard Options. There is a deductible if you enroll in the High Deductible Health Plan.
Coinsurance	Coinsurance is the percentage of our negotiated fee that you must pay for your care. Example: In our High Option Plan, you pay 20 percent of our allowance for durable medical equipment.
Differences between our Plan allowance and the bill	Network Providers agree to accept our Plan allowance so if you use a network provider, you never have to worry about paying the difference between our Plan allowance and the billed amount for covered services. Non-Network Providers: If you use a non-network provider, you will have to pay the difference between our Plan allowance and the billed amount.
Out of Pocket Maximum	The total amount of applicable Deductible, Copayments and/or Coinsurance that you must satisfy, before which CDPHP UBI will pay one hundred percent (100%) of the Allowed Amount for Covered benefits. All amounts you pay for Deductibles, Copayments and/or Coinsurances are applicable toward the Out of Pocket Maximum. The Member is also responsible for all differences, if any, between the Allowed Amount and the non-participating provider's charge regardless of whether the Out of Pocket Maximum has been met.
Your catastrophic protection out-of-pocket maximum	High Option (SG1 and SG2)—The High Option does not have a catastrophic protection out-of-pocket maximum. Standard Option (SG4 and SG5)—If the total amount of out-of-pocket expenses for covered inpatient facility charges (inpatient acute or rehabilitation hospital or skilled nursing facility) and inpatient professional services (physician hospital visits, surgery, anesthesia, lab, and X-ray, etc.) exceed $4,000 per person or $5,000 per family enrollment under the standard option in any calendar year, you do not have to pay any more for these inpatient-related services. However, out-of-pocket expenses for other than inpatient-related facility and professional services do not count toward your catastrophic protection limit, and you must continue to pay out-of-pocket for these services. Note: Penalty charges for not following the precertification process and any expenses in excess of the Plan allowance or benefit maximums do not count toward your catastrophic protection out-of-pocket maximum. High Deductible Health Plan (SX1 and SX2)—If you enroll in the High Deductible Health Plan, the out-of-pocket maximum is $5,100 under Self Only and $10,200 for Self and Family enrollment for in-network benefits. For out-of-network benefits, the out-of-pocket maximum is $10,000 for Self Only and $20,000 for Self and Family enrollment. After you have met the out-of-pocket maximum under the HDHP benefits, you will not pay coinsurance for covered HDHP services. The following services do not count toward the out-of-pocket maximum:

- Non covered services
- Amounts that exceed our allowable charge for a covered service
- Precertification penalties

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 from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

High and Standard Option Benefits

See page 9 for how our benefits changed this year. Pages 106, 108, and 110 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 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 more information about High and Standard Options benefits, contact us at 1-877-269-2134 or at our Web site at www.cdphp.com.

Each option offers unique features.

High Option

- Wide choice of participating providers in the CDPHP UBI network.
- No referrals for in-network specialty care.
- Primary care physician recommended but not required.
- Many preventive services at no charge.

Standard Option

- Same benefits and providers as High Option, but higher out-of-pocket costs.
- Moderate premium costs.

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care. You pay all charges for non-participating providers.
- A facility copay applies to services that appear in this section but are performed in the 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	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians • In physician's office	$20 per office visit $30 per visit for specialist	$25 per visit for primary care $40 per visit for specialist
Professional services of physicians • In an urgent care center	$40 per visit	$50 per visit
• During a hospital stay • In a skilled nursing facility	Nothing	10% of the Plan allowance
• Office medical consultations • Second surgical opinion/inpatient consultation	$20 per office visit $30 per visit for specialist	$25 per visit for primary care $40 per visit for specialist 10% of the Plan allowance for inpatient services
At home	$20 per visit	$25 per visit for primary care
Not covered: • *Surgery primarily for cosmetic purposes* • *Homemaker services*	*All charges*	*All charges*
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound	Nothing if you receive these services at a preferred facility; otherwise, $30 per office visit	Nothing if you receive these services at a preferred facility; otherwise, $40 per office visit 10% of the Plan allowance for inpatient services
Electrocardiogram and EEG	$30 per provider per visit	$40 per provider visit

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay	
Lab, X-ray and other diagnostic tests (cont.)	**High Option**	**Standard Option**
		10% of the Plan allowance for inpatient services
Non-routine Pap tests	$30 per office visit	$40 per office visit
Preventive care, adult	**High Option**	**Standard Option**
One routine annual physical exam (non-gynecological) per calendar year	Nothing	Nothing
Routine screenings, such as but not limited to: • Total Blood Cholesterol—Once every five years • Colorectal Cancer Screening, including • Fecal occult blood test – every five years starting at age 50 • Sigmoidoscopy, screening – every five years starting at age 50 • Double contrast barium enema—every five years starting at age 50 • Colonoscopy—once every 10 years starting at age 50.	$30 per office visit	$40 per office visit
Standard diagnostic testing for prostate cancer including but not limited to digital rectal examinations and prostate specific antigen tests.	Nothing	Nothing
One routine gynecological exam per calendar year	Nothing	Nothing
Routine Pap test	Nothing	Nothing
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 49, one every one to two calendar years • From age 50 to 70, annually • Over age 71, as indicated	Nothing	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): • Tetanus-diphtheria (Td) booster - once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older	Nothing for immunization; office visit copay applies	Nothing for immunization; office visit copay applies
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*	*All charges*

Benefit Description	You pay	
Preventive care, children	**High Option**	**Standard Option**
• Well-child care charges for routine examinations, immunizations and care (up to age 22). Visits covered at 2 weeks, 1 month, 2 months, 4 months, 6 months, 12 months, 15 months, and 18 months, then annually to age 22. • Childhood immunizations recommended by the American Academy of Pediatrics	Nothing	Nothing
Examinations (other than well-child care), such as: • Eye exams to determine the need for vision correction. Limited to one every 24 months. • Ear exams to determine the need for hearing correction	$30 per office visit	$40 per office visit
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 11 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). See Special Features (Section 5g) for childbirth education reimbursement program.	$30 per office visit for the initial diagnosis. You pay nothing thereafter.	$40 per office visit for the initial diagnosis. You pay nothing thereafter. 10% of the Plan allowance for inpatient services.
Not covered:Elective sonograms to determine fetal sex.	*All charges*	*All charges*

Benefit Description	You pay	
Family planning	**High Option**	**Standard Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Genetic counseling when approved • Visits to insert or implant covered contraceptive devices	$20 per office visit $30 per visit for specialist	$25 per visit for primary care $40 per visit for specialist 10% of the Plan allowance for inpatient services
Note: We cover oral contraceptives under the prescription drug benefit. Please refer to Section 5(f).		
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) • Fertility drugs Note: We cover fertility drugs under the prescription drug benefit for up to six cycles per pregnancy. See Section 5(f). Members must be at least 21 years of age but no more than 44 years old to be covered for infertility services..	$30 per office visit Nothing for inpatient services	$40 per visit for specialist 10% of the Plan allowance for inpatient services
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* - *Cost of donor sperm* - *Leuprolide Acetate when used for cessation of ovulation* - *Items such as ovulation predictor kits and home pregnancy kits* - *IVIG when utilized for infertility or pregnancy loss* - *Cost of donor egg*	*All charges*	*All charges*

Benefit Description	You pay	
Allergy care	**High Option**	**Standard Option**
• Testing and treatment	$20 per office visit $30 per visit for specialist	$25 per visit for primary care $40 per visit for specialist 10% of the Plan allowance for inpatient services
• Allergy injections • Allergy serum	Nothing	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 30. • Respiratory and inhalation therapy	$20 per office visit for chemotherapy $30 per office visit for all other therapies	$25 per office visit for chemotherapy $40 per office visit all other therapies 10% of the Plan allowance for inpatient services
Dialysis – hemodialysis and peritoneal dialysis	$20 per office visit if received as an outpatient. Covered in full if part of home care.	$25 per office visit if received as an outpatient. Covered in full if part of home care.
Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	$30 per office visit if received as an outpatient. Covered in full if part of home care.	$40 per office visit if received as an outpatient. Covered in full if part of home care.
Home dialysis – equipment and supplies	$30 per month	$40 per month
• Growth hormone therapy (GHT) Note: Please refer to Section 5(f) for coverage for prescription drugs. Prescription drugs for GHT are only covered when prior approved. See *Services requiring prior approval* in Section 3.	$30 per office visit	$40 per office visit
Physical and occupational therapies	**High Option**	**Standard Option**
Physical and occupational therapy are limited to one course each for two consecutive months for each specific diagnosis and related conditions per calendar year: • qualified physical therapists and • occupational therapists 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. • Medically necessary cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction.	$30 per office visit $30 per outpatient visit Nothing per visit during covered inpatient admission	$40 per office visit $40 per outpatient visit 10% of the Plan allowance for inpatient services

Physical and occupational therapies - continued on next page

Benefit Description	You pay	
Physical and occupational therapies (cont.)	**High Option**	**Standard Option**
Note: These services require prior approval. See Section 3.		
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Continuous ECG monitoring and Thallium stress tests* • *Services for chronic or maintenance phase of cardiac rehabilitation*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
Speech therapy is limited to one course for two consecutive months for each specific diagnosis and related conditions per calendar year. Note: Please refer to Section 3 for services requiring prior approval.	$30 per office visit $30 per outpatient visit Nothing per visit during covered inpatient admission	$40 per office visit $40 per outpatient visit 10% of the Plan allowance for inpatient services
Not covered: • *Care beyond treatment period.*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Hearing examinations and testing • Hearing aids and hearing aid repair	$30 per office visit Up to a $600 limit for routine hearing aids or repair to an existing one every three years	$40 per office visit Up to a $600 limit for routine hearing aids or repair to an existing one every three years
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Eyeglasses or contact lenses necessitated by certain medical conditions such as aphakia, keratoconus, or endocrine exophthalmos or following intraocular surgery. Replacement reviewed based on medical necessity.	20% of the Plan allowance	50% of the Plan allowance
• Routine eye exam and eye refractions once every 24 months • Eye exercises and orthoptics when approved	$30 per office visit	$40 per office visit
Not covered: • *Eyeglassesor contact lenses* • *Radial keratotomy and other refractive surgery*	*All charges*	*All charges*

Benefit Description	You pay	
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.	$20 for primary care office visit $30 per visit for specialist	$25 for primary care office visit $40 per visit for specialist
Not covered: • *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)*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• Artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy	20% of the Plan allowance. Must be preauthorized if cost is over $500	50% of the Plan allowance. Must be preauthorized if cost is over $500
Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device.	Nothing	Nothing
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Approved lumbosacral supports	20% of the Plan allowance. Must be preauthorized if cost is over $500	50% of the Plan allowance. Must be preauthorized if cost is over $500
Hair prosthesis. CDPHP provides benefits for the purchase of one medically necessary cranial prosthesis, wig, or toupee per lifetime per member for replacement of hair loss as a result of injury, disease, or treatment of a disease. Coverage is limited to a maximum amount of $400 per prosthesis, wig or toupee. This limitation is applied to the balance remaining after the member's payment of the coinsurance.	20% of the Plan allowance	50% of the Plan allowance
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
• *Prosthetic replacements provided less than 3 years after the last one we covered unless medically indicated* • *Stump hose*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers	20% of the Plan allowance. Must be preauthorized if cost is over $500 or item is rented	50% of the Plan allowance. Must be preauthorized if cost is over $500 or item is rented
• Blood glucose monitors; and • Insulin pumps.	$20 per item	$25 per item
Your Plan physician will call us for authorization of this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment. Note: See "Services requiring our prior approval" in Section 3.		
Not covered: Motorized wheelchairs.	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
• Home health care ordered by a Plan physician, approved by the Plan's medical director, and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. Some services include: home infusion therapy, medical supplies, drugs and medications. Please refer to Section 3, "Services requiring our prior approval."	Nothing	Nothing
• Oxygen therapy	20% of the Plan allowance	50% of the Plan allowance
Not covered: • *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.* • *Rest cures*	*All charges*	*All charges*

Benefit Description	You pay	
Chiropractic	**High Option**	**Standard Option**
• Medically necessary care for spinal manipulation	$30 per office visit	$40 per office visit
Alternative treatments	**High Option**	**Standard Option**
No benefit	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
CDPHP offers a variety of innovative wellness classes and disease management programs. Please refer to Section 5, Non-FEHB Benefits Available to Members, page 87.	Nothing	Nothing

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

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

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

YOU MUST GET PRECERTIFICATION 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 After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery)* • Surgical treatment (bariatric surgery) of morbid obesity, a condition in which you weigh 100 pounds or 100% over your normal weight according to current underwriting standards; there is documented failure of a non-surgical attempt; and your body mass index is 40 or higher (or 35 or higher and you have severe co-morbidities). Note: This procedure requires preauthorization. Please call the Plan at 1-877-269-2134 for further information. • Insertion of internal prosthetic devices. See 5(a), *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., Tubal ligation, Vasectomy)	$20 per primary care office visit $30 per visit for specialist care Nothing at outpatient or inpatient facility	$25 per primary care office visit $40 per visit for specialist care Nothing at outpatient facility 10% of the Plan allowance for inpatient services

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• Surgically implanted contraceptive and intrauterine devices (IUDs). Note: Devices are covered under 5 (f) Prescription drug coverage. • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done.	$20 per primary care office visit $30 per visit for specialist care Nothing at outpatient or inpatient facility	$25 per primary care office visit $40 per visit for specialist care Nothing at outpatient facility 10% of the Plan allowance for inpatient services
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by illness or injury if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see *Prosthetic devices*) 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.	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services
Not covered: • *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* • *Surgeries related to sex transformation*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • 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.	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Dental work related to TMJ*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to *Other services* in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description • Cornea • Heart • Heart/lung • Lung: single or double • Kidney • Liver • Pancreas • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services
Blood or marrow stem cell transplants limited to the stages of the following diagnoses: Allogeneic transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Severe combined immunodeficiency • Severe or very severe aplastic anemia Autologous transplant for • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Advanced neuroblastoma Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) Allogeneic blood or marrow stem cell transplants for • Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Advanced forms of myelodysplastic syndromes • Advanced neuroblastoma • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies • Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) • Myeloproliferative disorders • Sickle cell anemia • Thalassemia major (homozygous beta-thalassemia) • X-linked lymphoproliferative syndrome	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services
Autologous blood or marrow stem cell transplants for • Multiple myeloma • Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors • Breast cancer • Epithelial ovarian cancer	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Amyloidosis • Ewing's sarcoma • Medulloblastoma Allogeneic transplants for • Chronic lymphocytic leukemia • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma Nonmyeloablative allogeneic transplants for • 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 • Non-small cell lung cancer	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services
Autologous transplants for • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Early state (indolent or non-advanced) small cell lymphocytic lymphoma National Transplant Program (NTP) – CDPHP UBI facilitates organ transplants at a CDPHP UBI approved transplant center. Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence. **Note: We cover related medical and hospital expenses of the donor when we cover the recipient.** **Note: Please see Section 3 for "Services requiring our prior approval."**	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services
Not covered:	*All charges*	*All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient)	Nothing	10% of the Plan allowance for inpatient services
• Hospital outpatient department	Nothing	Nothing
• Skilled nursing facility	Nothing	10% of the Plan allowance for inpatient services
• Ambulatory surgical center Professional services provided in – • Office	Nothing	Nothing

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

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

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

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

Benefit Description	You pay	
Note: The calendar year deductible applies only when we say below: "(calendar year deductible applies)".		
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$100 copay per day up to a maximum of $500 per admission. For individual coverage, inpatient copays are limited to two per calendar year. For family coverage, inpatient copays are limited to three per calendar year. The copayment does not apply to hospital inpatient charges for newborn nursery care.	$500 per admission plus 10% of the Plan allowance. For individual coverage, inpatient copays are limited to two per calendar year. For family coverage, inpatient copays are limited to three per calendar year. The copayment does not apply to hospital inpatient charges for newborn nursery care.
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing	10% of the Plan allowance
Not covered: • *Custodial care*	*All charges*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care except when medically necessary in the hospital when ordered and approved by a CDPHP UBI participating physician*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service 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.	$75 per visit	$100 per visit
Services not associated with a medical procedure being done on the same day: Outpatient hospital diagnostic x-ray and laboratory tests.	Nothing if you receive these services at a preferred facility; otherwise, $30 per visit	Nothing if you receive these services at a preferred facility; otherwise, $40 per visit
Not covered: Blood and blood derivatives not replaced by the member. Storage of blood and blood derivatives, except in the case of autologous blood donations required for a scheduled surgical procedure.	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
Skilled nursing facility (SNF): up to 90 days in lieu of hospitalization.	Nothing	10% of the Plan allowance
Not covered: Custodial care	*All charges*	*All charges*

Benefit Description	You pay	
Hospice care	**High Option**	**Standard Option**
Up to 210 days combined inpatient and outpatient	Nothing	Nothing
Not covered: Independent nursing, homemaker services	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Local professional ambulance service when medically appropriate. Air ambulance if medically appropriate and approved.	$50 per trip	$100 per trip
Not covered: Transportation for convenience.	*All charges*	*All charges*

Section 5(d). Emergency services/accidents

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

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

Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

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

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

Emergencies outside our service area: If you have an emergency outside of CDPHP UBI's service area, simply go to the nearest hospital emergency room. If you are required to pay for services at the time of treatment, please request an itemized bill. Send the bill along with your name and member ID number to CDPHP's Member Services Department, 500 Patroon Creek Blvd., Albany, NY 12206.

If you are not admitted to the hospital for further services or care, you will be responsible for a $50 copayment under the High Option or $100 under the Standard Option. If you are admitted immediately, the emergency room copayment is waived and the hospital services will cost you $100 copay per day up to a maximum of $500 per admission under the High Option and $500 copayment plus 10% of the Plan allowance under the Standard Option.

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

Benefit Description	You pay	
Emergency within our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office	$20 per primary care visit $30 per visit for specialist	$25 per visit primary care $40 per visit for specialist
• Emergency care at an urgent care center	$40 per visit	$50 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: If the emergency results in admission to a hospital, the emergency room copay is waived. Please refer to Section 5c for inpatient hospital coverage.	$50 per visit	$100 per visit
Not covered: Elective care or non-emergency care	*All charges*	*All charges*

Benefit Description	You pay	
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office	$20 per visit primary care $30 per visit for specialist	$25 per visit primary care $40 per visit for specialist
• Emergency care at an urgent care center	$40 per visit	$50 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: If the emergency results in admission to a hospital, the emergency room copay is waived. Please refer to Section 5c for inpatient hospital coverage.	$50 per visit	$100 per visit
Ambulance	**High Option**	**Standard Option**
• Local professional ambulance service when medically appropriate • Air ambulance if medically appropriate and approved. Note: See 5(c) for non-emergency service.	$50 per trip	$100 per trip
Not covered: Transportation for convenience.	*All charges*	*All charges*

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.
- 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. Participating providers must provide all care.

Benefit Description	You pay	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Mental health and substance abuse benefits	**High Option**	**Standard Option**
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. 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.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$30 per visit	$40 per visit
• Diagnostic tests	$30 per visit or test	$40 per visit or test
• Services provided by a hospital or other facility	$30 per outpatient visit	$40 per outpatient visit
—Mental health	$20 per outpatient visit	$25 per outpatient visit
—Chemical abuse • Services in approved alternative care settings such as partial hospitalization, halfway house and residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$100 copay per day up to a maximum of $500 per admission. For individual coverage inpatient copays are limited to two per calendar year. For family coverage, inpatient copays are limited to three per calendar year.	$500 per admission plus 10% of the Plan allowance. For individual coverage, inpatient copays are limited to two per calendar year. For family coverage, inpatient copays are limited to three per calendar year.
Not covered: Services we have not approved. *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.*	*All charges*	*All charges*

Preauthorization	To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes: Mental Health Care--You have direct access to in-network mental health care. A direct access toll-free telephone number at United Behavioral Health, 1-888-320-9584 (TDD 1-800-486-7914), will connect you to a qualified mental health clinician who will assist and arrange for treatment. For your convenience, the telephone number for mental health services is imprinted on your CDPHP UBI ID card. Alcohol/Substance Abuse Benefits--You have access to alcohol and substance abuse care. These benefits are coordinated by United Behavioral Health (UBH). CDPHP UBI members can contact UBH directly at 1-888-320-9584 (TDD 1-800-486-7914).
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f). Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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.

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

- **Who can write your prescription.** A Plan physician or Plan dentist must write the prescription. You or your physician must obtain prior approval for coverage of certain prescription drugs. Please refer to Section 3, Services requiring our approval.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication. Prescription drugs listed on CDPHP's specialty pharmacy list must be obtained at CDPHP UBI's participating specialty pharmacy vendor(s) for up to a 30-day supply, upon approval from CDPHP UBI. Please refer to Section 3, Services requiring our approval. Approved maintenance prescriptions can be refilled through the mail for a 90-day supply.
- **We use a formulary.** A formulary is a list of prescription drugs covered by CDPHP UBI based on their efficacy and cost in providing effective patient care. Coverage is subject to the CDPHP UBI prescription drug formulary that is in effect on the date the prescription is filled. Coverage is available for non-formulary drugs.
- **These are the dispensing limitations.** Prescriptions filled at a participating pharmacy are limited to a 30-day supply. Maintenance prescriptions are filled up to a 90-day supply by mail order. Only certain maintenance prescriptions are available via mail order to insure quality, proper dosage, and medical appropriateness. Prescription refills received prior to the next scheduled refill date will not be filled.
- **Why use generic drugs?** Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your plan less money than brand name drugs.
- **When you do have to file a claim.** You do not have to submit claims.

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

Covered medications and supplies continued on next page

Benefit Description	You pay	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Self-administered injectable drugs • Drugs for sexual dysfunction within applicable limits. Please call the Plan for information. • Prescription contraceptive drugs and devices • Smoking cessation prescriptions up to a 12-week supply • Nutritional supplements for the therapeutic treatment of phenylketonuria (PKU). • Infertility prescriptions available for members between 21 and 44 years of age, up to six cycles per pregnancy attempt. • Prescription drugs for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low protein or which contain modified protein which are medically necessary for up to 12 months. Benefit limit of $2,500.	25% of the Plan allowance with a $400 per prescription maximum, up to a 30-day supply, and $4000 annual out-of-pocket maximum. The out-of-pocket maximum is the total amount of applicable Deductible, Copayments and/or Coinsurance to be satisfied, after which CDPHP UBI will pay one hundred percent (100%) of the Allowed Amount for Covered benefits. All amounts paid by the Member for Deductibles, Copayments and/or Coinsurances are applicable toward the Out of Pocket Maximum.	30% of the Plan allowance with a $400 per prescription maximum, up to a 30-day supply, and $6000 annual out-of-pocket maximum. The out-of-pocket maximum is the total amount of applicable Deductible, Copayments and/or Coinsurance to be satisfied, after which CDPHP UBI will pay one hundred percent (100%) of the Allowed Amount for Covered benefits. All amounts paid by the Member for Deductibles, Copayments and/or Coinsurances are applicable toward the Out of Pocket Maximum.
Insulin, oral agents to control blood sugar, needles, test strips, lancets, and visual reading and urine test strips	$20 per item	$25 per item
Durable medical equipment for insulin dependent persons	$20 per item	$25 per item
Non-insulin disposable needles and syringes for the administration of covered medication	20% of the Plan allowance	50% of the Plan allowance
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients, and food supplements that can be purchased without a prescription* • *Nonprescription medicines except for any over-the-counter products listed on our formulary* • *Weight loss prescriptions* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies*	*All charges*	*All charges*

Section 5(g). Dental benefits

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.

Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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.	$30 per visit	$40 per visit
Dental benefits We have no other dental benefits.	*All charges*	*All charges*

Section 5(h). Special features

Feature	Description
On-line tools	Easy-to-use Internet-based tools to help you manage your own health and make smarter decisions that may reduce health care costs. **Heath Coach Connections Dialog** • **Health Risk Assessment** – Health Risk Assessment tool called "How's your Health" is available online. This tool is specifically designed for members to promote improved decision–making. The objectives of the survey are to provide personalized information to individuals that reinforces self-reliance and self-care. • **Online Resources** – Online Resources include: • Evidence-based information about conditions and treatment options • Health Crossroads provides simple navigation through difficult decisions • Health Risk Assessment • Health tools • A single place for trusted health care information **Heathcare Advisor™ –** You will have the ability to: • Research medical conditions and illnesses • Understand treatments • Locate questions to ask your doctors • Compare hospitals, using a variety of criteria, providing necessary or desired treatments or services **My Online Wellness℠–** • Self-Care Centers- Focus on information specific to certain disease entities such as arthritis, asthma, hypertension, diabetes and others. • Rx Corner- Integrates your prescription drug benefits with drug news and tools. These programs are available to members through www.cdphp.com.
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Non-emergency care for full-time students out of the area	If you are away at school and need medical care (non-preventive) for an illness or injury, coverage is available. When a medical situation develops, call 1-800-274-2332 prior to seeking care and request that CDPHP UBI authorize coverage of necessary treatment by a practitioner in the area.

Feature	Description
Services for deaf and hearing impaired	The telephone system also includes a TDD system. Members may call 1-877-261-1164 for services.
Childbirth Education Reimbursement Program	CDPHP UBI will reimburse expectant mothers 50 percent of the cost, up to $30 per year, for participating in and completing childbirth education classes. Once you complete the class, send the receipt and certificate of completion to CDPHP UBI, 500 Patroon Creek Blvd, Albany, NY 12206, for reimbursement.
Centers of excellence	CDPHP facilitates care at approved transplant centers for medically necessary, non-experimental treatment.

High Deductible Health Plan Benefits

See page 9 for how our benefits changed this year and page 110 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 about these benefits 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 1-877-269-2134 or at our Web site at www.cdphp.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.

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 HRA based upon your eligibility.

With this Plan, certain preventive care visits are covered in full. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits 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 continue 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, disease management and wellness programs. These services are covered at 100% if you use a network provider and the services are fully 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 page 7 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 $62.50 per month for a Self Only enrollment or $125 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 $3,000 for an individual and $5, 950 for a family. See maximum contribution information on page 52. 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 HSA Bank, a division of Webster Bank, N.A.
- 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 health care flexible spending account (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 $750 per year for a Self Only enrollment and $1,500 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 CDPHP's wholly owned subsidiary, APA Partners.

- 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. See *Who is eligible to enroll?* in Section 12 under The Federal Flexible Spending Account Program – *FSAFEDS.*

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

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to $5,100 per person or $10,200 per family enrollment. For out-of-network services, your out-of-pocket maximum is $10,000 per person or $20,000 per family enrollment. 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 HSA Bank, this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS). The address for HSA Bank is: HSA Bank, P.O. Box 939, Sheboygan, WI 53082. The telephone number is 1-877-851-5273.	APA Partners is the HRA fiduciary for this Plan. The address for APA partners is: APA Partners, Inc., PO Box 1506., Latham, NY 12110-8006. The telephone number is 1-800-833-3650.
Fees	Set-up fee is paid by the HDHP. $2.25 per month administrative fee charged by the fiduciary and taken out of the account balance. $7.95 for 50 HSA checks (including 10 deposit tickets). $4.00 for processing manual withdrawal request. Additional fees apply to excess distribution/overdrafts, wire transfers, stop payment requests, corrected IRS filing, and additional paper copies of forms available online. For more information please call HSA Bank. The telephone number is 1-877-851-7041.	None.
Eligibility	You must: • 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 $62.50 will be made by the HDHP directly into your HSA each month.	For 2009, your HRA annual credit is $750 (prorated for mid-year enrollment).
• **Self and Family enrollment**	For 2009, a monthly premium pass through of $125 will be made by the HDHP directly into your HSA each month.	For 2009, your HRA annual credit is $1,500 (prorated for mid-year enrollment).
Contributions and credits	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 an individual and $5,950 for a family. 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. 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.	The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.

	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. 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). HSAs earn tax-free interest (does not affect your annual maximum contribution). Catch-up contribution discussed on page 55.	
• **Self only enrollment**	You may make an annual maximum contribution of $750.	You cannot contribute to the HRA.
• **Self and Family enrollment**	You may make an annual maximum contribution of $1,500.	You cannot contribute to the HRA.
Access funds	You can access your HSA by the following methods: Debit card Withdrawal form Checks	For qualified medical expenses under your HDHP, you will be need to submit a reimbursement form. A form may be obtained at www.apapartners.com or by calling 1-800-833-3650.
Distributions/withdrawals **Medical**	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. See IRS Publication 502 for a list of eligible medical expenses, including over-the-counter drugs.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See *Availability of funds* below for information on when funds are available in the HRA. 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.
Non-medical		Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.

	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. 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.	
Availability of funds	Funds are not available for withdrawal until all the following steps are completed: • 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. • The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you.	The entire amount of your HRA will be available to you upon your enrollment in the HDHP.
Account owner	FEHB enrollee	HDHP
Portable	You can take this account with you when you change plans, separate or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 54 for HSA eligibility.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. 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.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

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 newly enroll in an HDHP during Open Season and your effective data 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.

- **Minimum reimbursements from your HSA** — You can request reimbursement in any amount up to the account balance. You must retain an account balance to cover the $2.25 per month administrative fee or the account will be in jeopardy of being closed and you will be subject to additional fees.

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 51 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. 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.
- Certain in-network preventive care is covered at 100% (see page 58) and is not subject to the calendar year deductible. Additional preventive care is covered under Traditional medical coverage subject to the deductible.
- The deductible is $1,500 for Self Only enrollment for $3,000 for Self and Family enrollment for in-network services and $5,000 for Self Only enrollment or $10,000 for Self and Family enrollment for out-of-network services. 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, copayments and deductibles total $5,100 per person or $10,200 per family enrollment in any calendar year for in-network services or $10,000 per person or $20,000 per family enrollment for out-of-network services, 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 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 benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance or pre-certification penalties).
- 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	**In Network**	**Out of Network**
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.	100% of allowable charges until you meet the deductible of $1,500 per person or $3,000 per family enrollment for in-network services.	100% of allowable charges until you meet the deductible of $5,000 per person or $10,000 per family enrollment for out-of-network services. The family deductible can be satisfied by one or more family members.
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.	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.	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.

Section 5. Preventive care

Important things you should keep in mind about these benefits:

- Preventive care services listed in this Section are not subject to the deductible. You only owe your copay for covered preventive care services.
- You must use providers that are part of our network.

For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the deductible.*

Benefit Description	You pay	
Preventive care, adult	**In Network**	**Out of Network**
Routine screenings, such as, but not limited to: • Routine Prostate Specific Antigen (PSA) test — one annually for men age 50 and older • Routine annual digital rectal exam (DRE) for men age 40 and older	Nothing at a network provider	All charges until you satisfy your deductible, then 30% of our plan allowance and any difference between our allowance and the billed amount
• Routine physicals which include: One routine annual exam (non-gynecological) per calendar year including laboratory services directly related to the performance of the physical exam.	Nothing at a network provider	All charges until you satisfy your deductible, then 30% of our plan allowance and any difference between our allowance and the billed amount
• One routine gynecological exam per calendar year • Routine Pap tests • Routine mammogram — covered for women age 35 and older, as follows: —From age 35 through 39, one during this five year period —From age 40 through 49, one every one to two years —From age 50 through 70, annually —Age 71 and older, as indicated	Nothing at a network provider	All charges until you satisfy your deductible, then 30% of our plan allowance and any difference between our allowance and the billed amount
Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older	Nothing at a network provider	All charges until you satisfy your deductible, then 30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*	*All charges*

Benefit Description	You pay	
Preventive care, children	**In Network**	**Out of Network**
• Well-child care charges for routine examinations, immunizations and care (up to age 22). Visits covered at 2 weeks, 1 month, 2 months, 4 months, 6 months, 12 months, 15 months, and 18 months, then annually to age 22. • Childhood immunizations recommended by the American Academy of Pediatrics	Nothing at a network provider	All charges until you satisfy your deductible, then 30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.* • *Immunizations, boosters, and medications for travel.*	*All charges*	*All charges*

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 deductible is $1,500 for Self Only enrollment for $3,000 for Self and Family enrollment for in-network services and $5,000 for Self Only enrollment or $10,000 for Self and Family enrollment for out-of-network services. The 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 or copayments 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	**In Network**	**Out of Network**
Professional services of physicians • In physician's office • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: • *Surgery primarily for cosmetic purposes* • *Homemaker services*	*All charges*	*All charges*
Lab, X-ray and other diagnostic tests	**In Network**	**Out of Network**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound	10% of our plan allowance (Coinsurance waived at designated sites)	30% of our plan allowance and any difference between our allowance and the billed amount
• Electrocardiogram and EEG	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount

Benefit Description	You pay After the calendar year deductible…	
Preventive care, adult	**In Network**	**Out of Network**
Routine screenings, such as but not limited to: • Total Blood Cholesterol—Once every five years • Colorectal Cancer Screening, including — Fecal occult blood test – every five years starting at age 50 — Sigmoidoscopy, screening – every five years starting at age 50 — Double contrast barium enema—every five years starting at age 50 — Colonoscopy—once every 10 years starting at age 50.	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Preventive care, children	**In Network**	**Out of Network**
• Examinations (other than well-child care), such as: — Eye exams to determine the need for vision correction. Limited to one every 24 months. — Ear exams to determine the need for hearing correction	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Maternity care	**In Network**	**Out of Network**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 12 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See *Hospital benefits* (Section 5c) and *Surgerybenefits* (Section 5b).	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Maternity care (cont.)	**In Network**	**Out of Network**
Not covered: *Elective sonogram to determine fetal sex*	*All charges*	*All charges*
Family planning	**In Network**	**Out of Network**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Genetic counseling when approved • Visits to insert or implant covered contraceptive devices Note: We cover FDA approved contraceptives under the prescription drug benefit. Please refer to Section 5 (f).	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*	*All charges*
Infertility services	**In Network**	**Out of Network**
Diagnosis and treatment of infertility such as: • Artificial insemination: - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) • Fertility drugs Note: We cover fertility drugs under the prescription drug benefit for up to six cycles per pregnancy. See Section 5(f). Members must be at least 21 years of age but no more than 44 years old to be covered for infertility services.	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* • *in vitro fertilization* • *embryo transfer and gamete intra-fallopian transfer (GIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Leuprolide Acetate when used for cessation of ovulation*	*All charges*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Infertility services (cont.)	**In Network**	**Out of Network**
• *Items such as ovulation predictor kits and home pregnancy kits*	*All charges*	*All charges*
Allergy care	**In Network**	**Out of Network**
• Testing and treatment, including materials (such as allergy serum) • Allergy injections	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: • *Provocative food testing and sublingual allergy desensitization.*	*All charges*	*All charges*
Treatment therapies	**In Network**	**Out of Network**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 69. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Please refer to Section 5(f) for coverage for prescription drugs. Prescription drugs for GHT are only covered when prior approved. See *Services requiring our prior approval* in Section 3.	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Physical and occupational therapies	**In Network**	**Out of Network**
Physical and occupational therapy are limited to one course each for two consecutive months for each specific diagnosis and related conditions per calendar year. • *qualified physical therapists and* • *occupational therapists* 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. • Medically necessary cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction. Note: These services require prior approval. See Section 3.	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount

Physical and occupational therapies - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Physical and occupational therapies (cont.)	**In Network**	**Out of Network**
Not covered: • *Continuous ECG monitoring and Thallium stress tests* • *Long-term rehabilitative therapy* • *Services for chronic or maintenance phase of cardiac rehabilitation* • *Exercise programs*	*All charges*	*All charges*
Speech therapy	**In Network**	**Out of Network**
Speech therapy is limited to one course for two consecutive months for each specific diagnosis and related conditions per calendar year. Note: Please refer to Section 3 for services requiring prior approval.	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: Care beyond treatment period.	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**In Network**	**Out of Network**
• Hearing examinations and testing	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
• Hearing aids and hearing aid repair	Up to a $600 limit for routine hearing aids or repair to an existing one every three years.	Up to a $600 limit for routine hearing aids or repair to an existing one every three years.
Vision services (testing, treatment, and supplies)	**In Network**	**Out of Network**
• Eyeglasses or contact lenses necessitated by certain medical conditions such as aphakia, keratoconus, or endocrine exophthalmos or following intraocular surgery. Replacement reviewed based on medical necessity. • Routine eye exam and eye refractions once every 24 months • Eye exercises and orthoptics when approved	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses* • *Radial keratotomy and other refractive surgery*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Foot care	**In Network**	**Out of Network**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: • *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)*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**In Network**	**Out of Network**
• Artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices , such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Approved lumbosacral supports. • Hair prosthesis. CDPHP provides benefits for the purchase of one medically necessary cranial prosthesis, wig, or toupee per lifetime per member for replacement of hair loss as a result of injury, disease, or treatment of a disease. Coverage is limited to a maximum amount of $400 per prosthesis, wig, or toupee. This limitation is applied to the balance remaining after the member's payment of the coinsurance.	10% of our plan allowance. Lifetime limit of $25,000 per person	*All charges*
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports*	*All charges*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Orthopedic and prosthetic devices (cont.)	**In Network**	**Out of Network**
• *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than three years after the last one we covered* • *Stump hose*	*All charges*	*All charges*
Durable medical equipment (DME)	**In Network**	**Out of Network**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. Note: Call us at 1-800-274-2332 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.	10% of our plan allowance. Lifetime limit of $25,000 per person	*All charges*
Not covered: • *Motorized wheelchairs*	*All charges*	*All charges*
Home health services	**In Network**	**Out of Network**
• 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.	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: • *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.*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Chiropractic	**In Network**	**Out of Network**
• Medically necessary care for spinal manipulation	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Alternative treatments	**In Network**	**Out of Network**
No benefit	*All charges*	*All charges*
Educational classes and programs	**In Network**	**Out of Network**
CDPHP offers a variety of innovative wellness classes and disease management programs. Please refer to Section 5, Non-FEHB Benefits Available to Members, page 87.	No cost	*All charges*

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.
- The deductible is $1,500 for Self Only enrollment for $3,000 for Self and Family enrollment for in-network services and $5,000 for Self Only enrollment or $10,000 for Self and Family enrollment for out-of-network services. The family deductible can be satisfied by one or more family members. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments 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 precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible…	
Surgical procedures	**In Network**	**Out of Network**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery) • Insertion of internal prosthetic devices . See 5(a) *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Surgical procedures (cont.)	**In Network**	**Out of Network**
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.	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*	*All charges*
Reconstructive surgery	**In Network**	**Out of Network**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) 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.	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: • *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* • *Surgeries related to sex transformation*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Oral and maxillofacial surgery	**In Network**	**Out of Network**
Oral surgical procedures, limited to: • 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.	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*	*All charges*
Organ/tissue transplants	**In Network**	**Out of Network**
Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to *Other services* in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description and can safely tolerate the procedure. • 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 - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Blood or marrow stem cell transplants limited to the stages of the following diagnoses: • Allogeneic transplants for	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**In Network**	**Out of Network**
- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myleogenous leukemia - Hemoglobinopathy (i.e. Fanconi's, Thalessemia major) - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Amyloidosis • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Neuroblastoma - Amyloidosis • Autologous tandem transplants for - Recurrent germ cell tumors (including testicular cancer) - Muliple myeloma - De-novo myeloma	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
• Allogeneic blood or marrow stem cell transplants for - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced forms of myelodysplastic syndromes - Advanced neuroblastoma - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Mucolipidosis (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	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**In Network**	**Out of Network**
- Sickle cell anemia - Thalassemia major (homozygous beta-thalassemia) - X-linked lymphoproliferative syndrome • Autologous blood or marrow stem cell transplants for - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Amyloidosis - Ewing's sarcoma - Medulloblastoma • Allogeneic transplants for - Chronic lymphocytic leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma • Nonmyeloablative allogeneic transplants for - 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 - Non-small cell lung cancer • Autologous transplants for - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma National Transplant Program (NTP) – CDPHP UBI facilitates organ transplants at a CDPHP UBI approved transplant center.	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**In Network**	**Out of Network**
Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence. **Note: We cover related medical and hospital expenses of the donor when we cover the recipient.** **Note: Please see Section 3 for "Services requiring our prior approval."**	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia	**In Network**	**Out of Network**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount

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.
- The deductible is $1,500 for Self Only enrollment for $3,000 for Self and Family enrollment for in-network services and $5,000 for Self Only enrollment or $10,000 for Self and Family enrollment for out-of-network services. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments 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 PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You Pay After the calendar year deductible	
Inpatient hospital	**In Network**	**Out of Network**
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount

Inpatient hospital - continued on next page

Benefit Description	You Pay After the calendar year deductible	
Inpatient hospital (cont.)	**In Network**	**Out of Network**
• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care except when necessary in the hospital when ordered and approved by a CDPHP UBI participating physician*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**In Network**	**Out of Network**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service 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.	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: Blood and blood derivatives not replaced by the member	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**In Network**	**Out of Network**
Skilled nursing facility (SNF): Up to 90 days per year in lieu of hospitalization	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: Custodial care	*All charges*	*All charges*

Benefit Description	You Pay After the calendar year deductible	
Hospice care	**In Network**	**Out of Network**
Up to 210 combined inpatient and outpatient days	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: Independent nursing, homemaker services	*All charges*	*All charges*
Ambulance	**In Network**	**Out of Network**
• Local professional ambulance service when medically appropriate • Air ambulance if medically appropriate and approved	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: Transportation for convenience	*All charges*	*All charges*

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 deductible is $1,500 for Self Only enrollment for $3,000 for Self and Family enrollment for in-network services and $5,000 for Self Only enrollment or $10,000 for Self and Family enrollment for out-of-network services. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments 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:

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

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

Emergencies outside our service area: If you have an emergency outside of CDPHP UBI's service area, simply go to the nearest hospital emergency room. If you are required to pay for services at the time of treatment, please request an itemized bill. Send the bill along with your name and member ID number to CDPHP's Member Services Department, 500 Patroon Creek Blvd., Albany, NY 12206.

If you are not admitted to the hospital for further services or care, you will be responsible for the deductible and coinsurance. If you are admitted immediately, you will pay all charges until you satisfy your deductible.

After receiving emergency medical care, be sure your primary care physician is notified within forty-eight (48) hours, unless it is not reasonably possible to do so. He or she will need to know what services were provided before scheduling any of your follow-up care.

Benefit Description	You pay After the calendar year deductible…	
Emergency within our service area	**In Network**	**Out of Network**
• Emergency care at a doctor's office • Emergency care at an urgent care center	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Emergency care as an outpatient in a hospital, including doctors' services Note: We waive the emergency room coinsurance if you are admitted to the hospital. Please refer to Section 5(c) for inpatient hospital coverage.	10% of our plan allowance. Coinsurance waived if admitted within 24 hours.	10% of our plan allowance and any difference between our allowance and the billed amount. Coinsurance waived if admitted within 24 hours.
Not covered: Elective care or non-emergency care	*All charges*	*All charges*
Emergency outside our service area	**In Network**	**Out of Network**
• Emergency care at a doctor's office • Emergency care at an urgent care center	10% of our plan allowance	10% of our plan allowance
Emergency care as an outpatient in a hospital, including doctors' services Note: We waive the emergency room coinsurance if you are admitted to the hospital. Please refer to Section 5(c) for inpatient hospital coverage.	10% of our plan allowance. Coinsurance waived if admitted within 24 hours.	10% of our plan allowance. Coinsurance waived if admitted within 24 hours.
Not covered: Elective care or non-emergency care	*All charges*	*All charges*
Ambulance	**In Network**	**Out of Network**
• Local professional ambulance service when medically appropriate. • Air ambulance if medically appropriate and approved. Note: See 5(c) for non-emergency service.	10% of our plan allowance	10% of our plan allowance
Not covered: Transportation for convenience	*All charges*	*All charges*

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 deductible is $1,500 for Self Only enrollment for $3,000 for Self and Family enrollment for in-network services and $5,000 for Self Only enrollment or $10,000 for Self and Family enrollment for out-of-network services. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments 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	**In Network**	**Out of Network**
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. 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.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologist s, or clinical social workers • Medication management	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
• Diagnostic tests	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
• 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	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Not covered: Services we have not approved.	*All charges*	*All charges*

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.)	**In Network**	**Out of Network**
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.	*All charges*	*All charges*

Preauthorization

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

Mental Health Care--You have direct access to in-network mental health care. A direct access toll-free telephone number at United Behavioral Health, 1-888-320-9584 (TDD 1-800-486-7914), will connect you to a qualified mental health clinician who will assist and arrange for treatment. For your convenience, the telephone number for mental health services is imprinted on your CDPHP UBI ID card.

Alcohol/Substance Abuse Benefits--You have access to alcohol and substance abuse care. These benefits are coordinated by United Behavioral Health (UBH). CDPHP UBI members can contact UBH directly at 1-888-320-9584 (TDD 1-800-486-7914).

Limitation

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

Section 5(f). Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is $1,500 for Self Only enrollment for $3,000 for Self and Family enrollment for in-network services and $5,000 for Self Only enrollment or $10,000 for Self and Family enrollment for out-of-network services. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section. There is no out-of-network mail order pharmacy program.
- 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 dentist must write the prescription. You or your physician must obtain prior approval for coverage of certain prescription drugs. Please refer to Section 3, Services requiring our approval.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication. Prescription drugs listed on CDPHP's specialty pharmacy list must be obtained at CDPHP UBI's participating specialty pharmacy vendor(s) for up to a 30-day supply, upon approval from CDPHP UBI. Please refer to Section 3, Services requiring our approval. Approved maintenance prescriptions can be refilled through the mail for a 90-day supply.
- **We use a formulary.** A formulary is a list of prescription drugs covered by CDPHP UBI based on their efficacy and cost in providing effective patient care. Coverage is subject to the CDPHP UBI prescription drug formulary that is in effect on the date the prescription is filled. Coverage is available for non-formulary drugs at a higher copayment.
- **These are the dispensing limitations.** Prescriptions filled at a participating pharmacy are limited to a 30-day supply. Maintenance prescriptions are filled up to a 90-day supply by mail order. Only certain maintenance prescriptions are available via mail order to insure quality, proper dosage, and medical appropriateness. Prescription refills received prior to the next scheduled refill date will not be filled.
- **Why use generic drugs?** Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your plan less money than brand name drugs.
- **When you do have to file a claim.** You do not have to submit claims.

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

Benefit Description	You pay After the calendar year deductible…	
Covered medications and supplies	**In Network**	**Out of Network**
We cover the following medications and supplies prescribed by a licensed physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Self-administered injectable drugs • Drugs for sexual dysfunction within applicable limits. Please call the Plan for information. • Prescription contraceptive drugs and devices • Smoking cessation prescriptions up to a 12-week supply • Nutritional supplements for the therapeutic treatment of phenylketonuria (PKU). • Infertility prescriptions available for members between 21 and 44 years of age, up to six cycles per pregnancy attempt. • Prescription drugs for certain inherited disease of amino acid and organic acid metabolism shall include modified sold food products that are low protein or which contain modified protein which are medically necessary for up to 12 months. Benefit limit of $2,500.	Note: If there is no generic equivalent available, you will still have to pay the name brand coinsurance. All charges until you satisfy your deductible, then **Retail Pharmacy (30-day supply)** $15—generic $40—formulary brand $60—non-formulary brand **Mail Order (90-day supply)** $30—generic $80—formulary brand $120—non-formulary brand	*All charges*
Insulin, oral agents to control blood sugar, needles, test strips, lancets, and visual reading and urine test strips	10% of our plan allowance	*All charges*
Durable medical equipment for insulin dependent persons	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Non-insulin disposable needles and syringes for the administration of covered medication	10% of our plan allowance	*All Charges*
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients, and food supplements that can be purchased without a prescription* • *Nonprescription medicines except for any over-the-counter products listed on our formulary* • *Weight loss prescriptions* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-plan pharmacy except for out-of-area emergencies*	*All charges*	*All charges*

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.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See SEction 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- The deductible is $1,500 for Self Only enrollment for $3,000 for Self and Family enrollment for in-network services and $5,000 for Self Only enrollment or $10,000 for Self and Family enrollment for out-of-network services. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments 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.

Accidental injury benefit	In Network	Out of Network
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.	10% of our plan allowance	30% of our plan allowance and any difference between our allowance and the billed amount
Dental benefits We have no other dental benefits.	*All charges*	*All charges*

Section 5(h). Special features

Feature	Description
Feature	
On-line tools	Easy-to-use Internet-based tools to help you manage your own health and make smarter decisions that may reduce health care costs. **Heath Coach Connections Dialog** • **Health Risk Assessment** – Health Risk Assessment tool called "How's your Health" is available online. This tool is specifically designed for members to promote improved decision–making. The objectives of the survey are to provide personalized information to individuals that reinforces self-reliance and self-care. • **Online Resources** – Online Resources include: • Evidence-based information about conditions and treatment options • Health Crossroads provides simple navigation through difficult decisions • Health Risk Assessment • Health tools • A single place for trusted health care information **Heathcare Advisor™ –** You will have the ability to: • Research medical conditions and illnesses • Understand treatments • Locate questions to ask your doctors • Compare hospitals, using a variety of criteria, providing necessary or desired treatments or services **My Online Wellness℠–** • Self-Care Centers- Focus on information specific to certain disease entities such as arthritis, asthma, hypertension, diabetes and others. • Rx Corner- Integrates your prescription drug benefits with drug news and tools. These programs are available to members through www.cdphp.com.
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future.

Feature - continued on next page

Feature	Description
Feature (cont.)	
	• The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services for deaf and hearing impaired	The telephone system also includes a TDD system. Members may call 1-877-261-1164 for services.
Childbirth Education Reimbursement Program	After you have satisfied your deductible, CDPHP UBI will reimburse expectant mothers 50 percent of the cost, up to $30 per year, for participating in and completing childbirth education classes. Once you complete the class, send the receipt and certificate of completion to CDPHP UBI, 500 Patroon Creek Blvd., Albany, NY 12206, for reimbursement.
Centers of Excellence	CDPHP facilitates care at approved transplant centers for medically necessary, non-experimental treatment.

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

Special features	Description
Health education resources	My Online Wellness℠ at www.cdphp.com offers you 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 Web site links You may also request e-newsletters to keep you informed on a variety of issues related to your good health. Visit our Web site at www.cdphp.com and click on the My Online Wellness logo, or go directly to www.MyOnlineWellness.com.
Account management tools	For each HSA and HRA account holder, we maintain a complete claims payment history online through www.cdphp.com. 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 on-line at www.hsabank.com If you have an **HRA**, • Your HRA balance will be available online through www.apapartners.com • Your balance will also be shown on your EOB form.
Consumer choice information	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 in Find-A-Doc at www.cdphp.com. Hospital comparison and quality information is available through Healthcare Advisor™ at our Web site. Log into Online Health at www.cdphp.com. to use this tool. Pricing information for prescription drugs is available by going directly to www.caremark.com or linking to the Caremark site through Rx Corner at www.cdphp.com. Educational materials on the topics of HSAs, HRAs, and HDHPs are available at www.cdphp.com
Care support	Patient safety information is available online at www.cdphp.com. Personal health coaches are available to answer your health questions and support you in the management of chronic illnesses. Please refer to Section 5(h), page 84.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at, 518-641-3100 or visit their web site at www.cdphp.com.

iBenefit Report

We are pleased to provide our FEHB members with the iBenefit Report. CDPHP partners with Caremark to send this report to members who have savings opporunities of $50.00 or more. This report will help you become aware of the true costs of your prescription drugs and assist and you and your doctor in making more informed decisions about medication choices.

Wellness Programs

CDPHP UBI offers a variety of innovative wellness classes to help you manage your health. The programs are free, exclusively for CDPHP members, and provided by trained educators.

A schedule of up-to-date wellness programs appears on our Web site: www.cdphp.com and in SmartMoves, CDPHP UBI's quarterly member newsletter. Health topics may include:

- **Health Education** - High Blood Pressure, Diabetes 101, Diabetes Management/Meal Planning, Diabetes and Exercise, Peak Asthma Performance
- Fitness: Pilates, Dance, Body Sculpting, Walking for Fitness, Water Aerobics, and more
- **Nutrition:** Low-Fat Cooking, Stop Dieting and Start Losing Weight, Anti-aging Through Nutrition, World of Soy, and more
- **Stress Management:** Yoga, Stretch, Flex and Relax, Tai Chi, DeClutter –Destress Your Life, Meditation, and more
- **Healthy Families:** Rock Climbing, Healthy Eating Made Fun For Kids, Fit Kids, Backpacking, Guided Nature Walks, Yoga kids, Ice Fishing, Snowshoeing in the Park, and more.

Smoking Cessation Program –The Butt Stops Here is a seven-week smoking cessation program that covers behavior modification with the use of nicotine replacement therapy. There is a $10 per person fee for the nicotine replacement therapy.

Award Winning Weight Management Programs:

The **Weigh 2 Be** program was designed for members who want to take control of their health. The program addresses nutrition, exercise, and stress management. Enrolled members who complete 10 weeks of Weight Watchers® are eligible to receive a refund of up to $65 annually.

The **KidPower** program is available free to members ages 5 to 17. This program is designed to provide kids a variety of tools and educational materials to better manage their weight and modify their lifestyles. Each child who signs up with KidPower will receive a special educational kit, which includes a KidPower backpack, the book Trim Kids, and colored stickers to be used with the Stop Light diet refrigerator board.

Move It! – with CDPHP and Radio Disney! CDPHP has a health partnership with Radio Disney's Move it!, a youth and family fitness for kids and adults.

CDPHP is proud to provide **My Online Wellness,** an interactive Web site, to our members. This Web site is updated daily and offers:

- News, quizzes, polls, calculators, and fun facts!
- Pharmacy information—In-depth drug data, including details about your drug coverage if you log in securely.
- Modifiable features—Personalize your My Online Wellness page by registering and checking off the subjects that interest you.
- Request a newsletter to be e-mailed to you.

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:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs, or devices (see pages 30 and 70 for specifics concerning transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies required for obtaining or continuing employment or insurance, attending schools or camp, or travel; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

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

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical, hospital, and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at (518) 641-3140 or 1-877-269-2134.

When you must file a claim – such as for services you 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:

CDPHP Universal Benefits, Inc.
500 Patroon Creek Blvd.
Albany, NY 12206

Deadline for filing your claim

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

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny 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:

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: CDPHP UBI, 500 Patroon Creek Blvd., Albany, NY 12206; 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 2, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

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

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

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

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

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

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

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

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

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

a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at (518) 641-3140 or 1-877-269-2134 and we will expedite our review; or

b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Insurance Group 2 at (202) 606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member 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 the type of Medicare managed care plan you have.

- **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, such as preauthorization for inpatient hospital stays.

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 (518) 641-3140 or 1-877-269-2134 or see our Web site at www.cdphp.com.

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

- **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 the program.

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 Plan (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 plan 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 14.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 14.
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 does not have a direct medical benefit such as house cleaning, preparing meals, personal hygiene. Custodial care that lasts 90 days or longer is sometimes known as long-term care.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 14.
Experimental or investigational service	A procedure that is not approved by the Federal Food and Drug Administration and/or the National Institute of Health Technology Assessment.
Group health coverage	Medical benefits such as hospital, surgical, and preventive care that are purchased on an employer-sponsored basis.
Medical necessity	A service or treatment which is appropriate and consistent with the diagnosis and accepted standards in the medical community.
Out of Pocket Maximum	The total amount of applicable Deductible, Copayments and/or Coinsurance that you must satisfy, before which CDPHP UBI will pay one hundred percent (100%) of the Allowed Amount for Covered benefits. All amounts you pay for Deductibles, Copayments and/or Coinsurances are applicable toward the Out of Pocket Maximum. The Member is also responsible for all differences, if any, between the Allowed Amount and the non-participating provider's charge regardless of whether the Out of Pocket Maximum has been met.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance by the average community charges. Our providers accept the allowances as payment in full.
Us/We	Us and We refer to CDPHP Universal Benefits, Inc., an affiliate of Capital District Physicians' Health Plan, Inc. (CDPHP).
You	You refers to the enrollee and each covered family member.

High Deductible Health Plan (HDHP) Definitions

Calendar year deductible	The fixed amount of covered expenses you must incur for all covered services and supplies before the plan starts paying for those services.

Catastrophic limit	When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance, and copayments) for covered services is limited to $5,100 self and $10,200 for self and family for in-network providers and $10,000 self and $20,000 self and family for out-of-network providers. 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. Please refer to Section 4.
Health Reimbursement Arrangement (HRA)	An employer-funded account that may be used by you to cover the cost of qualified expenses (e.g., deductible). You are given the option to carry forward unused funds forward into future years.
Health Savings Account (HSA)	A special tax-advantaged account where money goes in tax-free, earns interest tax-free. and is not taxed when it is withdrawn to pay for qualified health care services.
Premium contribution to HSA/HRA	A portion of your share of the cost of health benefits is deposited into an HSA or HRA to be used for qualified health care expenses.

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.

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 a prepaid plan that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

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

When benefits and premiums start

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

Upon divorce

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal 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 protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

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

Section 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to 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 to pay for health and/or dependent 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 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)** helps 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 wthheld, 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)** –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 any other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses for your child(ren) under age 13 or for dependants unable to care for themselves that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

What expenses can I pay with an FSAFEDS account?

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

For the LEX HCFSA – Dental and vision care expenses (but not insurance premiums)

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

AND MUCH MORE! Visit www.FSAFEDS.com

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

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

Even if you enrolled for 2008, you must make a new election to continue participating in 2009. Enrollment DOES NOT carry over from year to year.

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

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

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

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

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

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, 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.

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

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

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

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). If you do not have access to a computer of phone, contact your employing office or retirement system for guidance on how to enroll.

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

Premiums	The premiums will vary by plan and by enrollment type (self, self plus one, or self and family). There is no government contribution to the premiums. If you are an active employee, your premiums will be taken from your salary on a pre-tax basis when your salary is sufficient to make the premium withholding. If you are an annuitant, premiums will be withheld from your monthly annuity check when your annuity is sufficient. Pre-tax premiums are not available to annuitants. For information on each plan's specific premiums, visit www.opm.gov/insure/dentalvision.
Who is eligible to enroll?	Federal and Postal Service employees eligible for FEHB coverage (whether or not enrolled) and annuitants (regardless of FEHB status) are eligible to enroll in a dental plan and/or a vision plan.
Enrollment types available	• Self-only, which covers only the enrolled employee or annuitant; • Self plus one, which covers the enrolled employee or annuitant plus one eligible family member specified by the enrollee; and • Self and family, which covers the enrolled employee or annuitant and all eligible family members.
Which family members are eligible to enroll?	Eligible family members include your spouse, unmarried dependent children under age 22, and unmarried dependent children age 22 or over incapable of self-support because of a mental or physical disability that existed before age 22.
When can I enroll	Eligible employees and annuitants can enroll in a dental and/or vision plan during this open season – November 10 to December 8, 2008. You can enroll, disenroll, or change your enrollment during subsequent annual open seasons, or because of a qualified life event. New employees will have 60 days from their first eligibility date to enroll.
When will coverage be effective?	The new program will be effective December 31, 2008. Coverage for those who enroll during this year's open season (November 10 – December 8, 2008) will be effective December 31, 2008. Coverage for any other enrollments will be effective on/or after December 31, 2008.
How does this coverage work with my FEHB plan's dental or vision coverage?	Some FEHB plans already cover some dental and vision services. When you are covered by more than one health/dental plan, federal law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered expenses. Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on 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.

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). 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 CDPHP UBI - 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: $20 primary care; $30 specialist	19
Services provided by a hospital:		
• **Inpatient**	$100 copay per day up to a maximum of $500 per admission. For individual coverage, inpatient copays are limited to two per calendar year. For family coverage, inpatient copays are limited to three per calendar year.	34
• **Outpatient**	$30 per visit $75 for outpatient surgery	35
Emergency benefits:		
• **In-area**	$50 per visit to hospital emergency room; $40 per visit to urgent care center	37
• **Out-of-area**	$50 per visit to hospital emergency room	38
Mental health and substance abuse treatment	Regular cost sharing	39
Prescription drugs:		
• Retail pharmacy/Mail order	25% of the Plan allowance with a $400 per prescription maximum, up to a 30-day supply, and $4000 annual out-of-pocket maximum. The out-of-pocket maximum is the total amount of applicable Deductible, Copayments and/or Coinsurance to be satisfied, after which CDPHP UBI will pay one hundred percent (100%) of the Allowed Amount for Covered benefits. All amounts paid by the Member for Deductibles, Copayments and/or Coinsurances are applicable toward the Out of Pocket Maximum	42
Dental care	$30 per visit for accidental injury benefit	43
Vision care	$30 per visit for one refraction every 24 months	24
Special features:	On-line tools	44

	Flexible benefits option Non-emergency medical care for full-time students attending school out of the area Services for the deaf and hearing impaired Childbirth Education Reimbursement Program Centers of Excellence for transplants/heart surgery	
Protection against catastrophic costs (out-of-pocket maximum)**:**	We do not have an out-of-pocket maximum for the High Option.	14

Summary of benefits for the Standard Option of CDPHP UBI - 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	You Pay
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $25 primary care; $40 specialist	19
Services provided by a hospital:		
• Inpatient	$500 copay per admission plus 10% of the Plan allowance. For individual coverage, inpatient copays are limited to two per calendar year. For family coverage, inpatient copays are limited to three per calendar year.	34
• Outpatient	$40 per visit $100 for outpatient surgery	35
Emergency benefits:		
• In-area	$100 per visit to hospital emergency room; $50 per visit to urgent care center	37
• Out-of-area	$100 per visit to hospital emergency room	38
Mental health and substance abuse treatment	Regular cost sharing	39
Prescription drugs:		
• Retail pharmacy/Mail order	30% of the Plan allowance with a $400 per prescription maximum, up to a 30-day supply, and $6000 annual out-of-pocket maximum. The out-of-pocket maximum is the total amount of applicable Deductible, Copayments and/or Coinsurance to be satisfied, after which CDPHP UBI will pay one hundred percent (100%) of the Allowed Amount for Covered benefits. All amounts paid by the Member for Deductibles, Copayments and/or Coinsurances are applicable toward the Out of Pocket Maximum.	42
Dental care	$40 per visit for accidental injury benefit	43
Vision care	$40 per visit for one refraction every 24 months	24
Special features:	On-line tools	44

	Flexible benefits option Non-emergency medical care for full-time students attending school out of the area Services for the deaf and hearing impaired Childbirth Education Reimbursement Program Centers of Excellence for transplants/heart surgery	
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $4,000/Self Only or $5,000/ family enrollment per year for certain services.	14

Summary of benefits for the HDHP of CDPHP UBI - 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 2008 for each month you are eligible for the HSA, will deposit $62.50 per month for Self Only enrollment or $125. per month for Self and Family enrollment to your HSA. For the Health Savings Account (HSA), you must satisfy your calendar year deductible of $1,500 for Self Only and $3,000for Self and Family before using your HSA. 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 $750 for Self Only and $1,500 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.

Below, an asterisk (*) means the item is subject to the $1,500 Self Only and $3,000 Self and Family calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-Plan physician or other health care professional.

HDHP Benefits	You Pay	Page
In-network medical preventive care	Nothing for certain preventive services received from a plan provider	58
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Plan provider: 10%* of our plan allowance Non-plan provider: 30%* of our plan allowance and any difference between our allowance and the billed amount	60
Services provided by a hospital:		
• Inpatient	Plan provider: 10%* of our plan allowance Non-plan provider: 30%* of our plan allowance and any difference between our allowance and the billed amount	74
• Outpatient	Plan provider: 10%* of our plan allowance Non-plan provider: 30%* of our plan allowance and any difference between our allowance and the billed amount	75
Emergency benefits:		
• In-area	Plan provider: 10%* of our plan allowance Non-plan provider: 10%* of our plan allowance and any difference between our allowance and the billed amount	78
• Out-of-area	Plan provider: 10%* of our plan allowance Non-plan provider: 10%* of our plan allowance and any difference between our allowance and the billed amount	78
Mental health and substance abuse treatment	Plan provider: 10%* of our plan allowance Non-plan provider: 30%* of our plan allowance and any difference between our allowance and the billed amount	79
Prescription drugs:		

HDHP Benefits	You Pay	Page
• Retail pharmacy	Plan provider—30-day supply Generic—$15* Brand formulary —$40* Brand non-formulary —$60*	82
• Mail order	Plan provider—Up to 90-day supply Generic—$30* Brand formulary —$80* Brand non-formulary —$120*	82
Dental care	All charges except for regular cost-sharing for treatment for accidental injury	83
Vision care	One refraction every 24 months Plan provider: 10%* of our plan allowance and any difference between our allowance and the billed amount Non-plan provider: 30%* of our plan allowance and any difference between our allowance and the billed amount	64
Special features:	On-line tools Flexible benefits option Services for the deaf and hearing impaired Childbirth Education Reimbursement Program Centers of Excellence for transplants/heart surgery	84
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,100 Self Only or $10,200 Self and Family enrollment per calendar year for services from plan providers $10,000 Self Only or $20,000 Self and Family for services from non-plan providers	7

2009 Rate Information for CDPHP UBI

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 Category 1 rates apply to certain career non-law enforcement Postal Service employees. **Postal Category 2 rates** apply to other career non-law enforcement Postal Service employees. *PostalEASE*, the employee self-service system used for FEHB enrollment, automatically provides the applicable premium to individual employees. Career non-law enforcement employees may also refer to the *Guide to Federal Benefits for United States Postal Service Employees,* RI 70-2, to determine their rates.

Different rates apply and a special Guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

For further assistance, Postal Service employees should call.

Human Resources Shared Service Center

1-877-477-3273, Option 5

TTY: 1-866-260-7507

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	SG1	155.66	67.38	337.26	145.99	179.45	43.59
High Option Self and Family	SG2	352.56	212.33	763.88	460.05	406.42	158.47
Standard Option Self Only	SG4	130.65	43.55	283.07	94.36	150.68	23.52
Standard Option Self and Family	SG5	337.07	112.36	730.33	243.44	388.76	60.67
HDHP Option Self Only	SX1	98.56	32.85	213.54	71.18	113.67	17.74
HDHP Option Self and Family	SX2	254.29	84.76	550.96	183.65	293.28	45.77