

# UnitedHealthcare Insurance Company, Inc.

<http://www.uhcfeds.com>

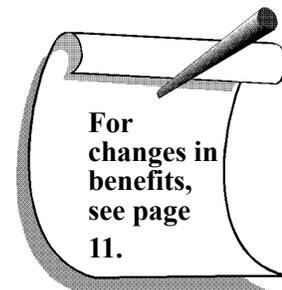


## 2009

## A consumer driven health plan option and high deductible health plan option

Serving the following states: Arizona, Arkansas, California, Colorado, District of Columbia, Florida, Georgia, Illinois, Iowa, Kansas, Louisiana, Maryland, Mississippi, Missouri, New Mexico, North Carolina, Nevada, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, Texas, Virginia, Washington State, and Wisconsin

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



HMO and POS products

This Plan has excellent accreditation from NCQA.

See the 2009 Guide To Federal Benefits for more information on NCQA.

### Enrollment code for this Plan:

**E91 High Deductible Health Plan – Self Only**

**E92 High Deductible Health Plan – Self and Family**

**E94 Consumer Driven Health Plan - Self Only**

**E95 Consumer Driven Health Plan - Self and Family**

**Special notice: This Plan is offering a Consumer Driven Health Plan (CDHP) option for the first time under the Federal Employees Health Benefits Program during the 2008 Open Season.**



Authorized for distribution by the:



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

RI 73-845

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

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

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

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

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**Please be advised**

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If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You may also have to wait until the next open enrollment period to enroll in Medicare Part D.

**Medicare's Low Income Benefits**

*For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at [www.socialsecurity.gov](http://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](http://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

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This brochure describes the benefits of UnitedHealthcare Insurance Company, Inc. under our contract (CS 2913) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for our administrative offices is:

UnitedHealthcare's Federal Employees Health Benefits (FEHB) Program

CDHP/HDHP  
6095 Marshalee Drive  
Suite 200  
Elkridge, MD 21075

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 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 11. Rates are shown at the end of this brochure.

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## Plain Language

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

Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means UnitedHealthcare Insurance Company, Inc.

We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.

Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

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

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## Stop Health Care Fraud!

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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 for your health care providers, authorized health benefits 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 1-800-FEP-8440 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.

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## **Preventing medical mistakes**

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

### **1. Ask questions if you have doubts or concerns.**

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

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

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

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

### **3. Get the results of any test or procedure.**

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

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

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

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

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

Visit these Web sites for more information about patient safety.

- [www.ahrq.gov/path/beactive.htm](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](http://www.npsf.org). The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- [www.talkaboutrx.org/consumer.html](http://www.talkaboutrx.org/consumer.html). The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- [www.leapfroggroup.org](http://www.leapfroggroup.org). The Leapfrog Group is active in promoting safe practices in hospital care.
- [www.ahqa.org](http://www.ahqa.org). The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- [www.quic.gov/report](http://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.

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## Section 1. Facts about this Consumer Driven Health Plan (CDHP) and High Deductible Health Plan (HDHP)

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This Plan offers you the choice of a Consumer Driven Health Plan (CDHP) or High Deductible Health Plan (HDHP). We do not require you to see specific physicians, hospitals, and other providers that contract with us, however, in order to get the most coverage we recommend you utilize in-network providers. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory. This Plan emphasizes preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

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

**You should join this 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.**

### **We have Point of Service (POS) benefits**

Our Consumer Driven Health Plan (CDHP) and High Deductible Health Plan (HDHP) offers POS benefits. This means you can receive covered services from a non-participating provider. However, out-of-network benefits may have higher out-of-pocket costs than our in-network benefits.

### **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.

### **General Features of our Consumer Driven Health Plan**

Features of our Consumer Driven Health Plan (CDHP) include:

#### **Preventive care services**

Preventive care services are covered at 100% if you use a network provider.

#### **Health Reimbursement Account (HRA)**

The HRA (also known as a personal medical fund) is funded by UnitedHealthcare and used to pay for non-preventive covered medical expenses before you pay any charges out of your pocket. If you join this Plan during open season, you will receive the full annual HRA (personal medical fund) of \$1,250 for Self Only and \$2,500 for Self and Family enrollment. If you join this Plan at any other time during the year, your HRA (personal medical fund) will be prorated at a rate of \$104.17 for Self Only or \$208.33 for Self and Family enrollment per month for each full month of coverage remaining in the calendar year.

#### **Deductible**

Your deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Your annual deductible is \$2,000 for Self Only or \$4,000 for Self and Family enrollment. You will only be responsible for a portion of this amount because your HRA (personal medical fund) will reduce the actually deductible you owe. This portion of the deductible is referred to as your member responsibility (see below).

If you elect this Plan outside of open season, your deductible will be prorated at the rate of \$166.67 for Self Only enrollment and \$333.33 for Self and Family enrollment for each full month of coverage remaining in the calendar year.

#### **Member responsibility**

Once you have exhausted the HRA (personal medical fund), you will then satisfy any remaining deductible. This remaining amount is known as your member responsibility. Your member responsibility is the bridge between your HRA (personal medical fund) and your Traditional medical plan.

If you elect this Plan during open season, your member responsibility will be \$750 for Self Only and \$1,500 for Self and Family enrollment. If you elect this Plan at any other time during the year, your member responsibility will be prorated at a rate of \$62.50 for Self Only or \$125 for Self and Family enrollment per month for each full month of coverage remaining in the calendar year.

### **Catastrophic protection**

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles, copays, and coinsurance cannot exceed \$3,000 for Self Only enrollment or \$6,000 for Self and Family enrollment in-network; or \$4,000 for Self Only enrollment or \$8,000 for Self and Family enrollment out-of-network.

### **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 HDHPs also offer health savings accounts or health reimbursement accounts. Please see below for more information about these savings features.

### **Preventive care services**

Covered preventive medical services are paid at 100% if you use a network provider.

### **Annual deductible**

The annual deductible must be met before Plan benefits are paid for care other than preventive care services. The annual deductible is: \$2,000 for Self Only coverage or \$4,000 for Self and Family coverage in-network; or \$3,000 for Self Only coverage or \$6,000 for Self and Family coverage out-of-network.

### **Health Savings Account (HSA)**

You are eligible for a HSA if you are enrolled in a HDHP, not covered by any other health plan that is not a 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 have received VA benefits within the last three months, not covered by your own or your spouse's flexible spending account (FSA), and 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 a 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 Account (HRA)**

If you are not eligible for a HSA, or become ineligible to continue a HSA, you are eligible for a Health Reimbursement Account (HRA). Although a HRA is similar to a HSA, there are major differences.

- A HRA does not earn interest.
- A HRA is not portable if you leave the Federal government or switch to another plan.

### **Catastrophic protection**

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

## **Health education resources and accounts management tools**

Connect to [www.uhcfeds.com](http://www.uhcfeds.com) to register for [myuhc.com](http://myuhc.com). On this site you can find health care at your fingertips, 24 hours a day. Keeping track of your benefits and claims, finding ways to save money, and learning more about how to stay healthy are easy at [myuhc.com](http://myuhc.com), your own secure personal member web site. Use [myuhc.com](http://myuhc.com):

- Check the status of your claims
- Search for network physicians and hospitals
- Verify your benefits—your coinsurance amounts, deductible status, and more
- Learn about health conditions, treatments, and procedures in easy-to-understand language
- Compare costs for treatments
- Find tools that help you make more informed health care decisions
- Chat online with a registered nurse
- Personal Health Manager is your health history, medical library, and customizable organizer that is secure, easy-to-use and interactive. Once you enter your preferences and needs, we'll automatically send you the information you want-or to browse at your leisure. You can use the site to estimate your treatment or plan costs, research health conditions, track your claims status and more.

Other tools available to our members are:

- Care24<sup>sm</sup>, gives you access to a registered nurse and master's level counselors who can answer questions about your health.
- UnitedHealthWellness <sup>SM</sup> is a customized, interactive health improvement program which also gives discounts on related services. You can take a personalized health assessment, sign up for an online better health program (like stress management or smoking cessation), work to meet your wellness goals, get reminders for screenings, and much more.
- Care Coordination<sup>SM</sup> is clinical expertise to help you make sound decisions and help you get access to proper care.

### **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](http://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.

- UnitedHealthcare Insurance Company has been in existence since 1972
- UnitedHealthcare Insurance Company is a for-profit organization

If you want more information about us, call 877-835-9861, or write to UnitedHealthcare's Federal Employees Health Benefits (FEHB) Program at 6095 Marshalee Drive, Suite 200, Elkridge, MD 21075. You may also visit our Web site at [www.uhcfeds.com](http://www.uhcfeds.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 areas are:

**Arizona** - All of Arizona

**Arkansas** - All of Arkansas

**California including the following counties:**

Alameda, Alpine, Amador, Calaveras, Contra Costa, El Dorado, Fresno, Imperial, Inyo, Kern, Kings, Los Angeles, Madera, Marin, Mariposa, Merced, Mono, Monterey, Napa, Orange, Placer, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Clara, Solano, Sonoma, Santa Barbara, Santa Cruz, Stanislaus, Tulare, Tuolumne, Ventura, and Yolo

**Colorado including the following counties:**

Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Crowley, Denver, Douglas, El Paso, Jefferson, Lincoln, Otero, Park and Teller

**District of Columbia** - All of District of Columbia

**Florida including the following counties:** Brevard, Charlotte, Citrus, Collier, Desoto, Duval, Flagler, Glades, Hardee, Hernando, Highlands, Hillsborough, Indian River, Lake, Lee, Levy, Manatee, Okeechobee, Orange, Osceola, Pasco, Pinellas, Polk, Sarasota, Seminole, St. Lucie, Sumter, and Volusia

**Georgia including the following counties:**

Atlanta/Athens: Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, De Kalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Heard, Henry, Jackson, Jasper, Jones, Morgan, Newton, Oconee, Paulding, Putnam, Rockdale, Spalding, and Walton

Macon: Bibb, Crawford, Crisp, Dodge, Dooly, Houston, Jones, Laurens, Macon, Monroe, Peach, Pulaski, Taylor, Telfair, Treutlen, Twiggs, Wheeler, Wilcox, and Wilkinson

**Illinois including the following counties: (St. Louis area)** Bond, Calhoun, Clinton, Greene, Jackson, Jefferson, Jersey, Macoupin, Madison, Marion, Monroe, Randolph, and Williamson

**Iowa including the following counties:** Adair, Appanoose, Audubon, Boone, Buena Vista, Calhoun, Carroll, Cerro Gordo, Chickasaw, Clarke, Clay, Dallas, Decatur, Dickinson, Emmet, Floyd, Franklin, Greene, Grundy, Guthrie, Hamilton, Hancock, Hardin, Howard, Humboldt,, Jasper, Kossuth, Lucas, Madison, Mahaska, Marion, Marshall, Mitchell, Monroe, Palo Alto, Pocahontas, Polk, Ringgold, Sac, Story, Tama, Taylor, Union, Warren, Wayne, Webster, Winnebago, Worth, and Wright

**Kansas including the following counties:** Anderson, Atchison, Dickinson, Douglas, Franklin, Johnson, Leavenworth, Linn, Miami, Montgomery, Morris, and Wyandotte

**Louisiana** - All of Louisiana

**Maryland** - All of Maryland

**Mississippi** - All of Mississippi

**Missouri including the following counties:**

Barry, Bates, Bollinger, Boone, Buchanan, Butler, Caldwell, Calloway, Camden, Cape Girardeau, Carroll, Cass, Chariton, Christian, Clay, Clinton, Cole, Cooper, Crawford, Dade, Dallas, Daviess, DeKalb, Dent, Douglas, Dunklin, Franklin, Gasconade, Greene, Grundy, Henry, Howard, Howell, Iron, Jackson, Jasper, Jefferson, Johnson, Laclede, Lafayette, Lawrence, Lewis, Lincoln, Livingston, Macon, Madison, Maries, McDonald, Mercer, Miller, Mississippi, Moniteau, Monroe, Montgomery, Morgan, New Madrid, Newton, Oregon, Pemiscot, Perry, Petis, Phelps, Pike, Platte, Polk, Pulaski, Ralls, Randolph, Ray, Reynolds, Ripley, Saline, Scott, St. Clair, St. Charles, St. Francis, St. Louis, St. Louis City, Ste. Genevieve, Stoddard, Stone, Taney, Texas, Vernon, Warren, Washington, Wayne, Webster, and Wright

**New Mexico** - All of New Mexico

**North Carolina including the following counties:** Alamance, Alexander, Alleghany, Anson, Ashe, Avery, Beaufort, Bertie, Bladen, Brunswick, Buncombe, Burke, Cabarrus, Caldwell, Carteret, Caswell, Catawba, Chatham, Cherokee, Chowan, Clay, Cleveland, Columbus, Craven, Cumberland, Currituck, Dare, Davidson, Davie, Duplin, Durham, Edgecombe, Forsyth, Gaston, Gates, Graham, Granville, Greene, Guilford, Halifax, Harnett, Haywood, Henderson, Hertford, Hoke, Iredell, Jackson, Johnston, Jones, Lee, Lenoir, Lincoln, Macon, Madison, Martin, McDowell, Mecklenburg, Mitchell, Montgomery, Moore, Nash, new Hanover, Northampton, Onslow, Orange, Pasquotank, Pender, Perquimans, Person, Pitt, Polk, Randolph, Richmond, Robeson, Rockingham, Rowan, Rutherford, Sampson, Scotland, Stanly, Stokes, Surry, Swain, Transylvania, Tyrrell, Union, Vance, Wake, Warren, Washington, Watauga, Wayne, Wilkes, Wilson, Yadkin, and Yancey

**Nevada** - All of Nevada

**Ohio including the following counties:** Allen, Ashland, Ashtabula, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Cuyahoga, Defiance, Delaware, Erie, Fairfield, Fayette, Franklin, Fulton, Gallia, Geauga, Guernsey, Hancock, Hardin, Harrison, Henry, Hocking, Holmes, Huron, Jackson, Jefferson, Knox, Lake, Lawrence, Licking, Lorain, Lucas, Madison, Mahoning, Marion, Medina, Meigs, Mercer, Monroe, Morgan, Morrow, Muskingum, Nobel, Ottawa, Paulding, Perry, Pickaway, Pike, Portage, Putnam, Richland, Ross, Sandusky, Scioto, Seneca, Stark, Summitt, Trumbull, Tuscarawas, Union, Van Wert, Vinton, Warren, Washington., Wayne, Williams, Wood, and Wyandot

**Oklahoma including the following counties:** Adair, Alfalfa, Atoka, Beaver, Beckham, Blaine, Bryan, Caddo, Canadian, Carter, Cherokee, Choctaw, Cimarron, Cleveland, Coal, Comanche, Cotton, Craig, Creek, Custer, Delaware, Dewey, Garfield, Garvin, Grady, Grant, Harmon, Haskell, Hughes, Jackson, Jefferson, Johnston, Kay, Kingfisher, Kiowa, Latimer, LeFlore, Lincoln, Logan, Love, Major, Marshall, Mayes, McClain, McCurtain, McIntosh, Murray, Muskogee, Noble, Nowata, Okfuskee, Oklahoma, Okmulgee, Osage, Ottawa, Pawnee, Payne, Pittsburgh, Pontotoc, Pottawatomie, Pushmataha, Roger Mills, Rogers, Seminole, Sequoyah, Stephens, Texas, Tillman, Tulsa, Wagoner, Washington, Washita, and Woodward

**Oregon including the following counties:** Benton, Clackamas, Clatsop, Columbia, Crook, Curry, Deschutes, Douglas, Hood River, Jackson, Jefferson, Josephine, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Wasco, Washington, and Yamhill.

**Rhode Island** - All of Rhode Island

**Tennessee** - All of Tennessee

**Texas including the following counties:**

Anderson, Andrews, Angelina, Aransas, Archer, Armstrong, Atascosa, Austin, Bailey, Bandera, Bastrop, Baylor, Bee, Bell, Bexar, Blanco, Borden, Bosque, Bowie, Brazoria, Brazos, Brewster, Briscoe, Brooks, Brown, Burleson, Burnet, Caldwell, Calhoun, Callahan, Cameron, Camp, Carson, Cass, Castro, Chambers, Cherokee, Childress, Clay, Cochran, Coke, Coleman, Collin, Collingsworth, Colorado, Comal, Comanche, Concho, Cooke, Coryell, Cottle, Crane, Crockett, Crosby, Culberson, Dallam, Dallas, Dawson, Deaf Smith, Delta, Denton, Dewitt, Dickens, Dimmit, Donley, Duval, Eastland, Ector, Edwards, El Paso, Ellis, Erath, Falls, Fannin, Fayette, Fisher, Floyd, Foard, Fort Bend, Franklin, Freestone, Frio, Gaines, Galveston, Garza, Gillespie, Glasscock, Goliad, Gonzales, Gray, Grayson, Gregg, Grimes, Guadalupe, Hale, Hall, Hamilton, Hansford, Hardeman, Hardin, Harris, Harrison, Hartley, Haskell, Hayes, Hemphill, Henderson, Hidalgo, Hill, Hockley, Hood, Hopkins, Houston, Howard, Hudspeth, Hunt, Hutchinson, Irion, Jack, Jackson, Jasper, Jeff Davis, Jefferson, Jim Hogg, Jim Wells, Johnson, Jones, Karnes, Kaufman, Kendall, Kenedy, Kent, Kerr, Kimble, King, Kinney, Kleberg, Knox, La Salle, Lamar, Lamb, Lampasas, Lavaca, Lee, Leon, Liberty, Limestone, Lipscomb, Live Oak, Llano, Loving, Lubbock, Lynn, Madison, Marion, Martin, Mason, Matagorda, Maverick, McCulloch, McLennan, Medina, Menard, Midland, Milam, Mills, Mitchell, Montague, Montgomery, Moore, Morris, Motley, Nacogdoches, Navarro, Newton, Nolan, Nueces, Ochiltree, Oldham, Orange, Palo Pinto, Panola, parker, Parmer, Pecos, Polk, Potter, Presidio, Rains, Randall, Reagan, Real, Red River, Reeves, Refugio, Roberts, Robertson, Rockwall, Runnels, Rusk, Sabine, San Augustine, San Jacinto, San Patricio, San Saba, Schleicher, Scurry, Shackelford, Shelby, Sherman, Smith, Somervell, Starr, Stephens, Sterling, Stonewall, Sutton, Swisher, Tarrant, Taylor, Terrell, Terry, Throckmorton, Titus, Tom Greer, Travis, Trinity, Tyler, Upshur, Upton, Uvalde, Val Verde, Van Zandt, Victoria, Walker, Waller, Ward, Washington, Webb, Wharton, Wheeler, Wichita, Wilbarger, Willacy, Williamson, Wilson, Winkler, Wise, Wood, Yoakum, Young, Zapata, and Zavala

**Virginia** - All of Virginia

**Washington State** - All of Washington State

**Wisconsin** - All of Wisconsin

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## Section 2. How we change for 2009

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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 this Plan

- **Your share of the non-Postal premium** under the HDHP will decrease for Self Only and Self and Family coverage. See page 126.
- **Consumer Driven Health Plan** - You now have two options to choose from: A High Deductible Health Plan (HDHP) or a Consumer Driven Health Plan (CDHP).
- **Out-of-network coinsurance** - Your HDHP out-of-network coinsurance has increased from 30% to 35% for preventive care and traditional medical coverage.
- **Premium pass through** - Your HDHP premium pass through has decreased from \$83.33 per month to \$62.50 per month for Self Only coverage and from \$166.66 per month to \$125 per month for Family coverage. See page 63.
- **Infertility services** - Assisted Reproductive Technology (ART) procedures such as IVF, GIFT, ZIFT, and embryo transfer are no longer covered benefits. See page 26 and 74.
- **Prescription drug ancillary charges** - You are no longer responsible for the difference between the cost of a Tier 2 or 3 drug and the cost of a Tier 1 drug when you choose to purchase a Tier 2 or 3 drug over a Tier 1.

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## Section 3. How you get care

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<b>Identification cards</b>	<p>We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.</p> <p>If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 877-835-9861 or write to us at UnitedHealthcare's Federal Employees Health Benefits (FEHB) Program at 6095 Marshalee Drive, Suite 200, Elkridge, MD 21075. You may also request replacement cards through our Web site: <a href="http://www.uhcfeds.com">www.uhcfeds.com</a>.</p>
<b>Where you get covered care</b>	<p>You get care from "Network providers" and "Network facilities." You will only pay deductibles and coinsurance. If you use our point-of-service program, you can also get care from non-Plan providers, but it will cost you more.</p>
<ul style="list-style-type: none"><li>• <b>Network providers</b></li></ul>	<p>Network providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.</p> <p>We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site at <a href="http://www.uhcfeds.com">www.uhcfeds.com</a>. You should also contact that provider to verify that they participate with the Plan.</p>
<ul style="list-style-type: none"><li>• <b>Network facilities</b></li></ul>	<p>Network facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site at <a href="http://www.uhcfeds.com">www.uhcfeds.com</a>. You should also contact that provider to verify that they participate with the Plan.</p>
<ul style="list-style-type: none"><li>• <b>Non-network providers and facilities</b></li></ul>	<p>You can access care from any licensed provider or facility. Providers and facilities not in the Plan's network are considered non-network providers and facilities. You can get care from non-network providers, but it will cost you more.</p>
<b>What you must do to get covered care</b>	<p><b>You do not need to select a primary care physician and you do not need written referrals to see a specialist for medical services.</b> The provider must be participating for services to be covered in-network. You must call United Behavioral Health at 1-800-558-7868 to obtain authorization for services to use mental health/substance abuse benefits. Prior authorization for prosthetic devices or durable medical equipment is required when the item costs more than \$1000 or for Growth Hormone Therapy (GHT). The Plan will provide benefits for covered services only when the services are medically necessary to prevent, diagnose or treat your illness or condition.</p>
<ul style="list-style-type: none"><li>• <b>Transitional care</b></li></ul>	<p>Specialty care: If you have a chronic or disabling condition and lose access to your network specialist because we:</p> <ul style="list-style-type: none"><li>• Terminate our contract with your specialist for other than cause; or</li><li>• Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or</li><li>• Reduce our service area and you enroll in another FEHB Plan,</li></ul> <p>you may be able to continue seeing your specialist and receive in-network benefits for up to 90 days after you receive notice of the change at in-network benefit level. Contact us, or if we drop out of the Program, contact your new plan.</p> <p>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 and receive the in-network benefit level.</p>

- **Hospital care**

In most cases, your Network physician will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility. Because you are still responsible for ensuring that we are asked to precertify your care, you should always ask your physician or hospital whether they have contacted the Plan. If you are using a non-network provider or facility, you are responsible for contacting the Plan at 877-835-9861.

**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 877-835-9861. 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 92<sup>nd</sup> 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...**

In most cases, your Network physician will make necessary hospital arrangements and supervise your care. If you are using a non-network provider or facility, you are responsible for contacting the Plan at 877-835-9861.

- **Your hospital stay**

This includes admission to a skilled nursing or other type of facility. Because you are still responsible for ensuring that we are asked to precertify your care, you should always ask your physician or hospital whether they have contacted the Plan. If you are using a non-network provider or facility, you are responsible for contacting the Plan at 877-835-9861.

- **How to precertify an admission**

If the admission is a non-urgent admission or if you are being admitted to a non-network hospital, you must get the admission precertified by calling the Plan at 877-835-9861. This must be done at least 4 business days before the admission. If the admission is an emergency or an urgent admission, you, the person's provider, or the hospital must notify us by calling 877-835-9861 within one business day or the same day of admission, or as soon as reasonably possible.

**NOTE:** If you do not notify us, your benefits will be reduced by \$100 per admission.

- **Maternity care**

You do not need to precertify a maternity admission for a routine delivery in a Network facility. We will provide benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery;
- 96 hours for the mother and newborn child following a cesarean section delivery.

**NOTE:** Non-network benefits require that you notify us as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described above. If you do not notify us, your benefits will be reduced by \$100 per admission.

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

If no one contacts us, we will decide whether hospital stay was medically necessary.

- If we determine that the stay was medically necessary, we will pay the inpatient charges, less the \$100 penalty.
- If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits.

If the precertification request was denied, we will not pay inpatient hospital benefits.

When the admission was precertified, but you remained in the hospital beyond the number of days we approved and did not get the additional days precertified then:

- for the portion of the admission that was precertified, we will pay the inpatient benefits, but
- for the portion of the admission that was not precertified, we will not pay the inpatient benefits.

**Circumstances beyond our control**

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

**Services requiring our prior approval**

Certain services require that you or your physician must obtain prior approval from us. We call this review and approval process prior authorization. You or your physician must obtain prior authorization for most out-of-network services as well as some network services such as, but not limited to the following:

- Mental health and substance abuse benefits
- Inpatient admissions
- Cancer clinical trials
- Accidental dental injury
- Emergency health services
- Orthopedic and prosthetic devices over \$1,000
- Durable medical equipment over \$1,000
- Growth hormone therapy (GHT)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiogram (MRA)
- Pet scans
- Nuclear medicine studies including nuclear cardiology
- Computed tomography (CT) scans

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## Section 4. Your costs for covered services

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

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

Example: You pay 10% of our allowance for in-network Physician's office visits under both CDHP and HDHP.

**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 expense you must incur for certain covered services and supplies before we start paying benefits for them. **Copayments and coinsurance amounts do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible.**

### Consumer Driven Health Plan (CDHP)

Your annual deductible is \$2,000 for Self Only or \$4,000 for Self and Family enrollment. You will only be responsible for a portion of this amount because your HRA (personal medical fund) will reduce the actual deductible you owe. Your deductible must be satisfied before the Traditional medical plan benefits apply. The Self and Family deductible may be satisfied by one or more family members. Excess HRA (personal medical fund) dollars which have been rolled-over from prior years will also be used to satisfy your deductible.

### High Deductible Health Plan

The calendar year deductible is \$2,000 for Self Only or \$4,000 for Self and Family enrollment in-network and \$3,000 for Self Only or \$6,000 for Self and Family enrollment out-of-network. The deductible must be satisfied before the Traditional Medical Plan benefits apply. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$4,000 in-network and \$6,000 out-of-network.

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

**Member responsibility** Your member responsibility is the bridge between your HRA (personal medical fund) and your Traditional medical plan. After you have used up your annual HRA of \$1,250 for Self Only or \$2,500 for Self and Family enrollment, you must satisfy your member responsibility. Your member responsibility is \$750 for Self Only or \$1,500 for Self and Family enrollment. The Self and Family member responsibility may be satisfied by one or more family members. Once you have satisfied your member responsibility, Traditional medical plan benefits apply.

**Differences between our Plan allowance and the bill** Network providers and facilities have contracted with the Plan to accept our Plan allowance. If you use a network provider or facility, you do not have to pay the difference between our Plan allowance and the billed amount for covered services.

If you are using non-network providers you will have to pay the difference between our Plan allowance and the billed amount.

**Your catastrophic protection out-of-pocket maximum**

### Consumer Driven Health Plan (CDHP)

After your deductible (member responsibility), copayments and coinsurance total \$3,000 for Self enrollment or \$6,000 for Family enrollment in-network (\$4,000 for Self enrollment or \$8,000 for Family enrollment out-of-network) in any calendar year, you do not have to pay any more for covered services. However, your expenses for the following services do not count towards your catastrophic protection out-of-pocket maximum, and you must continue to pay for these services:

- The \$100 penalty for failing to obtain precertification when using a non-network facility
- The balance billing charges incurred when you see a non-network provider

### **High Deductible Health Plan (HDHP)**

After your deductible, copayments and coinsurance total \$3,000 for Self enrollment or \$6,000 for Family enrollment in-network (\$6,000 for Self enrollment or \$12,000 for Family enrollment out-of-network) in any calendar year, you do not have to pay any more for covered services. However, your expenses for the following services do not count towards your catastrophic protection out-of-pocket maximum, and you must continue to pay for these services:

- The \$100 penalty for failing to obtain precertification when using a non-network facility
- The balance billing charges incurred when you see a non-network provider

### **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.

### **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.

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## Section 5. Consumer Driven Health Plan Benefits Overview

**This Plan offers a Consumer Driven Health Plan (CDHP). The CDHP benefit package is described here in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.**

CDHP Section 5, which describes the CDHP benefits, is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about CDHP benefits, contact us at 1-877-835-9861 or at our Web site at [www.uhcfeds.com](http://www.uhcfeds.com)

This CDHP focuses on you, the health care consumer, and gives you greater control in how you use your health care benefits. With this plan, eligible in-network medical preventive care is covered in full, and you can use the HRA (personal medical fund) for any covered care. If you use up your HRA (personal medical fund), the Traditional Medical Coverage begins after you satisfy your member responsibility. If you don't use up your HRA (personal medical fund) for the year, you can roll it over to the next year, as long as you continue to be enrolled in this CDHP.

**The CDHP includes:**

**In-network medical preventive care** This component covers 100% of preventive care for adults and children if you use a network provider. The covered medical services include office visits/exams, immunizations, and screenings. These services are fully described in Section 5.

**HRA (personal medical fund)** The Plan provides an annual HRA (personal medical fund). This fund is used to pay for non-preventive covered medical expenses before you pay any charges out of your pocket. If you elect this Plan during open season, you will receive the full annual HRA (personal medical fund) of \$1,250 for Self Only and \$2,500 for Self and Family enrollment. If you elect this Plan at any other time during the year, your HRA (personal medical fund) will be prorated at a rate of \$104.17 for Self Only or \$208.33 for Self and Family enrollment per month for each full month of coverage remaining in the calendar year.

**Example: Member enrolls in Self Only coverage beginning July 1st.**

Number of full months remaining in the calendar year: (July - December): 6 months

Prorated HRA for Self Only coverage (6 months x \$104.17): \$625

If you have a remaining HRA (personal medical fund) balance at the end of the calendar year, that balance will roll-over so you can use it in the future, as long as you continue to participate in the Plan. If you terminate your participation in the Plan, any remaining balance will be lost.

**Note:** In-network medical preventive care benefits paid under Section 5 do NOT count against your HRA (personal medical fund).

**Deductible** Your annual deductible is \$2,000 for Self Only or \$4,000 for Self and Family enrollment. You will only be responsible for a portion of this amount because your HRA (personal medical fund) will reduce the actually deductible you owe. Your deductible must be satisfied before the Traditional medical plan benefits apply. The Self and Family deductible may be satisfied by one or more family members. Excess HRA (personal medical fund) dollars which have been rolled-over from prior years will also be used to satisfy your deductible.

If you elect this Plan outside of open season, your deductible will be prorated at the rate of \$166.67 for Self Only enrollment and \$333.33 for Self and Family enrollment for each full month of coverage remaining in the calendar year.

**Example: Member enrolls in Self Only coverage beginning July 1st.**

Number of full months remaining in the calendar year: (July - December): 6 months

Prorated deductible for Self Only coverage (6 months x \$166.67): \$1,000

Traditional medical coverage	Under Traditional medical coverage, you must first use your annual HRA (personal medical fund) and then satisfy your member responsibility (\$750 for Self Only enrollment or \$1,500 for Self and Family enrollment). Once you have satisfied your member responsibility, the Plan generally pays 90% of the cost for in-network care and 60% (of the allowed amount) for out-of-network care.
Catastrophic protection for out-of-pocket expenses	Your annual maximum for out-of-pocket expenses (deductible, coinsurance, and copayments) for covered services is limited to \$3,000 for Self Only or \$6,000 for Self and Family enrollment in-network. If you use non-network providers, your out-of-pocket maximum is \$4,000 for Self Only and \$8,000 for Self and Family enrollment. Refer to Section 4 <i>Your catastrophic protection out-of-pocket maximum</i> for more details.
Member responsibility	<p>Once your annual HRA (personal medical fund) has been exhausted, you must satisfy your member responsibility before your Traditional medical coverage begins. Your member responsibility is the calendar year deductible minus your HRA.</p> <p>If you elect this Plan during open season, your member responsibility will be \$750 for Self Only and \$1,500 for Self and Family enrollment. If you elect this Plan at any other time during the year, your HRA (personal medical fund) will be prorated at a rate of \$62.50 for Self Only or \$125 for Self and Family enrollment per month for each full month of coverage remaining in the calendar year.</p> <p><b><u>Example: Member enrolls in Self Only coverage beginning July 1st.</u></b></p> <p>Number of full months remaining in the calendar year: (July - December): 6 months</p> <p>Prorated member responsibility for Self Only coverage (6 months x \$62.50): \$375</p>

**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 or member responsibility. You pay nothing for covered preventive care services provided in-network.
- The Plan pays 100% for the medical preventive care services listed in this Section when you use a in-network provider. In-network preventive care in this section does not use your HRA (personal medical fund).
- If you choose to access preventive care from a non-network provider, you will not qualify for 100% preventive care coverage. Please see Section 5 – *Traditional medical coverage subject to the member responsibility*.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the member responsibility*.

Benefit Description	You pay
<p><b>Preventive care, adult</b></p> <p>Routine screenings, such as:</p> <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Total Blood Cholesterol</li> <li>• Routine Prostate Specific Antigen (PSA) test — one annually for men age 50 and older</li> <li>• Colorectal Cancer Screening, including                             <ul style="list-style-type: none"> <li>- Fecal occult blood test yearly starting at age 50,</li> <li>- Sigmoidoscopy screening — every five years starting at age 50,</li> <li>- Double contrast barium enema — every five years starting at age 50;</li> <li>- Colonoscopy screening — every 10 years starting at age 50</li> </ul> </li> <li>• Routine annual digital rectal exam (DRE) for men age 40 and older</li> <li>• Routine well-woman exam including Pap test, one visit every 12 months from last date of service</li> <li>• Routine mammogram — covered for women age 35 and older, as follows:                             <ul style="list-style-type: none"> <li>- From age 35 through 39, one during this five year period</li> <li>- From age 40 through 64, one every calendar year</li> <li>- At age 65 and older, one every two consecutive calendar years</li> </ul> </li> </ul>	<p>In-network: Nothing at a network provider</p> <p>Out-of-network: All charges until you satisfy your member responsibility, then 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<ul style="list-style-type: none"> <li>• Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)</li> </ul>	<p>In-network: Nothing at a network provider</p> <p>Out-of-network: All charges until you satisfy your member responsibility, then 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<ul style="list-style-type: none"> <li>• Routine physicals which include:                             <ul style="list-style-type: none"> <li>-One exam every 24 months up to age 65</li> <li>-One exam every 12 months age 65 and older</li> </ul> </li> </ul>	<p>In-network: Nothing at a network provider</p> <p>Out-of-network: All charges until you satisfy your member responsibility, then 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

*Preventive care, adult - continued on next page*

Benefit Description	You pay
<b>Preventive care, adult (cont.)</b>	
<ul style="list-style-type: none"> <li>• Routine exams limited to:               <ul style="list-style-type: none"> <li>-One routine eye exam every other year</li> <li>-One routine OB/GYN exam every 12 months including 1 Pap smear and related services</li> <li>-One comprehensive hearing exam every other year</li> </ul> </li> </ul>	<p>In-network: Nothing at a network provider</p> <p>Out-of-network: All charges until you satisfy your member responsibility, then 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.</i></li> <li>• <i>Immunizations, boosters, and medications for travel or work-related exposure.</i></li> </ul>	<p><i>All Charges.</i></p>
<b>Preventive care, children</b>	
<p>Professional services, such as:</p> <ul style="list-style-type: none"> <li>• Well-child visits for routine examinations, immunizations and care (up to age 22)</li> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> </ul> <p>Examinations, such as:</p> <ul style="list-style-type: none"> <li>• Eye exam through age 17 every other year</li> <li>• Comprehensive hearing exams through age 17 every other year</li> </ul>	<p>In-network: Nothing at a network provider</p> <p>Out-of-network: All charges until you satisfy your member responsibility, then 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i></li> <li>• <i>Immunizations, boosters, and medications for travel.</i></li> </ul>	<p><i>All Charges.</i></p>

## Section 5. Traditional medical coverage subject to the member responsibility

### 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.
- In-network preventive care is covered at 100% (see page 20) and is not subject to the member responsibility.
- Your annual HRA (personal medical fund) of \$1,250 for Self Only enrollment and \$2,500 for Self and Family enrollment must be used first for eligible health care expenses. Please see page 18 for information regarding how your HRA is prorated if you elect this Plan outside of open season.
- Your deductible is \$2,000 for Self Only enrollment and \$4,000 for Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin. Your deductible is reduced by your HRA. This reduced amount is referred to as your member responsibility. Please see page 18 for information regarding how your deductible is prorated if you elect this Plan outside of open season.
- Your member responsibility is \$750 for Self Only enrollment and \$1,500 for Self and Family enrollment. The family member responsibility can be satisfied by one or more family members. The member responsibility applies to almost all benefits under Traditional medical coverage. You must pay your member responsibility before your Traditional medical coverage may begin. The member responsibility can be reduced by excess dollars in your Personal Medical Fund as a result of prior year roll-overs. Please see page 19 for information regarding how your member responsibility is prorated if you elect this Plan outside of open season.
- 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 member responsibility total \$3,000 for in-network and \$6,000 out-of-network for Self Only enrollment, and \$4,000 for in-network and \$8,000 out-of-network for Self and Family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket 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).
- 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 member responsibility...
<b>Member responsibility before Traditional medical coverage begins</b>	
<p>Once your annual HRA (personal medical fund) has been exhausted, you must satisfy your member responsibility before your Traditional medical coverage begins. Your member responsibility is the calendar year deductible minus your HRA. The member responsibility applies to almost all benefits in this Section. In the <b>You pay</b> column, we say “No member responsibility” 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 member responsibility.</p>	<p>100% of allowable charges until you meet the member responsibility of \$750 for Self Only coverage, and \$1,500 for Self and Family coverage.</p>
<p>After you meet the member responsibility, we pay the allowable charges (less your coinsurance or copayment) until you meet the catastrophic out-of-pocket maximum.</p>	<p>In-network: After you meet the member responsibility, you pay the indicated coinsurance or copayments for covered services.</p> <p>Out-of-network: After you meet the member responsibility, you pay the indicated coinsurance based on our Plan allowance and any difference between our allowance and the billed amount.</p>

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

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your annual HRA (personal medical fund) of \$1,250 for Self Only enrollment and \$2,500 for Self and Family enrollment must be used first for eligible health care expenses. Please see page 18 for information regarding how your HRA is prorated if you elect this Plan outside of open season.
- Your deductible is \$2,000 for Self Only enrollment and \$4,000 for Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin. Your deductible is reduced by your HRA. This reduced amount is referred to as your member responsibility. Please see page 18 for information regarding how your deductible is prorated if you elect this Plan outside of open season.
- The member responsibility \$750 for Self Only enrollment and \$1,500 for Self and Family enrollment. The family member responsibility can be satisfied by one or more family members. The member responsibility applies to almost all benefits under Traditional medical coverage. You must pay your member responsibility before your Traditional medical coverage may begin. The member responsibility can be reduced by excess dollars in your HRA (personal medical fund) as a result of prior year roll-overs. Please see page 19 for information regarding how your member responsibility is prorated if you elect this Plan outside of open season.
- 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 member responsibility...
<p><b>Diagnostic and treatment services</b></p> <p>Professional services of physicians</p> <ul style="list-style-type: none"> <li>• In physician’s office</li> <li>• In an urgent care center</li> <li>• During a hospital stay</li> <li>• In a skilled nursing facility</li> <li>• Office medical consultations</li> <li>• Second surgical opinion</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><b>Lab, X-ray and other diagnostic tests</b></p> <p>Tests, such as:</p> <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine Pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine mammograms</li> <li>• CAT Scans/MRI</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

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

Benefit Description	You pay After the calendar year member responsibility...
<b>Lab, X-ray and other diagnostic tests (cont.)</b>	
<ul style="list-style-type: none"> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<b>Maternity care</b>	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do not need to precertify your normal delivery; see page 13 for other circumstances, such as extended stays for you or your baby.</li> <li>• 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.</li> <li>• 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.</li> <li>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See <i>Hospital benefits</i> (Section 5c) and <i>Surgery benefits</i> (Section 5b).</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<b>Family planning</b>	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>• Voluntary sterilization (See Surgical procedures Section 5 (b))</li> <li>• Surgically implanted contraceptives</li> <li>• Administration of injectable contraceptive drugs (such as Depo Provera)</li> <li>• Insertion and removal of Intrauterine Devices (IUDs)</li> <li>• Diaphragms and fitting of diaphragms</li> <li>• Genetic Counseling</li> </ul> <p>Note: We cover oral and injectable contraceptives under the prescription drug benefit</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<i>Not covered: Reversal of voluntary surgical sterilization</i>	<i>All Charges.</i>

Benefit Description	You pay After the calendar year member responsibility...
<b>Infertility services</b>	
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> <li>• Artificial insemination limited to a lifetime maximum of three cycles:</li> <li>• intravaginal insemination (IVI)</li> <li>• intracervical insemination (ICI)</li> <li>• intrauterine insemination (IUI)</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> <li>- <i>in vitro fertilization</i></li> <li>- <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i></li> </ul> </li> <li>• <i>Cost of donor sperm</i></li> <li>• <i>Cost of donor egg</i></li> <li>• <i>Fertility drugs</i></li> </ul>	<p><i>All Charges.</i></p>
<b>Allergy care</b>	
<ul style="list-style-type: none"> <li>• Testing and treatment</li> <li>• Allergy injections</li> <li>• Allergy serum</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Provocative food testing and sublingual allergy desensitization.</i></p>	<p><i>All Charges.</i></p>
<b>Treatment therapies</b>	
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy</li> </ul> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 35.</p> <ul style="list-style-type: none"> <li>• Respiratory and inhalation therapy</li> <li>• Dialysis – hemodialysis and peritoneal dialysis</li> <li>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</li> <li>• Growth hormone therapy (GHT)</li> </ul> <p>Note: Growth hormone is covered under the prescription drug benefit.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

*Treatment therapies - continued on next page*

Benefit Description	You pay After the calendar year member responsibility...
<b>Treatment therapies (cont.)</b>	
<p>Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See Services requiring our prior approval in Section 3.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<b>Physical and occupational therapies</b>	
<p>Up to two consecutive months per condition per year for the services of each of the following:</p> <ul style="list-style-type: none"> <li>• qualified physical therapists and</li> <li>• occupational therapists</li> </ul> <p><b>Note:</b> We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <ul style="list-style-type: none"> <li>• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 36 sessions.</li> <li>• Pulmonary rehabilitation is provided for up to 20 visits per calendar year.</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Long-term rehabilitative therapy</li> <li>• Exercise programs</li> </ul>	<p><i>All Charges.</i></p>
<b>Speech therapy</b>	
<p>Up to two consecutive months per condition per calendar year.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Exercise programs</i></p>	<p><i>All Charges</i></p>
<b>Hearing services (testing, treatment, and supplies)</b>	
<ul style="list-style-type: none"> <li>• First hearing aid and testing only when necessitated by accidental injury</li> <li>• Hearing aids for children up to age 12 limited to \$1,000 every two calendar years</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• All other hearing testing</li> <li>• Hearing aids for members age 12 and over, testing and examinations for them</li> </ul>	<p><i>All Charges.</i></p>

Benefit Description	You pay After the calendar year member responsibility...
<p><b>Vision services (testing, treatment, and supplies)</b></p> <ul style="list-style-type: none"> <li>Initial pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)</li> </ul> <p>Note: For questions or claims please contact Vision Customer Service at 1-877-426-9300.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>Eyeglasses or contact lenses, except as shown above</li> <li>Eye exercises and orthoptics</li> <li>Radial keratotomy and other refractive surgery</li> </ul>	<p><i>All Charges.</i></p>
<p><b>Foot care</b></p> <p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>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</li> <li>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)</li> </ul>	<p><i>All Charges.</i></p>
<p><b>Orthopedic and prosthetic devices</b></p> <ul style="list-style-type: none"> <li>Benefits are limited to any combination of network and out-of-network benefits for a calendar year maximum of \$2,500.</li> <li>Artificial limbs and eyes; stump hose</li> <li>Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy</li> <li>Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy Note: See 5(b) for coverage of the surgery to insert the device.</li> </ul> <p><b>Note:</b> Call us at 877-835-9861 as soon as your Plan physician prescribes these items. You must notify us before obtaining any single item that costs more than \$1,000 or your benefits will be reduced by \$100 per occurrence.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Prosthesis for a scalp hair prosthesis for hair loss suffered as a result of chemotherapy limited to a maximum of \$350 per year.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

*Orthopedic and prosthetic devices - continued on next page*

Benefit Description	You pay After the calendar year member responsibility...
<b>Orthopedic and prosthetic devices (cont.)</b>	
<p>Ostomy Appliances and supplies combined network and out-of-network benefit maximum of \$1,000 per Plan year.</p>	<p>In-Network: 10% of eligible expenses Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Orthopedic and corrective shoes</li> <li>• Arch supports</li> <li>• Foot orthotics</li> <li>• Heel pads and heel cups</li> <li>• Lumbosacral supports</li> <li>• Corsets, trusses, elastic stockings, support hose, and other supportive devices</li> <li>• Prosthetic replacements provided less than 3 years after the last one we covered</li> </ul>	<p><i>All Charges.</i></p>
<b>Durable medical equipment</b>	
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Benefits are limited to any combination of network and out-of-network benefits for a calendar year maximum of \$2,500. Covered items include:</p> <ul style="list-style-type: none"> <li>• Oxygen and the rental of equipment to administer oxygen including tubing, connectors and masks</li> <li>• Dialysis equipment</li> <li>• Hospital beds</li> <li>• Wheelchairs</li> <li>• Crutches</li> <li>• Walker</li> <li>• Blood glucose monitors</li> <li>• Insulin pumps</li> </ul> <p><b>Note:</b> Call us at 877-835-9861 as soon as your Plan physician prescribes this equipment. You must notify us before obtaining any single item that costs more than \$1,000 or your benefits will be reduced by \$100 per occurrence. 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. We provide benefits only for a single purchase (including repair/ replacement) of durable medical equipment once every three years. We will decide if the equipment should be purchased or rented.</p>	<p>In-Network: 10% of eligible expenses Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

*Durable medical equipment - continued on next page*

Benefit Description	You pay After the calendar year member responsibility...
<b>Durable medical equipment (cont.)</b>	
<p>Not covered:</p> <ul style="list-style-type: none"> <li>• Motorized wheelchairs and other power-operated vehicles</li> <li>• Duplicate or backup equipment</li> <li>• Parts and labor costs for supplies and accessories replaced due to wear and tear such as wheelchair tires and tubes</li> <li>• Educational, vocational, or environmental equipment</li> <li>• Deluxe or upgraded equipment and supplies</li> <li>• Home or vehicle modifications, seat lifts</li> <li>• Activities of daily living aids (such as grab bars and utensil holders)</li> <li>• Paraffin baths, whirlpools, and cold therapy</li> <li>• Infertility monitors</li> <li>• Physical fitness equipment</li> <li>• Orthotic devices</li> <li>• Personal comfort items</li> <li>• Air conditioners, air purifiers and filters</li> <li>• Batteries and battery chargers</li> <li>• Dehumidifiers and humidifiers</li> </ul>	<p><i>All Charges.</i></p>
<b>Home health services</b>	
<ul style="list-style-type: none"> <li>• 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</li> <li>• Services include oxygen therapy, intravenous therapy and medications</li> </ul> <p><b>Note:</b> Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Prescription foods covered as follows:</p> <ul style="list-style-type: none"> <li>• Amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases which are prescribed for the therapeutic treatment of inherited metabolic diseases and are administered under the direction of a Physician</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

*Home health services - continued on next page*

Benefit Description	You pay After the calendar year member responsibility...
<b>Home health services (cont.)</b>	
<ul style="list-style-type: none"> <li>• Specialized formulas for the treatment of a disease or condition and are administered under the direction of a Physician</li> <li>• Medical foods which are determined to be the sole source of nutrition and that cannot be obtained without a physician’s prescription</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Nursing care requested by, or for the convenience of, the patient or the patient’s family</li> <li>• Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</li> <li>• Services for primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication</li> </ul>	<p><i>All Charges.</i></p>
<b>Chiropractic</b>	
<p>Diagnosis and related services for the manipulation of the spine and extremities to remove nerve interference or its effects. Limited to one treatment per day up to 24 visits per calendar year.</p> <p><b>Note:</b> The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<b>Alternative treatments</b>	
<p>Acupuncture – by a doctor of medicine or osteopathy for anesthesia, pain relief when:</p> <ul style="list-style-type: none"> <li>• Another method of pain management has failed, and</li> <li>• The service is performed in the provider’s office</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Naturopathic services</li> <li>• Hypnotherapy</li> <li>• Biofeedback</li> <li>• Acupressure</li> <li>• Aroma therapy</li> <li>• Massage therapy</li> <li>• Rolfing</li> </ul>	<p><i>All Charges.</i></p>

Benefit Description	You pay After the calendar year member responsibility...
<b>Educational classes and programs</b>	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> <li>• Diabetes self management for the treatment of insulin-dependent diabetes, insulin using diabetes, gestational diabetes and non-insulin-using diabetes. The training must be prescribed by a licensed health care professional who has appropriate state licensing authority.</li> <li>• Smoking cessation</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

**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.
- Your annual HRA (personal medical fund) of \$1,250 for Self Only enrollment and \$2,500 for Self and Family enrollment must be used first for eligible health care expenses. Please see page 18 for information regarding how your HRA is prorated if you elect this Plan outside of open season.
- Your deductible is \$2,000 for Self Only enrollment and \$4,000 for Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin. Your deductible is reduced by your HRA. This reduced amount is referred to as your member responsibility. Please see page 18 for information regarding how your deductible is prorated if you elect this Plan outside of open season.
- Your member responsibility is \$750 for Self Only enrollment and \$1,500 for Self and Family enrollment. The family member responsibility can be satisfied by one or more family members. The member responsibility applies to almost all benefits under Traditional medical coverage. You must pay your member responsibility before your Traditional medical coverage may begin. The member responsibility can be reduced by excess dollars in your HRA (personal medical fund) as a result of prior year roll-overs. Please see page 19 for information regarding how your member responsibility is prorated if you elect this Plan outside of open season.
- 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.).
- 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 member responsibility...
<b>Surgical procedures</b>	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care by the surgeon</li> <li>• Correction of amblyopia and strabismus</li> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies</li> <li>• Surgical treatment of morbid obesity (bariatric surgery)</li> </ul> <p>- Eligible members must be age 22 or over; and</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

*Surgical procedures - continued on next page*

Benefit Description	You pay After the calendar year member responsibility...
<b>Surgical procedures (cont.)</b>	
<ul style="list-style-type: none"> <li>- have a minimum Body Mass Index (BMI) of 40 or 35 (with at least 2 co-morbid conditions present), and</li> <li>- you must have completed a 6-month Plan physician supervised weight loss program; and</li> <li>- you must complete a pre-surgical psychological evaluation</li> </ul> <p>Individuals must weight 100 pounds or 100% over his or her normal weight according to current underwriting conditions.</p> <ul style="list-style-type: none"> <li>• Insertion of internal prosthetic devices . See 5(a) Orthopedic and prosthetic devices for device coverage information</li> <li>• Voluntary sterilization (e.g., tubal ligation, vasectomy)</li> <li>• Treatment of burns</li> </ul> <p><b>Note:</b> Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Routine treatment of conditions of the foot; see Foot care</i></li> </ul>	<p><i>All Charges.</i></p>
<b>Reconstructive surgery</b>	
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> <li>- the condition produced a major effect on the member’s appearance and</li> <li>- the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• 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.</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> <li>- surgery to produce a symmetrical appearance of breasts;</li> <li>- treatment of any physical complications, such as lymphedemas;</li> </ul> </li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Benefit Description	You pay After the calendar year member responsibility...
<b>Reconstructive surgery (cont.)</b>	
<p>- breast prostheses and surgical bras and replacements (see Prosthetic devices)</p> <p><b>Note:</b> If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p> <ul style="list-style-type: none"> <li>• Removal of breast implants implanted on or before July 1, 1994, without regard to the purpose of such implantation, which removal is determined to be medically necessary by the Physician.</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i></li> <li>• <i>Surgeries related to sex transformation</i></li> </ul>	<p><i>All Charges.</i></p>
<b>Oral and maxillofacial surgery</b>	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones</li> <li>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion</li> <li>• Removal of stones from salivary ducts</li> <li>• Excision of leukoplakia or malignancies</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> </ul>	<p><i>All Charges.</i></p>
<b>Organ/tissue transplants</b>	
<p>Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to <i>Other services</i> 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.</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

*Organ/tissue transplants - continued on next page*

Benefit Description	You pay After the calendar year member responsibility...
<b>Organ/tissue transplants (cont.)</b>	
<ul style="list-style-type: none"> <li>• Single, double or lobar lung</li> <li>• Kidney</li> <li>• Liver</li> <li>• Pancreas</li> <li>• Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis</li> <li>• Intestinal transplants               <ul style="list-style-type: none"> <li>- Small intestine</li> <li>- Small intestine with the liver</li> <li>- Small intestine with multiple organs such as the liver, stomach, and pancreas</li> </ul> </li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses:</p> <ul style="list-style-type: none"> <li>• Allogeneic transplants for:               <ul style="list-style-type: none"> <li>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia</li> <li>- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)</li> <li>- Advanced Hodgkin’s lymphoma</li> <li>- Advanced non-Hodgkin’s lymphoma</li> <li>- Chronic myelogenous leukemia</li> <li>- Hemoglobinopathy (i.e. Fanconi's Thalesmia major)</li> <li>- Myelodysplasia/Myelodysplastic syndromes</li> <li>- Severe combined immunodeficiency</li> <li>- Severe or very severe aplastic anemia</li> <li>- Amyloidosis</li> </ul> </li> <li>• Autologous transplant for:               <ul style="list-style-type: none"> <li>- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia</li> <li>- Advanced Hodgkin’s lymphoma</li> <li>- Advanced non-Hodgkin’s lymphoma</li> <li>- Neuroblastoma</li> <li>- Amyloidosis</li> </ul> </li> <li>• Autologous tandem transplants for               <ul style="list-style-type: none"> <li>- Recurrent germ cell tumors (including testicular cancer)</li> <li>- Multiple myeloma</li> <li>- De-novo myeloma</li> </ul> </li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

*Organ/tissue transplants - continued on next page*

Benefit Description	You pay After the calendar year member responsibility...
<b>Organ/tissue transplants (cont.)</b>	
<p>Blood or marrow stem cell transplants for:</p> <ul style="list-style-type: none"> <li>• Allogeneic transplants for:               <ul style="list-style-type: none"> <li>- Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott- Aldrich syndrome)</li> <li>- Advanced neuroblastoma</li> <li>- Infantile malignant osteoporosis</li> <li>- Kostmann’s syndrome</li> <li>- Leukocyte adhesion deficiencies</li> <li>- Mucopolipidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy)</li> <li>- Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome variants)</li> <li>- Myeloproliferative disorders</li> <li>- Sickle cell anemia</li> <li>- X-linked lymphoproliferative syndrome</li> </ul> </li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<ul style="list-style-type: none"> <li>• Autologous transplants for               <ul style="list-style-type: none"> <li>- Multiple myeloma</li> <li>- Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors</li> <li>- Breast cancer</li> <li>- Epithelial ovarian cancer</li> <li>- Ependymoblastoma</li> <li>- Ewing’s sarcoma</li> <li>- Medulloblastoma</li> <li>- Pineoblastoma</li> <li>- Waldenstrom's macroglobulinemia</li> </ul> </li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Mini-transplants (non-myeloblastic, reduced intensity conditioning) for covered transplants: Subject to medical necessity</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Tandem transplants for covered transplants: Subject to medical necessity</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols for:</p> <ul style="list-style-type: none"> <li>• Allogeneic transplants for:               <ul style="list-style-type: none"> <li>- Chronic lymphocytic leukemia</li> </ul> </li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

*Organ/tissue transplants - continued on next page*

Benefit Description	You pay After the calendar year member responsibility...
<b>Organ/tissue transplants (cont.)</b>	
<ul style="list-style-type: none"> <li>- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)</li> <li>- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma</li> <li>- Myelodysplasia/Myelodysplastic syndromes</li> <li>- Multiple myeloma</li> <li>- Multiple sclerosis</li>   <li>• Nonmyeloablative allogeneic transplants for:               <ul style="list-style-type: none"> <li>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia</li> <li>- Myelodysplasia/Myelodysplastic syndromes</li> <li>- Advanced Hodgkin’s lymphoma</li> <li>- Advanced non-Hodgkin’s lymphoma</li> <li>- Breast cancer</li> <li>- Chronic lymphocytic leukemia</li> <li>- Chronic myelogenous leukemia</li> <li>- Colon cancer</li> <li>- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma</li> <li>- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)</li> <li>- Multiple myeloma</li> <li>- Multiple sclerosis</li> <li>- Myeloproliferative disorders</li> <li>- Non-small cell lung cancer</li> <li>- Ovarian cancer</li> <li>- Prostate cancer</li> <li>- Renal cell carcinoma</li> <li>- Sarcomas</li> </ul> </li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<ul style="list-style-type: none"> <li>• Autologous transplants for:               <ul style="list-style-type: none"> <li>- Chronic lymphocytic leukemia</li> <li>- Chronic myelogenous leukemia</li> <li>- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma</li> <li>- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)</li> <li>- Small cell lung cancer</li> <li>- Multiple sclerosis</li> <li>- Systemic lupus erythematosus</li> <li>- Systemic sclerosis</li> </ul> </li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

*Organ/tissue transplants - continued on next page*

Benefit Description	You pay After the calendar year member responsibility...
<b>Organ/tissue transplants (cont.)</b>	
<p>National Transplant Program (NTP) – OptumHealth Care Solutions is used for organ tissue transplants</p> <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p><b>Note:</b> We cover related medical and hospital expenses of the donor when we cover the recipient. If you do not pre-authorize the service, benefits will be reduced by \$100 per occurrence.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i></li> <li>• <i>Implants of artificial organs</i></li> <li>• <i>Transplants not listed as covered</i></li> <li>• <i>All services related to non-covered transplants</i></li> <li>• <i>All services associated with complications resulting from the removal of an organ from a non- member</i></li> </ul>	<p><i>All Charges.</i></p>

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

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your annual HRA (personal medical fund) of \$1,250 for Self Only enrollment and \$2,500 for Self and Family enrollment must be used first for eligible health care expenses. Please see page 18 for information regarding how your HRA is prorated if you elect this Plan outside of open season.
- Your deductible is \$2,000 for Self Only enrollment and \$4,000 for Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin. Your deductible is reduced by your HRA. This reduced amount is referred to as your member responsibility. Please see page 18 for information regarding how your deductible is prorated if you elect this Plan outside of open season.
- Your member responsibility is \$750 for Self Only enrollment and \$1,500 for Self and Family enrollment. The family member responsibility can be satisfied by one or more family members. The member responsibility applies to almost all benefits under Traditional medical coverage. You must pay your member responsibility before your Traditional medical coverage may begin. The member responsibility can be reduced by excess dollars in your HRA (personal medical fund) as a result of prior year roll-overs. Please see page 19 for information regarding how your member responsibility is prorated if you elect this Plan outside of open season.
- 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 the facility (i.e. hospital, surgical center, etc.) or ambulance services for your surgery or care. Any cost associated with the professional charge (i.e. physicians, etc.) are Sections 5(a) or (b).
- 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 member responsibility...
<b>Inpatient hospital</b>	
Room and board, such as <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations</li> <li>• General nursing care</li> <li>• Meals and special diets</li> </ul>	In-Network: 10% of eligible expenses  Out-of-network: 40% 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 member responsibility...
<b>Inpatient hospital (cont.)</b>	
<p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. We will pay benefits for an inpatient stay of at least 48 hours following a mastectomy or lymph node dissections. If your hospital stay is elective, please notify us within five business days prior to your admission. For non- elective admissions, please notify us within one business day or the same day of admission. For emergency admissions, please notify us within one business day, the same day of admission, or as soon as it is reasonably possible. If you fail to notify us in a timely manner, your benefits will be reduced by \$100 per occurrence.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests and X-rays</li> <li>• Blood or blood plasma, if not donated or replaced</li> <li>• Dressings, splints, casts, and sterile tray services</li> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics, including nurse anesthetist services</li> <li>• Take-home items</li> <li>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Custodial care</i></li> <li>• <i>Non-covered facilities, such as nursing homes, schools</i></li> <li>• <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i></li> <li>• <i>Private nursing care</i></li> </ul>	<p><i>All Charges.</i></p>
<b>Outpatient hospital or ambulatory surgical center</b>	
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

*Outpatient hospital or ambulatory surgical center - continued on next page*

Benefit Description	You pay After the calendar year member responsibility...
<b>Outpatient hospital or ambulatory surgical center (cont.)</b>	
<ul style="list-style-type: none"> <li>• Pre-surgical testing</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> </ul> <p><b>Note:</b> We cover hospital services and supplies related to dental procedures when necessitated by a non- dental physical impairment. We do not cover the dental procedures.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All Charges.</i>
<b>Extended care benefits/Skilled nursing care facility benefits</b>	
<ul style="list-style-type: none"> <li>• Room and board in a semi-private room</li> <li>• General nursing</li> <li>• Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when ordered by a Physician and delivered or supervised by a licensed technical or professional medical personnel in order to obtain the specific medical outcome, and provide for the safety of the patient</li> <li>• Benefits up to 60 days when full time skilled nursing care is necessary and confinement is medically appropriate</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<i>Not covered: Custodial care</i>	<i>All Charges.</i>
<b>Hospice care</b>	
<ul style="list-style-type: none"> <li>• Inpatient care</li> <li>• Outpatient care</li> <li>• Family counseling</li> <li>• Supportive and palliative care for a terminally ill member is covered in the home or hospice facility</li> </ul> <p><b>Note:</b> These services must be provided by a licensed hospice agency.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<i>Not covered: Independent nursing, homemaker services</i>	<i>All Charges.</i>

Benefit Description	You pay After the calendar year member responsibility...
<b>Ambulance</b>	
Local professional ambulance service when medically appropriate	In-Network: 10% of eligible expenses  Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

## 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.
- Your annual HRA (personal medical fund) of \$1,250 for Self Only enrollment and \$2,500 for Self and Family enrollment must be used first for eligible health care expenses. Please see page 18 for information regarding how your HRA is prorated if you elect this Plan outside of open season.
- Your deductible is \$2,000 for Self Only enrollment and \$4,000 for Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin. Your deductible is reduced by your HRA. This reduced amount is referred to as your member responsibility. Please see page 18 for information regarding how your deductible is prorated if you elect this Plan outside of open season.
- Your member responsibility is \$750 for Self Only enrollment and \$1,500 for Self and Family enrollment. The family member responsibility can be satisfied by one or more family members. The member responsibility applies to almost all benefits under Traditional medical coverage. You must pay your member responsibility before your Traditional medical coverage may begin. The member responsibility can be reduced by excess dollars in your HRA (personal medical fund) as a result of prior year roll-overs. Please see page 19 for information regarding how your member responsibility is prorated if you elect this Plan outside of open season.
- 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.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.

### What is a medical emergency?

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

### What to do in case of emergency:

#### Emergencies within or outside our service area:

If you are in an emergency situation, please call your doctor. In extreme emergencies, if you are unable to contact your doctor, contact your local emergency system (e.g. 911 telephone system) or go to the nearest hospital emergency room. You or a family member must notify the Plan within 48 hours or as soon as possible after you receive outpatient emergency room.

If you need to be hospitalized, the Plan must be notified within 24 hours, the same day of admission, unless it was not reasonably possible to notify the Plan within that time. If you do not notify us, benefits will be reduced by \$100 per occurrence. Benefits will not be reduced for the outpatient emergency room visit.

Benefit Description	You pay After the calendar year member responsibility...
<b>Emergency within or outside our service area</b>	
<ul style="list-style-type: none"> <li>• Emergency care at a doctor’s office</li> <li>• Emergency care at an urgent care center</li> <li>• Emergency care as an outpatient in a hospital, including doctors’ services</li> </ul> <p>Note: We waive the ER copay if you are admitted to the hospital</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</i></li> <li>• <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></li> <li>• <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i></li> </ul>	<p><i>All Charges.</i></p>
<b>Ambulance</b>	
<p>Professional ambulance services when medically appropriate</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Air ambulance</i></p>	<p><i>All Charges.</i></p>

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

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

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your annual HRA (personal medical fund) of \$1,250 for Self Only enrollment and \$2,500 for Self and Family enrollment must be used first for eligible health care expenses. Please see page 18 for information regarding how your HRA is prorated if you elect this Plan outside of open season.
- Your deductible is \$2,000 for Self Only enrollment and \$4,000 for Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin. Your deductible is reduced by your HRA. This reduced amount is referred to as your member responsibility. Please see page 18 for information regarding how your deductible is prorated if you elect this Plan outside of open season.
- The member responsibility \$750 for Self Only enrollment and \$1,500 for Self and Family enrollment. The family member responsibility can be satisfied by one or more family members. The member responsibility applies to almost all benefits under Traditional medical coverage. You must pay your member responsibility before your Traditional medical coverage may begin. The member responsibility can be reduced by excess dollars in your HRA (personal medical fund) as a result of prior year roll-overs. Please see page 19 for information regarding how your member responsibility is prorated if you elect this Plan outside of open season.
- 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.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year member responsibility...
<b>Mental health and substance abuse benefits</b>	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than the cost sharing for other illnesses or conditions</p>
<ul style="list-style-type: none"> <li>• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</li> <li>• Medication management</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<ul style="list-style-type: none"> <li>• Diagnostic tests</li> </ul>	<p>In-Network: 10% of eligible expenses</p>

*Mental health and substance abuse benefits - continued on next page*

Benefit Description	You pay After the calendar year member responsibility...
<b>Mental health and substance abuse benefits (cont.)</b>	
	Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
<ul style="list-style-type: none"> <li>• Services provided by a hospital or other facility</li> <li>• Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All Charges.</i>

Preauthorization                      To be eligible to receive these benefits you must contact the Plan at 1-800-558-7868 for preauthorization of all mental health and substance abuse benefits.

Limitation                                If you do not notify us, we will reduce your benefits by \$100 per occurrence.

## Section 5(f). Prescription drug benefits

### Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page. Some injectible medications are provided by your medical benefit. Please see below for more information.
- 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.
- Your annual HRA (personal medical fund) of \$1,250 for Self Only enrollment and \$2,500 for Self and Family enrollment must be used first for eligible health care expenses. Please see page 18 for information regarding how your HRA is prorated if you elect this Plan outside of open season.
- Your deductible is \$2,000 for Self Only enrollment and \$4,000 for Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin. Your deductible is reduced by your HRA. This reduced amount is referred to as your member responsibility. Please see page 18 for information regarding how your deductible is prorated if you elect this Plan outside of open season.
- Your member responsibility is \$750 for Self Only enrollment and \$1,500 for Self and Family enrollment. The family member responsibility can be satisfied by one or more family members. The member responsibility applies to almost all benefits under Traditional medical coverage. You must pay your member responsibility before your Traditional medical coverage may begin. The member responsibility can be reduced by excess dollars in your HRA (personal medical fund) as a result of prior year roll-overs. Please see page 19 for information regarding how your member responsibility is prorated if you elect this Plan outside of open season.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Some prescription medications have Quantity Level Limits (QLL) and Quantity per Duration Limits (QD). Please see below for more information.
- Certain medications require your health care provider to request approval from us in order for these to be payable under the Pharmacy Plan. The Pharmacy Plan requires approval for these prescription medications to make sure that they are being prescribed and used according to the Food and Drug Administration (FDA)-approved indications and dosing schedules and meet the definition of a covered service. If your pharmacist tells you that your prescription medication requires approval, ask your pharmacist or physician to contact the Plan at the number on your Member ID card for further instructions.
- 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 health care provider licensed to write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy. You may fill prescriptions for maintenance medications either by mail or at a retail pharmacy. Maintenance medications are those medications anticipated to be required for six months or longer to treat a chronic condition such as high blood pressure, asthma, or diabetes. To locate the name of a Plan pharmacy near you, refer to your Directory of Health Care Professionals, call our Customer Service Department 1-877-835-9861, or visit our website, [www.uhcfeds.com](http://www.uhcfeds.com).

- **We use a Prescription Drug List (PDL).** Our PDL Management Committee creates a list that includes FDA approved prescription medications, products, or devices. Our Plan covers all prescription medications written in accordance with FDA guidelines for a particular therapeutic indication except for prescription medications or classes of medications listed under “Not Covered” in this section of the brochure. The PDL Management Committee decides the tier placement upon clinical information from the UnitedHealthcare Pharmacy and Therapeutics (P&T) Committee as well economic and financial considerations. You will find important information about our Prescription Drug List as well as other Plan information on our web site, [www.uhcfeds.com](http://www.uhcfeds.com). The PDL consists of Tiers 1, 2, and 3.

- **Tier 1** is your **lowest** copayment option (\$10 for up to a 31-day supply or \$25 for up to a 90-day supply through our mail order program) and includes all generic medications, as well as select preferred brand medications. Brand medications in Tier 1 include select insulin products, select inhalers for asthma, and select medications for migraine headaches for which no generic alternative(s) are available. For the lowest out-of-pocket expense, you should always consider Tier 1 medications if you and your provider decide they are appropriate for your treatment.

- **Tier 2** is your **middle** copayment option (\$25 for up to a 31-day supply or \$62.50 for up to a 90-day supply through our mail order program ) and contains all preferred brand medications not included in Tier 1. Preferred medications placed in Tiers 1 and 2 are those the PDL Management Committee has determined to provide better overall value than those in Tier 3. If you are currently taking a medication in Tier 2, ask your provider whether there are Tier 1 alternatives that may be appropriate for your treatment.

- **Tier 3** is your **highest** copayment option (\$40 for up to a 31-day supply or \$100 for up to a 90-day supply through our mail order program) and consists of only non-preferred brand medications. Sometimes there are alternatives available in Tier 1 or Tier 2. If you are currently taking a medication in Tier 3, ask your provider whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment.

Changes to the Tier level for all covered medications and supplies may be updated to be effective January 1 of each year. If new generic medications come to market throughout the Plan year they will be placed on Tier 1. Newly marketed brand medications will be evaluated by our PDL Management Committee and they will be placed in the appropriate Tier. A prescription medication may be removed from the PDL at anytime if the medication changes to over-the-counter status, or due to safety concerns declared by the Food and Drug Administration (FDA).

In rare cases, you will pay the full copayment amount for a medication when the actual cost of that medication is less than the discounted ingredient cost of the drug. This means if the medication you have filled costs \$6, you may have to pay the full copayment of \$10 if it is a Tier 1 medication. You will never pay more than the appropriate copayment for a medication. Contact our Member Services Department at 877-835-9861 with questions.

#### **These are the dispensing limitations.**

- **Non-maintenance medications** - Non-maintenance medications are drugs a member requires for less than (6) months to treat a short-term medical condition. You may obtain up to a maximum of a consecutive 31-day supply for a prescription per copayment at a Plan Retail pharmacy. You will pay **\$10** for Tier 1, **\$25** for Tier 2, and **\$40** for Tier 3 medications. You may refill once you have used 75% of the day supply of the prescription medication. For example, a prescription that was filled for a 31-day supply can be refilled after 24 days. While this process provides advancement on your next prescription refill, we cannot dispense more than the total quantity your prescription allows.
- **Maintenance medications** - Maintenance medications are drugs a member requires for six (6) months or more to treat a chronic condition. You may obtain up to a consecutive 90-day supply of maintenance medications as written by your provider, subject to QLL and QD limitations. The listing of the prescription medication classes which are considered maintenance medications by the Plan are available at [www.uhcfeds.com](http://www.uhcfeds.com). You may purchase maintenance medications through retail pharmacy or mail order. If you purchase a maintenance medication through a retail pharmacy, you will pay the applicable Tier copayment for each 30-day supply of medication for up to a maximum of a 90-day supply. For example, a Tier 1 prescription medication filled as a maintenance medication for a 90-day supply would have a copayment of **\$30**, Tier 2 would be **\$75** and Tier 3 would be **\$120**. If you purchase a maintenance medication through the mail order program, you will only be responsible for 2.5 copays for up to a 90-day supply. For example, a Tier 1 prescription medication filled as a maintenance medication for a 90-day supply would have a copayment of **\$25**, Tier 2 would be **\$62.50** and Tier 3 would be **\$100**.
- **Day Supply**-“Day supply” means consecutive days within the period of prescription. Where a prescription regimen includes “on and off days” when the medication is taken, the off days are included in the count of the day supply.

- **Injectable medications:** Medications typically covered under the pharmacy benefit and received through a retail or mail order pharmacy are those that are self-administered by you or a non-skilled caregiver. However, some prescription medications, those that are typically administered by a health care professional, are covered under your Medical benefit and need to be accessed through your provider or Specialty pharmacy. Contact the Health Plan at 877-835-9861 for more information on these medications.

**Special dispensing circumstances.** The Plan will give special consideration for filling prescription medications for members covered under the FEHB if:

- You are called to active duty, or
- You are officially called off-site as a result of a national or other emergency, or
- You are going to be on vacation for an extended period of time.

Your physician may need to request prior authorization from us in order to fill a prescription for the reasons listed above. Please contact us on 1-877-835-9861 for additional information.

- **Quantity Duration (QD):** Some medications have a limited amount that can be covered for a specific period of time.
- **Quantity Level Limits (QLL) :** Some medications have a limited amount that can be covered at one time.

Changes to quantity duration and quantity level limits may occur on January 1 each year. We base these processes upon the manufacturer's package size, FDA-approved dosing guidelines as defined in the product package insert and/or the medical literature or guidelines that support the use of doses other than the FDA-recommended dosage. If your prescription written by your provider exceeds the allowed quantity, please refer to Section 7, to file an appeal with the Plan.

- **Refill Frequency** - A process that allows you to receive a refill once when you have used 75 percent of the medications. For example, a prescription that was filled for a 31-day supply can be refilled after 24 days. While this process provides advancement on your next prescription refill, we cannot dispense more than the total quantity your prescription allows.

- **Half Tablet Program.** With certain medications, you may elect to join the voluntary Half Tablet Program. This Program allows you to save money in copayments by electing a double strength medication, receiving half the quantity, and splitting the tablet in half. If you take advantage of this Program, you will pay half a copayment at a retail pharmacy or through mail order. Your provider must write the prescription for the increased dosage, with the instructions to "take a half tablet". A free tablet splitter is provided. For more information on this Program please visit our Frequently Asked Questions at [www.halftablet.com](http://www.halftablet.com) or call 1-877-471-1860.

- **Specialty Pharmacy Program.** Our Specialty Pharmacy Program includes high cost medications for rare, unusual or complex diseases. Members may choose to obtain these medications through one of our designated specialty pharmacy. You will pay the applicable Tier copay for your specialty medications and receive up to a maximum of a consecutive 31-day supply of your prescription medication. Although you may continue to receive your specialty medications through a retail pharmacy, our specialty pharmacy providers will give you superior assistance and support to you during your treatment. This Program may offer the following benefits to members:

- Expertise in storing, handling and distributing these unique medications
- Access to products and services that are not available through a traditional retail pharmacy
- Access to nurses and pharmacists with expertise in complex and high cost diseases
- Educational materials as well as support and development of a necessary care plan
- Free supplies such as syringes and needles

For more information on this voluntary Specialty Pharmacy Program, please call 1-866-429-8177, 24 hours a day, seven days a week.

- **Why use Tier 1 drugs?** Medications in Tier 1 offer the best health care value and are available at the lowest copayment. Tier 2 medications are available at a higher copayment and Tier 3 medications are available at the highest copayment level. This approach helps to assure access to a wide range of medications and control health care costs for you.

Benefit Description	You pay After the calendar year member responsibility...
<b>Covered medications and supplies</b>	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> <li>• 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</li> <li>• Insulin, with a copayment charge applied every 2 vials</li> <li>• Disposable needles and syringes for the administration of covered medications</li> <li>• Drugs for sexual dysfunction</li> <li>• Oral and injectable contraceptive drugs</li> <li>• Oral fertility drug (Clomid)</li> <li>• Compound drugs that contain at least one ingredient that requires a prescription</li> </ul> <p><b>Note:</b> Intravenous fluids and medications for home use, implantable drugs, and some injectable drugs are covered under Section (5a) <i>Medical services and supplies</i> or Section (5b) <i>Surgical and anesthesia services</i>.</p>	<p>Network/non-network retail pharmacy for up to a maximum of a 31-day supply:</p> <p>Tier 1- \$ 10</p> <p>Tier 2- \$ 25</p> <p>Tier 3- \$ 40</p> <p>Plan mail order pharmacy for up to a maximum of a 90-day supply:</p> <p>Tier 1- \$ 25</p> <p>Tier 2- \$ 62.50</p> <p>Tier 3- \$ 100</p>
<ul style="list-style-type: none"> <li>• Diabetic supplies limited to insulin syringes, needles, glucose test tape, Benedict’s solution or equivalents and acetone test tablets.</li> <li>• Implanted contraceptive drugs and devices such as Norplant</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Medications used for cosmetic purposes</i></li> <li>• <i>Any product dispensed for the purpose of appetite suppression and other weight loss products</i></li> <li>• <i>Drugs to enhance athletic performance</i></li> <li>• <i>Medical supplies such as dressings and antiseptics</i></li> <li>• <i>Artificial insemination fertility drugs except Clomid (clomiphene)</i></li> <li>• <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i></li> <li>• <i>Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed</i></li> <li>• <i>Vitamins, nutrients and food supplements that can be purchased without a prescription</i></li> </ul>	<p><i>All Charges.</i></p>

*Covered medications and supplies - continued on next page*

Benefit Description	You pay After the calendar year member responsibility...
<b>Covered medications and supplies (cont.)</b>	
<ul style="list-style-type: none"> <li>• <i>Nonprescription medicines or drugs available over-the-counter that do not require a prescription order by federal or state law before being dispensed, and any drug that is therapeutically equivalent to an over-the-counter</i></li> <li>• <i>Compound drugs that do not contain at least one covered ingredient that requires a Prescription Order or Refill</i></li> <li>• <i>Alcohol swabs and bio-hazard disposable containers</i></li> </ul>	<p><i>All Charges.</i></p>

**Section 5(g). Dental benefits**

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in the 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*.
- Your annual HRA (personal medical fund) of \$1,250 for Self Only enrollment and \$2,500 for Self and Family enrollment must be used first for eligible health care expenses. Please see page 18 for information regarding how your HRA is prorated if you elect this Plan outside of open season.
- Your deductible is \$2,000 for Self Only enrollment and \$4,000 for Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin. Your deductible is reduced by your HRA. This reduced amount is referred to as your member responsibility. Please see page 18 for information regarding how your deductible is prorated if you elect this Plan outside of open season.
- Your member responsibility is \$750 for Self Only enrollment and \$1,500 for Self and Family enrollment. The family member responsibility can be satisfied by one or more family members. The member responsibility applies to almost all benefits under Traditional medical coverage. You must pay your member responsibility before your Traditional medical coverage may begin. The member responsibility can be reduced by excess dollars in your HRA (personal medical fund) as a result of prior year roll-overs. Please see page 19 for information regarding how your member responsibility is prorated if you elect this Plan outside of open season.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or 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 describe below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year member responsibility...
<b>Accidental injury benefit</b>	
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.	In-Network: 10% of eligible expenses  Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
<b>Dental benefits</b>	
Please refer to page XX for a description of our non-FEHB dental benefits	

**Section 5(h). Special features**

Feature	Description
<p><b>Flexible benefits option</b></p>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> <li>• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue.</li> <li>• Alternative benefits will be made available for a limited period and are subject to our ongoing review. You must cooperate with the review process.</li> <li>• By approving an alternative benefit, we cannot guarantee you will get it in the future.</li> <li>• The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits.</li> <li>• If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request.</li> <li>• Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</li> </ul>
<p><b>Care24</b></p>	<p>For any of your health concerns you may call 1-888-887-4114, 24 hours a day, seven days a week and talk with a registered nurse with an average of 15 years of experience who will discuss treatment options and answer your health questions. Members may learn self-care for minor illnesses and injuries; understand diagnosed conditions; manage chronic diseases; discover and evaluate possible benefits and risks of various treatment options; learn about specific medications; prepare questions for doctor visits; develop and maintain healthful living habits; and connect with community support groups.</p>
<p><b>Transplant Centers of Excellence</b></p>	<p>OptumHealth Care Solutions provides you access to one of the nation’s leading transplant networks, managing more than 10,000 referrals each year. Centers of Excellence are selected through a process of quality measurement and cover all phases of patient health care from evaluation, pre-transplant, transplant, post-transplant and 12-month follow-up health care. Contact OptumHealth Care Solutions at 1-888-936-7246 to discuss information about transplants and physicians.</p>
<p><b>Cancer Resource Services</b></p>	<p>Cancer is one of the most prevalent conditions in medicine. Cancer Resource Services (CRS) provides unparalleled clinical and economic value in managing complex cancers - providing patients with access to expertise at leading cancer centers throughout the country. Call 1-866-936-6002 to discuss information about cancer centers and physicians.</p>

*Feature - continued on next page*

Feature	Description
<b>Feature (cont.)</b>	
<b>Healthy Pregnancy Program</b>	<p>With our Healthy Pregnancy Program, UnitedHealthcare enrollees receive personal support through all stages of pregnancy and delivery. Some features of the program include a pregnancy assessment to identify special needs, identification of pregnancy risk factors, a 24-hour toll-free phone number to experienced nurses and customized maternity educational materials. To enroll in the Healthy Pregnancy Program, simply call toll-free at 1-800-411-7984; or visit <a href="http://www.healthy-pregnancy.com">www.healthy-pregnancy.com</a>.</p>
<b>ParentSteps</b>	<p>ParentSteps Infertility Centers of Excellence Network provides access to some of the best infertility clinics in the country. These clinics have high pregnancy rates AND low incidence of multiple births. ParentSteps offers the ability to purchase treatment cycles and infertility medications at group discount prices. ParentSteps also provides infertility nurse specialists who can educate you on your diagnosis and treatment options. For more information, please visit ParentSteps at <a href="http://www.urnparentsteps.com">www.urnparentsteps.com</a> or call 1-866-774-4626.</p>
<b>Congenital Heart Disease Research Services (CHDRS)</b>	<p>Members can access the Congenital Heart Disease Centers of Excellence Network, providing care that is planned, coordinated and provided by a team of experts who specialize in treating Congenital Heart Disease. Potential benefits include accurate diagnosis, appropriate surgical interventions, higher survival rates and decreased costs. Participation is voluntary. Contact CHD Resource Services at 1-888-936-7246 before receiving care. More information is also available at <a href="http://www.urnweb.com">www.urnweb.com</a>.</p>
<b>Kidney Resource Services (KRS)</b>	<p>Kidney Resource Services provides access to top-performing dialysis centers and nurse consulting services to support the management of kidney diseases. Kidney transplantation candidates have access to the Transplant Centers of Excellence Network and Transplant Resources Services nurse consulting services. Please call a KRS nurse at 1-888-936-7246 for all inquiries and prior authorizations related to End Stage Renal Disease, including dialysis or vascular access for dialysis. Information is also available at <a href="http://www.urnweb.com">www.urnweb.com</a>.</p>
<b>Bariatric Resource Services (BRS)</b>	<p>Bariatric Resource Services (BRS) is a surgical weight loss solution for those individual(s) who qualify clinically for bariatric surgery. Specialized nurses provide support through all stages of the weight loss surgery process. Our program is dedicated to providing support both before and after surgery. Nurses help with decision support in preparation for surgery, information and education important in the selection of a bariatric surgery program, and post surgery and lifestyle management. Nurses can provide information on the nation's leading obesity surgery centers, known as Centers of Excellence. Covered participants seeking coverage for bariatric surgery should notify OptumHealth Care Solutions as soon as the possibility of a bariatric surgery procedure arises (and before the time a pre-surgical evaluation is performed) at a bariatric surgery center by calling OptumHealth Care Solutions at 1-888-936-7246 to enroll in the program.</p>
<b>Health and Wellness Education Information</b>	<p>You can find healthy living articles and general information on <a href="http://www.myuhc.com">www.myuhc.com</a>. Health and wellness topics and categories including addiction, family, fitness and nutrition, healthy aging, healthy pregnancy, preventive medicine, relationships and much more.</p>

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- **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 is \$3,000 for an individual and \$5,950 for a family. See maximum contribution information on page 63. 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 OptumHealth Bank
- 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 a HCFSA. Instead, when you inform us of your coverage in a HCFSA, we will establish a HRA for you.

- **Health Reimbursement Account (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 a 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 UnitedHealthcare Insurance Company
- 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 (HCFSAs). However, you must meet FSAFEDS eligibility requirements.

- **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 \$3,000 per person or \$6,000 per family enrollment in-Network and \$6,000 per person or \$12,000 per family enrollment out-of-network. 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.

Connect to [www.uhcfeds.com](http://www.uhcfeds.com) to register for [myuhc.com](http://myuhc.com). On this site you can find health care at your fingertips, 24 hours a day. Keeping track of your benefits and claims, finding ways to save money, and learning more about how to stay healthy are easy at [myuhc.com](http://myuhc.com), your own secure personal member web site.

**Section 5. Savings – HSAs and HRAs**

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Account (HRA): Provided when you are ineligible for an HSA
<b>Administrator</b>	The Plan will establish a HSA for you with OptumHealth Bank, this HDHP’s fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS).	UnitedHealthcare Insurance Company, Inc. is the HRA fiduciary for this Plan.
<b>Fees</b>	<p>When you enroll in our HSA, you will automatically be enrolled in the Health eAccess HSA option. This account does not earn interest, but may be the right choice for you if you would like lower monthly fees and are an active spender. A letter will be mailed to you within approximately 90 days after you have opened your HSA explaining interest bearing options. These options have higher monthly fees. The fees below are the possible charges associated with the Health eAccess HSA option, however, you may incur additional fees beyond your basic monthly maintenance fee:</p> <p>\$4.00 per month administrative fee charged by OptumHealth Bank (if your HSA is below \$100)</p> <p>\$1.00 per month administrative fee charged by OptumHealth Bank (if your HSA is between \$100 - \$499)</p> <p>Fee is waived (if your HSA is \$500 or more)</p> <p>\$1.50 UnitedHealthcare Health Savings Account MasterCard® Debit Card ATM Withdrawal Fee</p> <p>\$10.00 Manual Withdrawal/Distribution Fee</p> <p>\$2.00 Account Closure Fee</p> <p>\$25.00 Overdraft Fee</p> <p>\$10.00 Check Order Fee (book of 25)</p> <p>\$25.00 Merchant Debit Card Receipt-Copy</p> <p>\$5.00 Electronic Funds Transfer-ACH (1<sup>st</sup> one free per year)</p> <p>\$20.00 Electronic Funds Transfer- Wire Transfer</p>	None.

	<p>\$15.00 Stop Payment Fee</p> <p>\$10.00 Monthly Statement-Reprint</p> <p>\$15.00 Insufficient Funds Fee (for deposit made to your HSA)</p> <p>\$20.00 Refund of Excess Contribution Fee</p> <p>\$5.00 Mailing Additional Forms Fee (1<sup>st</sup> one free per year; forms on web site)</p> <p>\$10.00 Research Fee (per hour)</p> <p>As well as other types of fees normally associated with bank checking accounts.</p>	
<p><b>Eligibility</b></p>	<p>You must:</p> <ul style="list-style-type: none"> <li>• Enroll in the UnitedHealthcare Insurance Company, Inc. High Deductible Health Plan (HDHP)</li> <li>• Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage)</li> <li>• Not be enrolled in Medicare</li> <li>• Not be claimed as a dependent on someone else’s tax return</li> <li>• Not have received VA benefits in the last three months</li> <li>• Complete and return all banking paperwork including the initial application to open your HSA with OptumHealth Bank</li> </ul>	<p>You must enroll in the UnitedHealthcare Insurance Company, Inc. High Deductible Health Plan HDHP.</p> <p>Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.</p>
<p><b>Funding</b></p>	<p>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 UnitedHealthcare Insurance Company Inc. High Deductible Health Plan. Note: If you are new to this Plan based on an Open Season change, your first premium pass-through will be made on or about the fourth Thursday in February. This is due to the Government payment cycle.</p> <p>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.).</p>	<p>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.</p>

<ul style="list-style-type: none"> <li>• <b>Self Only enrollment</b></li> </ul>	<p>For 2009, a premium pass through of \$62.50 will be made by the UnitedHealthcare Insurance Company Inc. into your HSA each month.</p>	<p>For 2009, your HRA annual credit is \$750 (prorated for mid-year enrollment).</p>
<ul style="list-style-type: none"> <li>• <b>Self and Family enrollment</b></li> </ul>	<p>For 2009, a monthly premium pass through of \$125 will be made by the UnitedHealthcare Insurance Company, Inc. High Deductible Health Plan directly into your HSA each month.</p>	<p>For 2009, your HRA annual credit is \$1,500 (prorated for mid-year enrollment).</p>
<p><b>Contributions/credits</b></p>	<p>The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed maximum contribution amount set by the IRS of \$3,000 for an individual and \$5,950 for a family.</p> <p>If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution.</p> <p>You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year.</p> <p>If you do not meet the 12 month requirement, the maximum contribution is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.</p> <p>You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP).</p> <p>HSAs earn tax-free interest (does not affect your annual maximum contribution).</p> <p>Catch-up contribution discussed on page 67.</p>	<p>The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.</p>

<ul style="list-style-type: none"> <li>• <b>Self Only enrollment</b></li> </ul>	<p>You may make an annual maximum contribution of \$2,250.</p>	<p>You cannot contribute to the HRA.</p>
<ul style="list-style-type: none"> <li>• <b>Self and Family enrollment</b></li> </ul>	<p>You may make an annual maximum contribution of \$4,450.</p>	<p>You cannot contribute to the HRA.</p>
<p><b>Access funds</b></p>	<p>You can access your HSA by the following methods:</p> <p>UnitedHealthcare Health Savings Account MasterCard® Debit Card must be activated in order to have access to HSA funds</p> <p>On-line bill payment</p> <p>Checks (if you choose to purchase these)</p> <p>ATM Withdrawals</p>	<p>For qualified medical expenses under the UnitedHealthcare Insurance Company Inc. High Deductible Health Plan, you will be automatically reimbursed when claims are submitted through the UnitedHealthcare Insurance Company Inc. High Deductible Health Plan. You may also use your HRA Consumer Account Card when used for qualified transactions with select retailers and in-network providers. For expenses not covered by the UnitedHealthcare Insurance Company Inc. HDHP, such as orthodontia, you will need to submit documentation for reimbursement.</p>
<p><b>Distributions/withdrawals</b></p> <ul style="list-style-type: none"> <li>• <b>Medical</b></li> </ul>	<p>You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the UnitedHealthcare Insurance Company Inc. HDHP) from the funds available in your HSA. You may use the UnitedHealthcare Health Savings Account MasterCard® Debit Card or checks (optional) for all qualified expenses.</p> <p>Medical expenses are not allowable if they occur before the first full month your enrollment is effective, and they are not reimbursable from your HSA until the first of the month following the effective date of your enrollment in this HDHP and the date your HSA account is established.</p> <p>For most new Federal enrollees who enroll in January, the first date medical expenses would be allowable is February 1, 2009.</p> <p>See IRS Publication 502 for a list of eligible medical expenses, including over-the-counter drugs.</p>	<p>You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the UnitedHealthcare Insurance Company Inc. HDHP.</p> <p>Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan.</p> <p>See <i>Availability of funds</i> below for information on when funds are available in the HRA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses. Over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.</p>
<ul style="list-style-type: none"> <li>• <b>Non-medical</b></li> </ul>	<p>If you are under age 65, withdrawal of funds for non-medical expenses will create a 10% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds.</p> <p>When you turn age 65, distributions can be used for any reason without being subject to the 10% penalty, however they will be subject to ordinary income tax.</p>	<p>Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.</p>

<p><b>Availability of funds</b></p>	<p>Funds are not available for withdrawal until all the following steps are completed:</p> <ul style="list-style-type: none"> <li>• Your enrollment in the UnitedHealthcare Insurance Company Inc. High Deductible Health Plan is effective (effective date is determined by your agency in accord with the event permitting the enrollment change).</li> <li>• The UnitedHealthcare Insurance Company Inc. High Deductible Health Plan receives record of your enrollment and provides information to the fiduciary (OptumHealth Bank) to initiate the HSA account set-up.</li> <li>• You must complete and send the application located in your 2009 Summary of Benefits booklet, which is also available on our web site, <a href="http://www.uhcfeds.com">www.uhcfeds.com</a> to OptumHealth Bank. If these materials are not received prior to the receipt of your enrollment by the Plan, the fiduciary (OptumHealth Bank) will send you the <b>mandatory</b> HSA paperwork which includes an HSA Application, HSA Custodial Agreement, Beneficiary Form, Privacy Policy and an HSA Fee Schedule for you to complete.</li> </ul> <p>The fiduciary (OptumHealth Bank) receives the completed paperwork back from you and your HSA is completely established.</p>	<p>The entire amount of your HRA will be available to you upon your enrollment in the UnitedHealthcare Insurance Company, Inc. High Deductible Health Plan</p>
<p><b>Account owner</b></p>	<p>FEHB enrollee</p>	<p>UnitedHealthcare Insurance Company Inc. High Deductible Health Plan</p>

<p><b>Portable</b></p>	<p>You can take this account with you when you change plans, separate or retire.</p> <p>If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 62 for HSA eligibility.</p>	<p>If you retire and remain in the UnitedHealthcare Insurance Company, Inc. High Deductible Health Plan, you may continue to use and accumulate credits in your HRA.</p> <p>If you terminate employment or change health plans, only eligible expenses incurred while covered under the UnitedHealthcare Insurance Company, Inc. High Deductible Health Plan will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.</p>
<p><b>Annual rollover</b></p>	<p>Yes, accumulates without a maximum cap.</p>	<p>Yes, accumulates without a maximum cap.</p>

**If You Have an HSA**

**If you have an HSA**

• **Contributions**

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

If you newly enroll in an HDHP during Open Season and your effective date is after January 1st or you otherwise have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of the first year of your 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 <http://www.ustreas.gov/offices/public-affairs/hsa>.

• **If you die**

If you do not have a named beneficiary, it becomes part of your taxable estate. To declare a beneficiary, complete and return the beneficiary form located in your Benefit Summary Booklet to OptumHealth Bank.

• **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](http://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 be able to view your monthly statements from OptumHealth Bank online. This statement shows the “premium pass through deposits”, withdrawals, and interest earned on your account. You may also request a paper statement.

• **Minimum reimbursements from your HSA**

You may make payments to providers or reimbursements to yourself in any amount via your UnitedHealthcare Health Savings Account MasterCard® Debit Card, check, online bill pay, or ATM withdrawal.

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## If You Have an HRA

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- **Why an HRA is established**

If you don't qualify for an HSA when you enroll in the UnitedHealthcare Insurance Company, Inc. High Deductible Health Plan, 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 61 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 UnitedHealthcare Insurance Company, Inc. High Deductible Health Plan
  - An HRA does not earn interest, and
  - HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.

**Section 5. Preventive care**

**Important things you should keep in mind about these benefits:**

- Preventive care services listed in this Section are not subject to the deductible. You pay nothing for covered preventive care services provided in-network.
- The Plan pays 100% for the medical preventive care services listed in this Section when you use a in-network provider. In-network preventive care in this section does not use your HSA or HRA funds.
- If you choose to access preventive care from a non-network provider, you will not qualify for 100% preventive care coverage. Please see Section 5 – *Traditional medical coverage subject to the deductible*.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the deductible*.

Benefit Description	You pay
<b>Preventive care, adult</b>	
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Total Blood Cholesterol</li> <li>• Routine Prostate Specific Antigen (PSA) test — one annually for men age 50 and older</li> <li>• Colorectal Cancer Screening, including                             <ul style="list-style-type: none"> <li>- Fecal occult blood test yearly starting at age 50,</li> <li>- Sigmoidoscopy screening — every five years starting at age 50,</li> <li>- Double contrast barium enema — every five years starting at age 50;</li> <li>- Colonoscopy screening — every 10 years starting at age 50</li> </ul> </li> <li>• Routine annual digital rectal exam (DRE) for men age 40 and older</li> <li>• Routine well-woman exam including Pap test, one visit every 12 months from last date of service</li> <li>• Routine mammogram — covered for women age 35 and older, as follows:                             <ul style="list-style-type: none"> <li>- From age 35 through 39, one during this five year period</li> <li>- From age 40 through 64, one every calendar year</li> <li>- At age 65 and older, one every two consecutive calendar years</li> </ul> </li> </ul>	<p>In-Network: Nothing at a network provider</p> <p>Out-of-network: All charges until you satisfy your deductible, then 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<ul style="list-style-type: none"> <li>• Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)</li> </ul>	<p>In-Network: Nothing at a network provider</p> <p>Out-of-network: All charges until you satisfy your deductible, then 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<ul style="list-style-type: none"> <li>• Routine physicals which include:                             <ul style="list-style-type: none"> <li>- One exam every 24 months up to age 65</li> <li>- One exam every 12 months age 65 and older</li> </ul> </li> </ul>	<p>In-Network: Nothing at a network provider</p>

*Preventive care, adult - continued on next page*

Benefit Description	You pay
<b>Preventive care, adult (cont.)</b>	
<ul style="list-style-type: none"> <li>• Routine exams limited to:               <ul style="list-style-type: none"> <li>- One routine eye exam every other year</li> <li>- One routine OB/GYN exam every 12 months including 1 Pap smear and related services</li> <li>- One comprehensive hearing exam every other year</li> </ul> </li> </ul>	<p>In-Network: Nothing at a network provider</p> <p>Out-of-network: All charges until you satisfy your deductible, then 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.</i></li> <li>• <i>Immunizations, boosters, and medications for travel or work-related exposure.</i></li> </ul>	<p><i>All Charges.</i></p>
<b>Preventive care, children</b>	
<p>Professional services, such as:</p> <ul style="list-style-type: none"> <li>• Well-child visits for routine examinations, immunizations and care (up to age 22)</li> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> </ul> <p>Examinations, such as:</p> <ul style="list-style-type: none"> <li>• Eye exam through age 17 every other year</li> <li>• Comprehensive hearing exams through age 17 every other year</li> </ul>	<p>In-Network: Nothing at a network provider</p> <p>Out-of-network: All charges until you satisfy your deductible, then 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i></li> <li>• <i>Immunizations, boosters, and medications for travel.</i></li> </ul>	<p><i>All Charges.</i></p>

**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.
- In-network preventive care is covered at 100% (see page 69) and is not subject to the calendar year deductible.
- The deductible is \$2,000 for in-network and \$3,000 out-of-network for Self Only enrollment, and \$4,000 for in-network and \$6,000 out-of-network for Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your coinsurance and copayments for covered expenses.
- When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments and deductibles total \$3,000 for in-network and \$6,000 out-of-network for Self Only enrollment, and \$6,000 for in-network and \$12,000 out-of-network for Self and Family enrollment in any calendar year, you do not have to pay any more for covered services from network providers. However, certain expenses do not count toward your out-of-pocket 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).
- 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...
<b>Deductible before Traditional medical coverage begins</b>	
The deductible applies to almost all benefits in this Section. In the <b>You pay</b> 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 \$2,000 for in-network and \$3,000 out-of-network for Self Only coverage, and \$4,000 for in-network and \$6,000 out-of-network for Self and Family coverage.
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	<p>In-network: After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA or HRA, or you can pay for them out-of-pocket.</p> <p>Out-of-network: After you meet the deductible, you pay the indicated coinsurance based on our Plan allowance and any difference between our allowance and the billed amount.</p>

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

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$2,000 for in-network and \$3,000 out-of-network for Self Only enrollment, and \$4,000 for in-network and \$6,000 out-of-network for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts 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...
<b>Diagnostic and treatment services</b>	
Professional services of physicians <ul style="list-style-type: none"> <li>• In physician’s office</li> <li>• In an urgent care center</li> <li>• During a hospital stay</li> <li>• In a skilled nursing facility</li> <li>• Office medical consultations</li> <li>• Second surgical opinion</li> </ul>	In-Network: 10% of eligible expenses  Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.
<b>Lab, X-ray and other diagnostic tests</b>	
Tests, such as: <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine Pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine mammograms</li> <li>• CAT Scans/MRI</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	In-Network: 10% of eligible expenses  Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.

Benefit Description	You pay After the calendar year deductible...
<b>Maternity care</b>	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do not need to precertify your normal delivery; see page 13 for other circumstances, such as extended stays for you or your baby.</li> <li>• 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.</li> <li>• We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to a circumcision.</li> <li>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See <i>Hospital benefits</i> (Section 5c) and <i>Surgery benefits</i> (Section 5b).</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<b>Family planning</b>	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>• Voluntary sterilization (See Surgical procedures Section 5 (b))</li> <li>• Surgically implanted contraceptives</li> <li>• Administration of injectable contraceptive drugs (such as Depo Provera)</li> <li>• Insertion and removal of Intrauterine Devices (IUDs)</li> <li>• Diaphragms and fitting of diaphragms</li> <li>• Genetic Counseling</li> </ul> <p>Note: We cover oral and injectable contraceptives under the prescription drug benefit.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<i>Not covered: Reversal of voluntary surgical sterilization</i>	<i>All Charges.</i>

Benefit Description	You pay After the calendar year deductible...
<b>Infertility services</b>	
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> <li>• Artificial insemination limited to a lifetime maximum of three cycles               <ul style="list-style-type: none"> <li>- intravaginal insemination (IVI)</li> <li>- intracervical insemination (ICI)</li> <li>- intrauterine insemination (IUI)</li> </ul> </li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> <li>- <i>in vitro fertilization</i></li> <li>- <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i></li> </ul> </li> <li>• <i>Cost of donor sperm</i></li> <li>• <i>Cost of donor egg</i></li> <li>• <i>Fertility drugs</i></li> </ul>	<p><i>All Charges.</i></p>
<b>Allergy care</b>	
<ul style="list-style-type: none"> <li>• Testing and treatment</li> <li>• Allergy injections</li> <li>• Allergy serum</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Provocative food testing and sublingual allergy desensitization.</i></p>	<p><i>All Charges.</i></p>
<b>Treatment therapies</b>	
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy</li> </ul> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 82.</p> <ul style="list-style-type: none"> <li>• Respiratory and inhalation therapy</li> <li>• Dialysis – hemodialysis and peritoneal dialysis</li> <li>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</li> <li>• Growth hormone therapy (GHT)</li> </ul> <p>Note: Growth hormone is covered under the prescription drug benefit.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>

*Treatment therapies - continued on next page*

Benefit Description	You pay After the calendar year deductible...
<b>Treatment therapies (cont.)</b>	
<p>Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<b>Physical and occupational therapies</b>	
<p>Up to two consecutive months per condition per year for the services of each of the following:</p> <ul style="list-style-type: none"> <li>• qualified physical therapists and</li> <li>• occupational therapists</li> </ul> <p><b>Note:</b> We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <ul style="list-style-type: none"> <li>• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 36 sessions.</li> <li>• Pulmonary rehabilitation is provided for up to 20 visits per calendar year.</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Long-term rehabilitative therapy</i></li> <li>• <i>Exercise programs</i></li> </ul>	<p><i>All Charges.</i></p>
<b>Speech therapy</b>	
<p>Up to two consecutive months per condition per calendar year</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Exercise programs</i></p>	<p><i>All Charges.</i></p>
<b>Hearing services (testing, treatment, and supplies)</b>	
<ul style="list-style-type: none"> <li>• First hearing aid and testing only when necessitated by accidental injury</li> <li>• Hearing aids for children up to age 12 limited to \$1,000 every two calendar years</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>All other hearing testing</i></li> <li>• <i>Hearing aids for members 12 and over, testing and examinations for them</i></li> </ul>	<p><i>All Charges.</i></p>

Benefit Description	You pay After the calendar year deductible...
<b>Vision services (testing, treatment, and supplies)</b>	
<ul style="list-style-type: none"> <li>Initial pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)</li> </ul> <p>Note: For questions or claims please contact Vision Customer Service at 1-877-426-9300.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>Eyeglasses or contact lenses, except as shown above</li> <li>Eye exercises and orthoptics</li> <li>Radial keratotomy and other refractive surgery</li> </ul>	<p><i>All Charges.</i></p>
<b>Foot care</b>	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>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</li> <li>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)</li> </ul>	<p><i>All Charges.</i></p>
<b>Orthopedic and prosthetic devices</b>	
<ul style="list-style-type: none"> <li>Benefits are limited to any combination of network and out-of-network benefits for a calendar year maximum of \$2,500.</li> <li>Artificial limbs and eyes; stump hose</li> <li>Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy</li> <li>Internal prosthetic devices , such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy Note: See 5(b) for coverage of the surgery to insert the device.</li> </ul> <p><b>Note:</b> Call us at 877-835-9861 as soon as your Plan physician prescribes these items. You must notify us before obtaining any single item that costs more than \$1,000 or your benefits will be reduced by \$100 per occurrence.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Prosthesis for a scalp hair prosthesis for hair loss suffered as a result of chemotherapy limited to a maximum of \$350 per year.</p>	<p>In-Network: 10% of eligible expenses; Out-of-network: 35% of Plan allowance and difference between allowance and the billed amount.</p>

Benefit Description	You pay After the calendar year deductible...
<b>Orthopedic and prosthetic devices (cont.)</b>	
<p>Ostomy Appliances and supplies combined network and out-of-network benefit maximum of \$1,000 per Plan year.</p>	<p>In-Network: 10% of eligible expenses Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Orthopedic and corrective shoes</li> <li>• Arch supports</li> <li>• Foot orthotics</li> <li>• Heel pads and heel cups</li> <li>• Lumbosacral supports</li> <li>• Corsets, trusses, elastic stockings, support hose, and other supportive devices</li> <li>• Prosthetic replacements provided less than 3 years after the last one we covered</li> </ul>	<p><i>All Charges.</i></p>
<b>Durable medical equipment (DME)</b>	
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Benefits are limited to any combination of network and out-of-network benefits for a calendar year maximum of \$2,500. Covered items include:</p> <ul style="list-style-type: none"> <li>• Oxygen and the rental of equipment to administer oxygen including tubing, connectors and masks</li> <li>• Dialysis equipment</li> <li>• Hospital beds</li> <li>• Wheelchairs</li> <li>• Crutches</li> <li>• Walker</li> <li>• Blood glucose monitors</li> <li>• Insulin pumps</li> </ul> <p><b>Note:</b> Call us at 877-835-9861 as soon as your Plan physician prescribes this equipment. You must notify us before obtaining any single item that costs more than \$1,000 or your benefits will be reduced by \$100 per occurrence. 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. We provide benefits only for a single purchase (including repair/replacement) of durable medical equipment once every three years. We will decide if the equipment should be purchased or rented.</p>	<p>In-Network: 10% of eligible expenses Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Motorized wheelchairs and other power vehicles</li> </ul>	<p><i>All Charges.</i></p>

Benefit Description	You pay After the calendar year deductible...
<b>Durable medical equipment (DME) (cont.)</b>	
<ul style="list-style-type: none"> <li>• Duplicate or backup equipment</li> <li>• Parts and labor costs for supplies and accessories replaced due to wear and tear such as wheelchair tires</li> <li>• Educational, vocational, or environmental equipment</li> <li>• Deluxe or upgraded equipment and supplies</li> <li>• Home or vehicle modifications, seat lifts</li> <li>• Activities of daily living aids (such as grab bars)</li> <li>• Paraffin baths, whirlpools, and cold therapy</li> <li>• Infertility monitors</li> <li>• Physical fitness equipment</li> <li>• Orthotic devices</li> <li>• Personal comfort items</li> <li>• Air conditioners, air purifiers and filters</li> <li>• Batteries and battery chargers</li> <li>• Dehumidifiers and humidifiers</li> </ul>	<p>All Charges.</p>
<b>Home health services</b>	
<ul style="list-style-type: none"> <li>• 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</li> <li>• Services include oxygen therapy, intravenous therapy and medications</li> </ul> <p><b>Note:</b> Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount with a maximum benefit of 80 visits per Plan year.</p>
<p>Prescription foods covered as follows:</p> <ul style="list-style-type: none"> <li>• Amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases which are prescribed for the therapeutic treatment of inherited metabolic diseases and are administered under the direction of a Physician</li> <li>• Specialized formulas for the treatment of a disease or condition and are administered under the direction of a Physician</li> <li>• Medical foods which are determined to be the sole source of nutrition and cannot be obtained without a physician's prescription</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Benefit Description	You pay After the calendar year deductible...
<b>Home health services (cont.)</b>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Nursing care requested by, or for the convenience of, the patient or the patient’s family</li> <li>• Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</li> <li>• Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication</li> </ul>	<p><i>All Charges.</i></p>
<b>Chiropractic</b>	
<ul style="list-style-type: none"> <li>• Diagnosis and related services for the manipulation of the spine and extremities to remove nerve interference or its effects. Limited to one treatment per day up to 24 visits per calendar year.</li> </ul> <p><b>Note:</b> The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<b>Alternative treatments</b>	
<p>Acupuncture – by a doctor of medicine or osteopathy for anesthesia, pain relief when:</p> <ul style="list-style-type: none"> <li>• Another method of pain management has failed, and</li> <li>• The service is performed in the provider’s office</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Naturopathic services</li> <li>• Hypnotherapy</li> <li>• Biofeedback</li> <li>• Acupressure</li> <li>• Aroma therapy</li> <li>• Massage therapy</li> <li>• Rolfing</li> </ul>	<p><i>All Charges.</i></p>
<b>Educational classes and programs</b>	
<ul style="list-style-type: none"> <li>• Diabetes self management (must be prescribed by a licensed health care professional)</li> <li>• Smoking cessation</li> </ul>	<p>In-Network: 10% of eligible expenses;</p> <p>Out-of-network: 35% of Plan allowance and difference between allowance and billed amount.</p>

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

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$2,000 for in-network and \$3,000 out-of-network for Self Only enrollment, and \$4,000 for in-network and \$6,000 out-of-network for Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- 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...
<p><b>Surgical procedures</b></p> <p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care by the surgeon</li> <li>• Correction of amblyopia and strabismus</li> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies</li> <li>• Surgical treatment of morbid obesity (bariatric surgery) Individuals must weigh 100 pounds or 100% over his or her normal weight according to current underwriting standards.                             <ul style="list-style-type: none"> <li>- Eligible members must be age 22 or over; and</li> <li>- have a minimum Body Mass Index (BMI) of 40 or 35 (with at least 2 co-morbid conditions present), and</li> <li>- you must have completed a 6-month Plan physician supervised weight-loss program; and</li> <li>- you must complete a pre-surgical psychological evaluation</li> </ul> </li> <li>• Insertion of internal prosthetic devices . See 5(a) <i>Orthopedic and prosthetic devices</i> for device coverage information</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>

*Surgical procedures - continued on next page*

Benefit Description	You pay After the calendar year deductible...
<b>Surgical procedures (cont.)</b>	
<ul style="list-style-type: none"> <li>• Voluntary sterilization (e.g., tubal ligation, vasectomy)</li> <li>• Treatment of burns</li> </ul> <p><b>Note:</b> Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Routine treatment of conditions of the foot; see Foot care</i></li> </ul>	<p><i>All Charges.</i></p>
<b>Reconstructive surgery</b>	
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if:               <ul style="list-style-type: none"> <li>- the condition produced a major effect on the member’s appearance and</li> <li>- the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• 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.</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as:               <ul style="list-style-type: none"> <li>- surgery to produce a symmetrical appearance of breasts;</li> <li>- treatment of any physical complications, such as lymphedemas;</li> <li>- breast prostheses and surgical bras and replacements (see Prosthetic devices)</li> </ul> </li> </ul> <p><b>Note:</b> If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p> <ul style="list-style-type: none"> <li>• Removal of breast implants implanted on or before July 1, 1994, without regard to the purpose of such implantation, which removal is determined to be medically necessary by the Physician.</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p>	<p><i>All Charges.</i></p>

*Reconstructive surgery - continued on next page*

Benefit Description	You pay After the calendar year deductible...
<b>Reconstructive surgery (cont.)</b>	
<ul style="list-style-type: none"> <li>• <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i></li> <li>• <i>Surgeries related to sex transformation</i></li> </ul>	<i>All Charges.</i>
<b>Oral and maxillofacial surgery</b>	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones</li> <li>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion</li> <li>• Removal of stones from salivary ducts</li> <li>• Excision of leukoplakia or malignancies</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> </ul>	<i>All Charges.</i>
<b>Organ/tissue transplants</b>	
<p>Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to <i>Other services</i> 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.</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Single, double or lobar lung</li> <li>• Kidney</li> <li>• Liver</li> <li>• Pancreas</li> <li>• Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis</li> <li>• Intestinal transplants <ul style="list-style-type: none"> <li>- Small intestine</li> <li>- Small intestine with the liver</li> </ul> </li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>

*Organ/tissue transplants - continued on next page*

Benefit Description	You pay After the calendar year deductible...
<b>Organ/tissue transplants (cont.)</b>	
<ul style="list-style-type: none"> <li>- Small intestine with multiple organs, such as the liver, stomach, and pancreas</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses:</p> <ul style="list-style-type: none"> <li>• Allogeneic transplants for:               <ul style="list-style-type: none"> <li>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia</li> <li>- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)</li> <li>- Advanced Hodgkin’s lymphoma</li> <li>- Advanced non-Hodgkin’s lymphoma</li> <li>- Chronic myleogenous leukemia</li> <li>- Hemoglobinopathy (i.e. Fanconi's Thalesmia major)</li> <li>- Myelodysplasia/Myelodysplastic syndromes</li> <li>- Severe combined immunodeficiency</li> <li>- Severe or very severe aplastic anemia</li> <li>- Amyloidosis</li> </ul> </li> <li>• Autologous transplant for:               <ul style="list-style-type: none"> <li>- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia</li> <li>- Advanced Hodgkin’s lymphoma</li> <li>- Advanced non-Hodgkin’s lymphoma</li> <li>- Neuroblastoma</li> <li>- Amyloidosis</li> </ul> </li> <li>• Autologous tandem transplants for               <ul style="list-style-type: none"> <li>- Recurrent germ cell tumors (including testicular cancer)</li> <li>- Multiple myeloma</li> <li>- De-novo myeloma</li> </ul> </li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Blood or marrow stem cell transplants for:</p> <ul style="list-style-type: none"> <li>• Allogeneic transplants for:               <ul style="list-style-type: none"> <li>- Phagocytic/Hemophagocytic deficiency diseases (e. g., Wiskott- Aldrich syndrome)</li> <li>- Advanced neuroblastoma</li> <li>- Infantile malignant osteoporosis</li> <li>- Kostmann’s syndrome</li> <li>- Leukocyte adhesion deficiencies</li> </ul> </li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Benefit Description	You pay After the calendar year deductible...
<b>Organ/tissue transplants (cont.)</b>	
<ul style="list-style-type: none"> <li>- Mucopolysaccharidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy)</li> <li>- Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome variants)</li> <li>- Myeloproliferative disorders</li> <li>- Sickle cell anemia</li> <li>- X-linked lymphoproliferative syndrome</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<ul style="list-style-type: none"> <li>• Autologous transplants for               <ul style="list-style-type: none"> <li>- Multiple myeloma</li> <li>- Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors</li> <li>- Breast cancer</li> <li>- Epithelial ovarian cancer</li> <li>- Ependyoblastoma</li> <li>- Ewing’s sarcoma</li> <li>- Medulloblastoma</li> <li>- Pineoblastoma</li> <li>- Waldenstrom's macroglobulinemia</li> </ul> </li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Mini-transplants (non-myeloblastic, reduced intensity conditioning) for covered transplants: Subject to medical necessity</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Tandem transplants for covered transplants: Subject to medical necessity</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols for:</p> <ul style="list-style-type: none"> <li>• Allogeneic transplants for:               <ul style="list-style-type: none"> <li>- Chronic lymphocytic leukemia</li> <li>- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)</li> <li>- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma</li> <li>- Myelodysplasia/Myelodysplastic syndromes</li> <li>- Multiple myeloma</li> <li>- Multiple sclerosis</li> </ul> </li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>

*Organ/tissue transplants - continued on next page*

Benefit Description	You pay After the calendar year deductible...
<b>Organ/tissue transplants (cont.)</b>	
<ul style="list-style-type: none"> <li>• Nonmyeloablative allogeneic transplants for:               <ul style="list-style-type: none"> <li>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia</li> <li>- Myelodysplasia/Myelodysplastic syndromes</li> <li>- Advanced Hodgkin’s lymphoma</li> <li>- Advanced non-Hodgkin’s lymphoma</li> <li>- Breast cancer</li> <li>- Chronic lymphocytic leukemia</li> <li>- Chronic myelogenous leukemia</li> <li>- Colon cancer</li> <li>- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma</li> <li>- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)</li> <li>- Multiple myeloma</li> <li>- Multiple sclerosis</li> <li>- Myeloproliferative disorders</li> <li>- Non-small cell lung cancer</li> <li>- Ovarian cancer</li> <li>- Prostate cancer</li> <li>- Renal cell carcinoma</li> <li>- Sarcomas</li> </ul> </li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<ul style="list-style-type: none"> <li>• Autologous transplants for:               <ul style="list-style-type: none"> <li>- Chronic lymphocytic leukemia</li> <li>- Chronic myelogenous leukemia</li> <li>- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma</li> <li>- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)</li> <li>- Small cell lung cancer</li> <li>- Multiple sclerosis</li> <li>- Systemic lupus erythematosus</li> <li>- Systemic sclerosis</li> </ul> </li> </ul> <p>National Transplant Program (NTP) – OptumHealth Care Solutions is used for organ tissue transplants</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>

*Organ/tissue transplants - continued on next page*

Benefit Description	You pay After the calendar year deductible...
<b>Organ/tissue transplants (cont.)</b>	
<p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p><b>Note:</b> We cover related medical and hospital expenses of the donor when we cover the recipient. If you do not pre-authorize the service, benefits will be reduced by \$100 per occurrence.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i></li> <li>• <i>Implants of artificial organs</i></li> <li>• <i>Transplants not listed as covered</i></li> <li>• <i>All services related to non-covered transplants</i></li> <li>• <i>All services associated with complications resulting from the removal of an organ from a non-member</i></li> </ul>	<p><i>All Charges.</i></p>
<b>Anesthesia</b>	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>• Hospital (inpatient)</li> <li>• Hospital outpatient department</li> <li>• Skilled nursing facility</li> <li>• Ambulatory surgical center</li> <li>• Office</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>

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

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$2,000 for in-network and \$3,000 out-of-network for Self Only enrollment, and \$4,000 for in-network and \$6,000 out-of-network for Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- 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
<b>Inpatient hospital</b>	
Room and board, such as <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations</li> <li>• General nursing care</li> <li>• Meals and special diets</li> </ul> <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. We will pay benefits for an inpatient stay of at least 48 hours following a mastectomy or lymph node dissections. If your hospital stay is elective, please notify us within five business days prior to your admission. For non-elective admissions, please notify us within one business day or the same day of admission. For emergency admissions, please notify us within one business, the same day of admission, or as soon as it is reasonably possible. If you fail to notify us in a timely manner, your benefits will be reduced by \$100 per occurrence.</p>	In-Network: 10% of eligible expenses  Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.
Other hospital services and supplies, such as: <ul style="list-style-type: none"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests and X-rays</li> <li>• Blood or blood plasma, if not donated or replaced</li> <li>• Dressings, splints, casts, and sterile tray services</li> </ul>	In-Network: 10% of eligible expenses  Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.

*Inpatient hospital - continued on next page*

Benefit Description	You Pay
<b>Inpatient hospital (cont.)</b>	
<ul style="list-style-type: none"> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics, including nurse anesthetist services</li> <li>• Take-home items</li> <li>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Custodial care</li> <li>• Non-covered facilities, such as nursing homes, schools</li> <li>• Personal comfort items, such as telephone, television, barber services, guest meals and beds</li> <li>• Private nursing care</li> </ul>	<p><i>All Charges.</i></p>
<b>Outpatient hospital or ambulatory surgical center</b>	
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> </ul> <p><b>Note:</b> We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Blood and blood derivatives not replaced by the member</i></p>	<p><i>All Charges.</i></p>
<b>Extended care benefits/Skilled nursing care facility benefits</b>	
<ul style="list-style-type: none"> <li>• Room and board in a semi-private room</li> <li>• General nursing</li> <li>• Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when ordered by a Physician and delivered or supervised by a licensed technical or professional medical personnel in order to obtain the specific medical outcome, and provide for the safety of the patient</li> <li>• Benefits up to 60 days when full time skilled nursing care is necessary and confinement is medically appropriate</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>

*Extended care benefits/Skilled nursing care facility benefits - continued on next page*

Benefit Description	You Pay
<b>Extended care benefits/Skilled nursing care facility benefits (cont.)</b>	
<i>Not covered: Custodial care</i>	<i>All charges.</i>
<b>Hospice care</b>	
<ul style="list-style-type: none"> <li>• Inpatient care</li> <li>• Outpatient care</li> <li>• Family counseling</li> <li>• Supportive and palliative care for a terminally ill member is covered in the home or hospice facility</li> </ul> <p><b>Note:</b> These services must be provided by a licensed hospice agency.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges.</i>
<b>Ambulance</b>	
Local professional ambulance service when medically appropriate	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>

**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.
- The deductible is \$2,000 for in-network and \$3,000 out-of-network for Self Only enrollment, and \$4,000 for in-network and \$6,000 out-of-network for Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- 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.

**What is a medical emergency?**

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

**What to do in case of emergency:**

**Emergencies within or outside our service area:**

If you are in an emergency situation, please call your doctor. In extreme emergencies, if you are unable to contact your doctor, contact your local emergency system (e.g. 911 telephone system) or go to the nearest hospital emergency room. You or a family member must notify the Plan within 48 hours or as soon as possible after you receive outpatient emergency room.

If you need to be hospitalized, the Plan must be notified within 24 hours, the same day of admission, unless it was not reasonably possible to notify the Plan within that time. If you do not notify us, benefits will be reduced by \$100 per occurrence. Benefits will not be reduced for the outpatient emergency room visit.

Benefit Description	You pay After the calendar year deductible...
<b>Emergency within or outside our service area</b>	
<ul style="list-style-type: none"> <li>• Emergency care at a doctor’s office</li> <li>• Emergency care at an urgent care center</li> <li>• Emergency care as an outpatient in a hospital, including doctors’ services</li> </ul> <p>Note: We waive the ER copay if you are admitted to the hospital</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Benefit Description	You pay After the calendar year deductible...
<b>Emergency within or outside our service area (cont.)</b>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</i></li> <li>• <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></li> <li>• <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i></li> </ul>	<p><i>All Charges.</i></p>
<b>Ambulance</b>	
<p>Professional ambulance service when medically appropriate.</p> <p>Note: See 5(c) for non-emergency service.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Air ambulance</i></p>	<p><i>All Charges.</i></p>

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

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

**Important things to keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is \$2,000 for in-network and \$3,000 out-of-network for Self Only enrollment, and \$4,000 for in-network and \$6,000 out-of-network for Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- 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...
<b>Mental health and substance abuse benefits</b>	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> <li>• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</li> <li>• Medication management</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<ul style="list-style-type: none"> <li>• Diagnostic tests</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<ul style="list-style-type: none"> <li>• Services provided by a hospital or other facility</li> <li>• Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Services we have not approved.</i></p>	<p><i>All Charges.</i></p>

*Mental health and substance abuse benefits - continued on next page*

Benefit Description	You pay After the calendar year deductible...
<b>Mental health and substance abuse benefits (cont.)</b>	
<i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i>	<i>All Charges.</i>

Preauthorization                      To be eligible to receive these benefits you must contact the Plan at 1-800-558-7868 for preauthorization of all mental health and substance abuse benefits.

Limitation                                If you do not notify us, we will reduce your benefits by \$100 per occurrence.

**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. Some injectable medications are provided by your medical benefit. Please see below for more information.
- 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 \$2,000 for in-network and \$3,000 out-of-network for Self Only enrollment, and \$4,000 for in-network and \$6,000 out-of-network for Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- 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.
- Some prescription medications have Quantity Level Limits (QLL) and Quantity per Duration Limits (QD). Please see below for more information.
- Certain medications require your health care provider to request approval from us in order for these to be payable under the Pharmacy Plan. The Pharmacy Plan requires approval for these prescription medications to make sure that they are being prescribed and used according to the Food and Drug Administration (FDA)-approved indications and dosing schedules and meet the definition of a covered service. If your pharmacist tells you that your prescription medication requires approval, ask your pharmacist or physician to contact the Plan at the number on your Member ID card for further instructions.
- 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 health care provider licensed to write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy. You may fill prescriptions for maintenance medications either by mail or at a retail pharmacy. Maintenance medications are those medications anticipated to be required for six months or longer to treat a chronic condition such as high blood pressure, asthma, or diabetes. To locate the name of a Plan pharmacy near you, refer to your Directory of Health Care Professionals, call our Customer Service Department 1-877-835-9861, or visit our website, [www.uhcfeds.com](http://www.uhcfeds.com).
- **We use a Prescription Drug List (PDL).** Our PDL Management Committee creates a list that includes FDA approved prescription medications, products, or devices. Our Plan covers all prescription medications written in accordance with FDA guidelines for a particular therapeutic indication except for prescription medications or classes of medications listed under “Not Covered” in this section of the brochure. The PDL Management Committee decides the tier placement upon clinical information from the UnitedHealthcare Pharmacy and Therapeutics (P&T) Committee as well economic and financial considerations. You will find important information about our Prescription Drug List as well as other Plan information on our web site, [www.uhcfeds.com](http://www.uhcfeds.com). The PDL consists of Tiers 1, 2, and 3.
- **Tier 1** is your **lowest** copayment option (\$10 for up to a 31-day supply or \$25 for up to a 90-day supply through our mail order program) and includes all generic medications, as well as select preferred brand medications. Brand medications in Tier 1 include select insulin products, select inhalers for asthma, and select medications for migraine headaches for which no generic alternative(s) are available. For the lowest out-of-pocket expense, you should always consider Tier 1 medications if you and your provider decide they are appropriate for your treatment.
- **Tier 2** is your **middle** copayment option (\$30 for up to a 31-day supply or \$75 for up to a 90-day supply through our mail order program ) and contains all preferred brand medications not included in Tier 1. Preferred medications placed in Tiers 1 and 2 are those the PDL Management Committee has determined to provide better overall value than those in Tier 3. If you are currently taking a medication in Tier 2, ask your provider whether there are Tier 1 alternatives that may be appropriate for your treatment.

- **Tier 3** is your **highest** copayment option (\$50 for up to a 31-day supply or \$125 for up to a 90-day supply through our mail order program) and consists of only non-preferred brand medications. Sometimes there are alternatives available in Tier 1 or Tier 2. If you are currently taking a medication in Tier 3, ask your provider whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment.

Changes to the Tier level for all covered medications and supplies may be updated to be effective January 1 of each year. If new generic medications come to market throughout the Plan year they will be placed on Tier 1. Newly marketed brand medications will be evaluated by our PDL Management Committee and they will be placed in the appropriate Tier. A prescription medication may be removed from the PDL at anytime if the medication changes to over-the-counter status, or due to safety concerns declared by the Food and Drug Administration (FDA).

In rare cases, you will pay the full copayment amount for a medication when the actual cost of that medication is less than the discounted ingredient cost of the drug. This means if the medication you have filled costs \$6, you may have to pay the full copayment of \$10 if it is a Tier 1 medication. You will never pay more than the appropriate copayment for a medication. Contact our Member Services Department at 877-835-9861 with questions.

#### These are the dispensing limitations.

- **Non-maintenance medications** - Non-maintenance medications are drugs a member requires for less than (6) months to treat a short-term medical condition. You may obtain up to a maximum of a consecutive 31-day supply for a prescription per copayment at a Plan Retail pharmacy. You will pay **\$10** for Tier 1, **\$30** for Tier 2, and **\$50** for Tier 3 medications. You may refill once you have used 75% of the day supply of the prescription medication. For example, a prescription that was filled for a 31-day supply can be refilled after 24 days. While this process provides advancement on your next prescription refill, we cannot dispense more than the total quantity your prescription allows.
- **Maintenance medications** - Maintenance medications are drugs a member requires for six (6) months or more to treat a chronic condition. You may obtain up to a consecutive 90-day supply of maintenance medications as written by your provider, subject to QLL and QD limitations. The listing of the prescription medication classes which are considered maintenance medications by the Plan are available at [www.uhcfeds.com](http://www.uhcfeds.com). You may purchase maintenance medications through retail pharmacy or mail order. If you purchase a maintenance medication through a retail pharmacy, you will pay the applicable Tier copayment for each 30-day supply of medication for up to a maximum of a 90-day supply. For example, a Tier 1 prescription medication filled as a maintenance medication for a 90-day supply would have a copayment of **\$30**, Tier 2 would be **\$90** and Tier 3 would be **\$150**. If you purchase a maintenance medication through the mail order program, you will only be responsible for 2.5 copays for up to a 90-day supply. For example, a Tier 1 prescription medication filled as a maintenance medication for a 90-day supply would have a copayment of **\$25**, Tier 2 would be **\$75** and Tier 3 would be **\$125**.
- **Day Supply** - “Day supply” means consecutive days within the period of prescription. Where a prescription regimen includes “on and off days” when the medication is taken, the off days are included in the count of the day supply.
- **Injectable medications** - Medications typically covered under the pharmacy benefit and received through a retail or mail order pharmacy are those that are self-administered by you or a non-skilled caregiver. However, some prescription medications, those that are typically administered by a health care professional, are covered under your Medical benefit and need to be accessed through your provider or Specialty pharmacy. Contact the Health Plan at 877-835-9861 for more information on these medications.

**Special dispensing circumstances.** The Plan will give special consideration for filling prescription medications for members covered under the FEHB if:

- You are called to active duty, or
- You are officially called off-site as a result of a national or other emergency, or
- You are going to be on vacation for an extended period of time.

Your physician may need to request prior authorization from us in order to fill a prescription for the reasons listed above. Please contact us on 1-877-835-9861 for additional information.

- **Quantity Duration (QD):** Some medications have a limited amount that can be covered for a specific period of time.
- **Quantity Level Limits (QLL) :** Some medications have a limited amount that can be covered at one time.

Changes to quantity duration and quantity level limits may occur on January 1 each year. We base these processes upon the manufacturer’s package size, FDA-approved dosing guidelines as defined in the product package insert and/or the medical literature or guidelines that support the use of doses other than the FDA-recommended dosage. If your prescription written by your provider exceeds the allowed quantity, please refer to Section 7, to file an appeal with the Plan.

- **Refill Frequency** - A process that allows you to receive a refill once when you have used 75 percent of the medications. For example, a prescription that was filled for a 31-day supply can be refilled after 24 days. While this process provides advancement on your next prescription refill, we cannot dispense more than the total quantity your prescription allows.
- **Half Tablet Program** - With certain medications, you may elect to join the voluntary Half Tablet Program. This Program allows you to save money in copayments by electing a double strength medication, receiving half the quantity, and splitting the tablet in half. If you take advantage of this Program, you will pay half a copayment at a retail pharmacy or through mail order. Your provider must write the prescription for the increased dosage, with the instructions to “take a half tablet”. A free tablet splitter is provided. For more information on this Program please visit our Frequently Asked Questions at [www.halftablet.com](http://www.halftablet.com) or call 1-877-471-1860.
- **Specialty Pharmacy Program** - Our Specialty Pharmacy Program includes high cost medications for rare, unusual or complex diseases. Members may choose to obtain these medications through one of our designated specialty pharmacy. You will pay the applicable Tier copay for your specialty medications and receive up to a maximum of a consecutive 31-day supply of your prescription medication. Although you may continue to receive your specialty medications through a retail pharmacy, our specialty pharmacy providers will give you superior assistance and support to you during your treatment. This Program may offer the following benefits to members:

- Expertise in storing, handling and distributing these unique medications
- Access to products and services that are not available through a traditional retail pharmacy
- Access to nurses and pharmacists with expertise in complex and high cost diseases
- Educational materials as well as support and development of a necessary care plan
- Free supplies such as syringes and needles

For more information on this voluntary Specialty Pharmacy Program, please call 1-866-429-8177, 24 hours a day, seven days a week.

• **Why use Tier 1 drugs?** Medications in Tier 1 offer the best health care value and are available at the lowest copayment. Tier 2 medications are available at a higher copayment and Tier 3 medications are available at the highest copayment level. This approach helps to assure access to a wide range of medications and control health care costs for you.

Benefit Description	You pay After the calendar year deductible...
<p><b>Covered medications and supplies</b></p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> <li>• 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</li> <li>• Insulin, with a copayment charge applied every 2 vials</li> <li>• Disposable needles and syringes for the administration of covered medications</li> <li>• Drugs for sexual dysfunction</li> <li>• Oral and injectable contraceptive drugs</li> <li>• Oral fertility drug (Chlomid)</li> </ul>	<p>Network/non-network retail pharmacy for up to a maximum of a 31-day supply:</p> <p>Tier 1- \$ 10</p> <p>Tier 2- \$ 30</p> <p>Tier 3- \$ 50</p> <p>Plan mail order pharmacy for up to a 90-day supply:</p> <p>Tier 1- \$ 25</p> <p>Tier 2- \$ 75</p> <p>Tier 3- \$ 125</p>

*Covered medications and supplies - continued on next page*

Benefit Description	You pay After the calendar year deductible...
<b>Covered medications and supplies (cont.)</b>	
<ul style="list-style-type: none"> <li>Compound drugs that contain at least one ingredient that requires a prescription</li> </ul> <p><b>Note:</b> Intravenous fluids and medications for home use, implantable drugs, and some injectable drugs are covered under Section (5a) Medical services and supplies or Section (5b) Surgical and anesthesia services.</p>	<p>Network/non-network retail pharmacy for up to a maximum of a 31-day supply:</p> <ul style="list-style-type: none"> <li>Tier 1- \$ 10</li> <li>Tier 2- \$ 30</li> <li>Tier 3- \$ 50</li> </ul> <p>Plan mail order pharmacy for up to a 90-day supply:</p> <ul style="list-style-type: none"> <li>Tier 1- \$ 25</li> <li>Tier 2- \$ 75</li> <li>Tier 3- \$ 125</li> </ul>
<ul style="list-style-type: none"> <li>Diabetic supplies limited to insulin syringes, needles, glucose test tape, Benedict’s solution or equivalents and acetone test tablets.</li> <li>Implanted contraceptive drugs and devices such as Norplant</li> </ul>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Medications used for cosmetic purposes</i></li> <li><i>Any product dispensed for the purpose of appetite suppression and other weight loss products</i></li> <li><i>Drugs to enhance athletic performance</i></li> <li><i>Medical supplies such as dressings and antiseptics</i></li> <li><i>Artificial insemination fertility drugs except Clomid (clomiphene)</i></li> <li><i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i></li> <li><i>Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed</i></li> <li><i>Vitamins, nutrients and food supplements that can be purchased without a prescription</i></li> <li><i>Nonprescription medicines or drugs available over-the-counter that do not require a prescription order by federal or state law before being dispensed, and any drug that is therapeutically equivalent to an over-the-counter</i></li> <li><i>Compound drugs that do not contain at least one covered ingredient that requires a Prescription Order or Refill</i></li> <li><i>Alcohol swabs and bio-hazard disposable containers</i></li> </ul>	<p><i>All charges.</i></p>

**Section 5(g). Dental benefits**

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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 FEHBP Plan. See Section 9 *Coordinating benefits with other coverage*.
- The deductible is \$2,000 for in-network and \$3,000 out-of-network for Self Only enrollment, and \$4,000 for in-network and \$6,000 out-of-network for Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- 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.

Benefit description	You pay
<p><b>Accidental injury benefit</b></p> <p>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.</p>	<p>In-Network: 10% of eligible expenses</p> <p>Out-of-network: 35% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><b>Dental benefits</b></p> <p>Please refer to page 102 for a description of our non-FEHB dental benefits</p>	

**Section 5(h). Special features**

Feature	Description
<p><b>Flexible benefits option</b></p>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> <li>• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue.</li> <li>• Alternative benefits will be made available for a limited period and are subject to our ongoing review. You must cooperate with the review process.</li> <li>• By approving an alternative benefit, we cannot guarantee you will get it in the future.</li> <li>• The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits.</li> <li>• If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request.</li> <li>• Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</li> </ul>
<p><b>Care24</b></p>	<p>For any of your health concerns you may call 1-888-887-4114, 24 hours a day, seven days a week and talk with a registered nurse with an average of 15 years of experience who will discuss treatment options and answer your health questions. Members may learn self-care for minor illnesses and injuries; understand diagnosed conditions; manage chronic diseases; discover and evaluate possible benefits and risks of various treatment options; learn about specific medications; prepare questions for doctor visits; develop and maintain healthful living habits; and connect with community support groups.</p>
<p><b>Transplant Centers of Excellence</b></p>	<p>OptumHealth Care Solutions provides you access to one of the nation’s leading transplant networks, managing more than 10,000 referrals each year. Centers of Excellence are selected through a process of quality measurement and cover all phases of patient health care from evaluation, pre-transplant, transplant, post-transplant and 12-month follow-up health care. Contact OptumHealth Care Solutions at 1-888-936-7246 to discuss information about transplants and physicians.</p>
<p><b>Cancer Resource Services</b></p>	<p>Cancer is one of the most prevalent conditions in medicine. Cancer Resource Services (CRS) provides unparalleled clinical and economic value in managing complex cancers-providing patients with access to expertise at leading cancer centers throughout the country. Call 1-866-936-6002 to discuss information about cancer centers and physicians.</p>

*Feature - continued on next page*

Feature	Description
<b>Feature (cont.)</b>	
<b>Healthy Pregnancy Program</b>	<p>With our Healthy Pregnancy Program, UnitedHealthcare enrollees receive personal support through all stages of pregnancy and delivery. Some features of the program include a pregnancy assessment to identify special needs, identification of pregnancy risk factors, a 24-hour toll-free phone number to experienced nurses and customized maternity educational materials. To enroll in the Healthy Pregnancy Program, simply call toll-free at 1-800-411-7984; or visit <a href="http://www.healthy-pregnancy.com">www.healthy-pregnancy.com</a>.</p>
<b>ParentSteps</b>	<p>ParentSteps Infertility Centers of Excellence Network provides access to some of the best infertility clinics in the country. These clinics have high pregnancy rates AND low incidence of multiple births. ParentSteps offers the ability to purchase treatment cycles and infertility medications at group discount prices. ParentSteps also provides infertility nurse specialists who can educate you on your diagnosis and treatment options. For more information, please visit ParentSteps at <a href="http://www.urnparentsteps.com">www.urnparentsteps.com</a> or call 1-866-774-4626.</p>
<b>Congenital Heart Disease Resource Service (CHDRS)</b>	<p>Members can access the Congenital Heart Disease Centers of Excellence Network, providing care that is planned, coordinated and provided by a team of experts who specialize in treating Congenital Heart Disease. Potential benefits include accurate diagnosis, appropriate surgical interventions, higher survival rates and decreased costs. Participation is voluntary. Contact CHD Resource Services at 1-888-936-7246 before receiving care. More information is also available at <a href="http://www.urnweb.com">www.urnweb.com</a>.</p>
<b>Kidney Resource Services (KRS)</b>	<p>Kidney Resource Services provides access to top-performing dialysis centers and nurse consulting services to support the management of kidney diseases. Kidney transplantation candidates have access to the Transplant Centers of Excellence Network and Transplant Resources Services nurse consulting services. Please call a KRS nurse at 1-888-936-7246 for all inquiries and prior authorizations related to End Stage Renal Disease, including dialysis or vascular access for dialysis. Information is also available at <a href="http://www.urnweb.com">www.urnweb.com</a>.</p>
<b>Bariatric Resource Services (BRS)</b>	<p>Bariatric Resource Services (BRS) is a surgical weight loss solution for those individual(s) who qualify clinically for bariatric surgery. Specialized nurses provide support through all stages of the weight loss surgery process. Our program is dedicated to providing support both before and after surgery. Nurses help with decision support in preparation for surgery, information and education important in the selection of a bariatric surgery program, and post surgery and lifestyle management. Nurses can provide information on the nation's leading obesity surgery centers, known as Centers of Excellence. Covered participants seeking coverage for bariatric surgery should notify OptumHealth Care Solutions as soon as the possibility of a bariatric surgery procedure arises (and before the time a pre-surgical evaluation is performed) at a bariatric surgery center by calling OptumHealth Care Solutions at 1-888-936-7246 to enroll in the program.</p>
<b>Health and Wellness Education Information</b>	<p>You can find healthy living articles and general information on <a href="http://www.myuhc.com">www.myuhc.com</a>. Health and wellness topics and categories including addiction, family, fitness and nutrition, healthy aging, healthy pregnancy, preventive medicine, relationships and much more.</p>

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

Special features	Description
<p><b>Health education resources</b></p>	<p>Connect to <a href="http://www.uhctoday.com/fehbp">www.uhctoday.com/fehbp</a> to register for <a href="http://myuhc.com">myuhc.com</a>. On this site you can find health care at your fingertips, 24 hours a day. Keeping track of your benefits and claims, finding ways to save money, and learning more about how to stay healthy are easy at <a href="http://myuhc.com">myuhc.com</a>., your own secure personal member web site. Use <a href="http://myuhc.com">myuhc.com</a> to:</p> <ul style="list-style-type: none"> <li>• Learn about health conditions, treatments, and procedures in easy-to understand language</li> <li>• Compare your costs for treatments</li> <li>• Find tools that help you make more informed health care decisions</li> <li>• Chat online with a registered nurse</li> </ul> <p>Use the Personal Health Manager, your health history, medical library, and customizable organizer that is secure, easy-to-use and interactive. Once you enter your preferences and needs, we'll automatically send you the information you want to browse at your leisure. You can use the site to estimate your treatment or plan costs, research health conditions, track your claims status and more.</p>
<p><b>Account management tools</b></p>	<p>Connect to <a href="http://www.uhctoday.com/fehbp">www.uhctoday.com/fehbp</a> to register for <a href="http://myuhc.com">myuhc.com</a> to:</p> <p>Check the status of your claims</p> <ul style="list-style-type: none"> <li>• Search for network physicians and hospitals</li> <li>• Verify your benefits—your copayment amounts, deductible status, and more</li> <li>• View your monthly statements from OptumHealth Bank online. This statement shows the “premium pass through deposits”, withdrawals, and interest earned on your account. You may also request a paper statement.</li> <li>• Make payments to providers or reimbursements to yourself in any amount via your UnitedHealthcare Health Savings Account MasterCard® Debit Card, check, online bill pay, or ATM withdrawal</li> </ul>
<p><b>Consumer choice information</b></p>	<p>As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Directories, pricing information for medical care and prescription drugs as well as educational materials for the HSA and HRAs are available online at <a href="http://myuhc.com">myuhc.com</a>.</p>
<p><b>Care support</b></p>	<p>Care24 gives you access to a registered nurse and master’s level counselors who can answer questions about your health.</p> <p>UnitedHealthWellness is a customized, interactive health improvement program and discounts on related services. You can take a personalized health assessment, sign up for an online better health program (like stress management or smoking cessation), work to meet your wellness goals, get reminders for screenings, and much more.</p> <p>Care Coordination is clinical expertise to help you make sound decisions and help you get access to proper care. For each HSA and HRA account holder, we maintain a complete claims payment history online through <a href="http://myuhc.com">myuhc.com</a>.</p>

## **Non-FEHB benefits available to Plan members**

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket 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 877-835-9861.

### **PPO Dental Plan**

UnitedHealthcare provides a PPO Dental Plan to our enrolled Federal members. There is no additional premium for this benefit and enrollment is automatic. See the 2009 Federal Employees Health Benefit Summary, visit us on the web at [www.uhcfeds.com](http://www.uhcfeds.com).

### **Hearing Aid Hardware and Services From Leading Manufacturers**

Get hearing aids from leading manufacturers at exceptionally competitive pricing, through a large nationwide network of credentialed ENT physicians and audiologists. Advice on purchase, as well as full service, extended warranties, and more, are available to all Plan members and their extended family, including parents and grandparents. UnitedHealthcare FEHB CDHP/HDHP members can first get a comprehensive hearing examination through the medical plan, then contact EPIC Hearing Healthcare toll free at 1-866-956-5400 (TTY access 626-723-2173) and you will get full information, including pricing, which is standard nationwide.

### **UnitedHealth Wellness <sup>SM</sup>**

As a comprehensive portfolio of wellness programs and services offered through UnitedHealthcare, UnitedHealth Wellness can help improve your total health and well-being. UnitedHealth Wellness is not insurance. Instead, it is our commitment to bring you more ways than ever to stay healthy. For more information, please also visit us on the web at [www.unitedhealthwellness.com](http://www.unitedhealthwellness.com) or call 1-888-848-9355. We are pleased to offer you the following portfolio of wellness programs and services:

#### **Online Health Coach: Exercise Program**

This program provides personalized exercise routines to help you meet the challenges of getting in shape. This staged approach to getting fit walks you through five program levels. Plus, you'll receive tips on nutrition, fitness articles and access to interactive tools to help you keep your exercise routine for life. Program features include:

- **Weight Tracker** to monitor your weight over the course of the program
- **Exercise Planner/Tracker** to create and view your personal exercise program
- **Exercise recommendations** for the type and length of exercise, plus your target heart rate range and the number of calories you'll burn
- **Body Mass Index (BMI) Calculator** to help you find your ideal weight
- **Calorie Burner Calculator**
- **Motivational support** to help you achieve your goals and much, much more!

To access this program, log on to [www.myuhc.com](http://www.myuhc.com), click 'Health & Wellness', then 'Your Personal Health Center' on the right side of the screen.

#### **Discounts on wellness products and services**

Receive discounts on wellness products and health care services not covered by you medical, dental or vision plans. From nutrition supplements and fitness gear, to LASIK procedures and teeth whitening, this is the place to go before you buy anything. Log on to [www.myuhc.com](http://www.myuhc.com) and click 'Health&Wellness'. A discount link is located on the bottom, left side of the screen.

#### **Online Personal Health Manager**

Available on [myuhc.com](http://myuhc.com), the online Personal Health Manager helps you manage your health information all in one place.

- Securely record your current health status or conditions
- Provide access to only those people you approve
- Document your medical contacts

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

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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.**

We do not cover the following:

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

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## Section 7. Filing a claim for covered services

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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 and hospital benefits**

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

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

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

**Submit your claims to:** UnitedHealthcare, P.O. Box 740800, Atlanta, GA 30374-0800

**Submit your international claims to:** UnitedHealthcare Insurance Company P.O. Box 740817, Atlanta, GA 30374-0817.

### **Prescription drugs**

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

### **Deadline for filing your claim**

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

### **When we need more information**

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

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## Section 8. The disputed claims process

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Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3. Disagreements between you and the CDHP and HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

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

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

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

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

We will write to you with our decision.

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

You must write to OPM within

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

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

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

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

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

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

## 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 877-835-9861 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
  - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
  - You may call OPM's Health Insurance Group III at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

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## Section 9. Coordinating benefits with other coverage

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### 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.”

We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines order of benefit determination rules. The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other plan’s benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of this plan’s total allowable expense.

When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

### 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](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

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

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

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

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

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

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

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

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

**Claims process when you have the Original Medicare Plan** – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-877-835-9861 or see our Web site at [www.uhctoday.com/fehbp](http://www.uhctoday.com/fehbp).

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

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs 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](http://www.medicare.gov).

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

**This Plan and our Medicare Advantage plan:** You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments or coinsurance for your FEHB plan. For more information on our Medicare Advantage plan, please contact 1-800-504-4848 to see if this program is available in your area.

**This Plan and another plan's Medicare Advantage plan:** You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, 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.)**

<b>Primary Payer Chart</b>		
<b>A. When you - or your covered spouse - are age 65 or over and have Medicare and you...</b>	<b>The primary payer for the individual with Medicare is...</b>	
	<b>Medicare</b>	<b>This Plan</b>
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>B. When you or a covered family member...</b>		
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 <b>(30-month coordination period)</b>		✓
• 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 <b>(for 30 month coordination period)</b>		✓
• 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 <b>(for the 30 month coordination period)</b>		✓
• Medicare based on ESRD <b>(after the 30 month coordination period)</b>	✓	
<b>C. When either you or a covered family member are eligible for Medicare solely due to disability and you...</b>		
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	✓	
<b>D. When you are covered under the FEHB Spouse Equity provision as a former spouse</b>		
	✓	

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

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

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

**Workers' Compensation**

We do not cover services that:

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

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

**Medicaid**

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

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

**When other Government agencies are responsible for your care**

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

**When others are responsible for injuries**

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

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

**When you have Federal Employees Dental and Vision Insurance 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 plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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## Section 10. Definitions of terms we use in this brochure

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<b>Calendar year</b>	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.
<b>Catastrophic limit</b>	<p>When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance, and copayments) for covered services is limited to the following:</p> <p><b>CDHP</b></p> <p><u>Self Only:</u></p> <p>In-network: Your annual out-of-pocket maximum is \$3,000</p> <p>Out-of-network: Your annual out-of-pocket maximum is \$4,000</p> <p><u>Self and Family:</u></p> <p>In-network: Your annual out-of-pocket maximum is \$6,000</p> <p>Out-of-network: Your annual out-of-pocket maximum is \$8,000</p> <p><b>HDHP</b></p> <p><u>Self Only:</u></p> <p>In-network: Your annual out-of-pocket maximum is \$3,000</p> <p>Out-of-network: Your annual out-of-pocket maximum is \$6,000</p> <p><u>Self and Family:</u></p> <p>In-network: Your annual out-of-pocket maximum is \$6,000</p> <p>Out-of-network: Your annual out-of-pocket maximum is \$12,000</p> <p>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. Refer to Section 4.</p>
<b>Coinsurance</b>	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 15.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services. See page 15.
<b>Cost-sharing</b>	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.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Custodial care</b>	Services that are non-health related, such as daily living activities, or services which are health related, but do not seek to cure, or services which do not require a trained medical professional. Custodial care that lasts 90 days or more is sometimes known as long term care.
<b>Deductible</b>	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 15.
<b>Experimental or investigational service</b>	UnitedHealthcare, Inc. determines “Medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, diagnostic procedures, drug therapies, or devices to be experimental or investigational when one of the following applies (at the time it makes a determination regarding coverage in a particular case):

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service as appropriate for the proposed use;
- Subject to review and approval by any Institutional Review Board for the proposed use;
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 Clinical Trial set forth in the FDA regulations, regardless of when the trial is actually subject to FDA oversight;
- Not demonstrated through the prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition, illness or diagnosis for which it was proposed.

<b>Health Reimbursement Account (HRA)</b>	A HRA is a tax-sheltered account designed to reimburse medical expenses. The funds in this type of account can best be described as “credits”. These credits are applied toward your medical expenses until they are exhausted at which time you must pay any remaining deductible and coinsurance amounts up to the catastrophic limit.
<b>Health Savings Account (HSA)</b>	A HSA is consumer-oriented tax-advantaged savings account. HSAs allow for tax deductible contributions as well as tax free earnings and withdrawals for qualified medical expenses.
<b>Medical necessity</b>	Services which are reasonably necessary in the exercise of good medical practice in accordance with professional standards accepted in the United States for the treatment of an active illness or injury. We determine medical necessity.
<b>Member responsibility</b>	Your member responsibility is the bridge between your HRA (personal medical fund) and your Traditional medical plan. Once you have exhausted the HRA (personal medical fund), you will then satisfy any remaining deductible. This remaining amount is referred to as your member responsibility.
<b>Plan allowance</b>	Allowable expense (plan allowance) is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.
<b>Premium contributions to HSA/HRA</b>	The amount of money we contribute to your HSA or HRA.
<b>Us/We</b>	Us and We refer to UnitedHealthcare Insurance Company, Inc.
<b>You</b>	You refers to the enrollee and each covered family member.

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## Section 11. FEHB Facts

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### Coverage information

- **No pre-existing condition limitation**

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

- **Where you can get information about enrolling in the FEHB Program**

See [www.opm.gov/insure/health](http://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;
- What happens when your enrollment ends; and
- When the next open season for enrollment begins.

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

- **Types of coverage available for you and your family**

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

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

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

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

- **Children's Equity Act**

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

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

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

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

• **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2009 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2008 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

• **When you retire**

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

**When you lose benefits**

• **When FEHB coverage ends**

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

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

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31<sup>st</sup> 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 60<sup>th</sup> day after the end of the 31 day temporary extension.

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

- **Upon divorce**

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

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## Section 12. Three Federal Programs complement FEHB benefits

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### Important information

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

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

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

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

### The Federal Flexible Spending Account Program - FSAFEDS

#### What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money.

**Annuitants are not eligible to enroll.**

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

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

#### Where can I get more information about FSAFEDS?

Visit [www.FSAFEDS.com](http://www.FSAFEDS.com) or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450.

### The Federal Employees Dental and Vision Insurance Program - FEDVIP

#### Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

#### Dental Insurance

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

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.

- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period

**Vision Information**

Vision plans 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/dental/vision](http://www.opm.gov/insure/dental/vision). 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](http://www.BENEFEDS.com). For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877- 889-5680).

**The Federal Long Term Care Insurance Program - FLTCIP**

**Its important protection**

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit [www.ltcfeds.com](http://www.ltcfeds.com).

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

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## Summary of benefits for the CDHP of the UnitedHealthcare Insurance Company Inc. - 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.

For the Consumer Driven Health Plan (CDHP), your health charges are applied to your annual HRA (personal medical fund) of \$1,250 for Self Only and \$2,500 for Self and Family (prorated based upon when you enroll). Once your HRA (personal medical fund) is exhausted, you must satisfy your calendar year member responsibility of \$750 for Self Only enrollment or \$1,500 for Self and Family enrollment. Once your member responsibility is satisfied, Traditional medical coverage begins.

CDHP Benefits	You Pay	Page
<b>In-network medical preventive care</b>	Nothing	20
<b>Medical services provided by physicians:</b>		24
Diagnostic and treatment services provided in the office	In-network: 10% of eligible expenses Out-of-network: 40% of eligible expenses	24
<b>Services provided by a hospital:</b>		40
• Inpatient	In-network: 10% of eligible expenses Out-of-network: 40% of eligible expenses	40
• Outpatient	In-network: 10% of eligible expenses Out-of-network: 40% of eligible expenses	41
<b>Emergency benefits:</b>		44
In-area or Out-of-area	In-network: 10% of eligible expenses Out-of-network: 40% of eligible expenses	44
<b>Mental health and substance abuse treatment:</b>	Regular cost sharing	46
<b>Prescription drugs:</b>		48
• Retail pharmacy	Tier 1: \$10 Tier 2: \$25 Tier 3: \$40	51
• Mail order	Tier 1: \$25 Tier 2: \$62.50 Tier 3: \$100	51
<b>Dental care:</b>	Please refer to page 102 for a description of our non-FEHB dental benefit.	53
<b>Vision care:</b>	One eye exam every other calendar year	21
<b>Special features:</b>	Care24, Transplant Centers of Excellence, Cancer Resource Services, Healthy Pregnancy Program, Bariatric Resource Services, and Health and Wellness Educational Information	54

CDHP Benefits	You Pay	Page
Protection against catastrophic costs (out-of-pocket maximum):	In-network: Nothing after \$3,000 Self Only or \$6,000 Self and Family per year  Out-of-network: Nothing after \$4,000 Self Only or \$8,000 Self and Family per year	15

## Summary of benefits for the HDHP of the UnitedHealthcare Insurance Company Inc. - 2009

**Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside. If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

In 2009 for each month you are eligible for the HSA, we will deposit \$62.50 per month for Self Only enrollment or \$125 per month for Self and Family enrollment to your HSA. Your Health Savings Account (HSA) funds can be used to meet your calendar year deductible of \$2,000 in-network (\$3,000 out-of-network) for Self Only enrollment or \$4,000 in-network (\$6,000 out-of-network) for Self and Family enrollment. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

HDHP Benefits	You Pay	Page
<b>In-network medical preventive care</b>	Nothing	69
<b>Medical services provided by physicians:</b>		72
Diagnostic and treatment services provided in the office	In-network: 10% of eligible expenses Out-of-network: 35% of eligible expenses	72
<b>Services provided by a hospital:</b>		87
• Inpatient	In-network: 10% of eligible expenses Out-of-network: 35% of eligible expenses	87
• Outpatient	In-network: 10% of eligible expenses Out-of-network: 35% of eligible expenses	88
<b>Emergency benefits:</b>		90
• In-area or Out-of-area	In-network: 10% of eligible expenses Out-of-network: 35% of eligible expenses	90
<b>Mental health and substance abuse treatment:</b>	Regular cost sharing	92
<b>Prescription drugs:</b>		94
• Retail pharmacy	Tier 1: \$10 Tier 2: \$30 Tier 3: \$50	96
• Mail order	Tier 1: \$25 Tier 2: \$75 Tier 3: \$125	96
<b>Dental care:</b>	Please refer to page 102 for a description of our non-FEHB dental benefit.	98
<b>Vision care:</b>	One eye exam every other calendar year	69
<b>Special features:</b>	Care 24, Transplant Centers of Excellence, Cancer Resource Services, Healthy Pregnancy Program, Health and Wellness Programs	99

HDHP Benefits	You Pay	Page
<b>Protection against catastrophic costs</b> (out-of-pocket maximum):	In-network: Nothing after \$3,000/Self Only or \$6,000 Self and Family per year.  Out-of-network: Nothing after \$6,000/Self Only or \$12,000/Self and Family per year.	16

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## 2009 Rate Information for - UnitedHealthcare Insurance Company, Inc. Consumer Driven Health Plan and High Deductible Health Plan

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

**Postal rates** apply to career Postal Service employees. Most employees should refer to the Guide to Benefits *for Career UnitedStates Postal Service Employees, RI 70-2*, and to the rates shown below.

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

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

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

Arizona, Arkansas, California, Colorado, District of Columbia, Florida, Georgia, Illinois, Iowa, Kansas, Louisiana, Maryland, Mississippi, Missouri, New Mexico, North Carolina, Nevada, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, Texas, Virginia, Washington State, and Wisconsin

<b>CDHP Option Self Only</b>	E94	\$123.59	\$41.20	\$267.79	\$89.26	\$142.54	\$22.25
<b>CDHP Option Self and Family</b>	E95	\$273.59	\$91.19	\$592.77	\$197.59	\$315.53	\$49.25
<b>HDHP Option Self Only</b>	E91	\$105.68	\$35.23	\$228.98	\$76.33	\$121.89	\$19.02
<b>HDHP Option Self and Family</b>	E92	\$236.10	\$78.70	\$511.55	\$170.52	\$272.30	\$42.50