

United Healthcare of the Midwest, Inc.

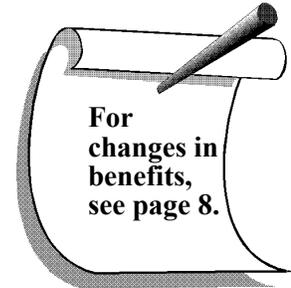
<http://www.uhcfeds.com>



2009

A Health Maintenance Organization

Serving : Kansas City, Missouri
St. Louis, Missouri



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

Enrollment codes for Kansas City, MO:

GX1 High Option – Self Only
GX2 High Option – Self and Family

Enrollment codes for St. Louis, MO:

B91 High Option - Self Only
B92 High Option - Self and Family



HMO and POS products
This plan has full accreditation from NCQA
See the 2009 Guide for more information on NCQA.

Authorized for distribution by the:



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

RI 73-847

**Important Notice from United Healthcare of the Midwest, Inc. About
Our Prescription Drug Coverage and Medicare**

OPM has determined that United Healthcare of the Midwest, Inc. 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 it is considered Credible 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.

Please be advised

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

Medicare's Low Income Benefits

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

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

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

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Introduction

This brochure describes the benefits of United Healthcare of the Midwest, Inc. under our contract (CS 2906) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for our administrative offices is:

United Healthcare of the Midwest, Inc.
Federal Employees Health Benefits (FEHB) Program
6095 Marshalee Drive, Suite 200
Elkridge, MD 21075

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 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 8. Rates are shown at the end of this brochure.

Plain Language

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

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

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

Stop Health Care Fraud!

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

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

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

- 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 1-877-835-9861 and explain the situation.
 - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

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

Preventing medical mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

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

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

3. Get the results of any test or procedure.

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

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

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

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:

Exactly what will you be doing?

About how long will it take?

What will happen after surgery?

How can I expect to feel during recovery?

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety:

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

Section 1. Facts about this HMO Plan

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

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

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

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

General Features of our High Option Plan

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your Primary Care Provider (PCP) or by another participating provider in the network. We have a wide service area of participating providers you must use to access care. You will not have to routinely file claims for medical services and we have Customer Service Department available at 1-877-835-9861. We participate in the FSAFEDS Paperless Reimbursement Program (see Section 12 for more details).

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.

United Healthcare of the Midwest, Inc. is a health maintenance organization. You do not need to select a Primary Care Physician (PCP) and you do not need to get written referrals to see a participating specialist for medical service. The provider must be participating for services to be covered. You must call United Behavioral Health at 1-800-558-7868 to obtain authorization for services to use Mental Health/Substance Abuse benefits. Women may see a Plan gynecologist for their routine examinations.

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

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

Your rights

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

- United Healthcare of the Midwest, Inc. has been in existence since 1985
- United Healthcare of the Midwest, Inc. is a for-profit organization

If you want more information about us, call 1-877-835-9861, or write to United Healthcare of the Midwest, Inc., Federal Employees Health Benefits (FEHB) Program, P.O. Box 30432, Salt Lake City, UT 84130-0432. You may also visit our Web site at 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 area is:

Kansas City, MO (Enrollment code GX1 and GX2)

Kansas Counties of: Anderson, Atchison, Douglas, Franklin, Jackson, Jefferson, Johnson, Leavenworth, Linn, Miami, Osage, Shawnee, and Wyandotte.

Missouri Counties of: Cass, Clay, Jackson, Johnson, Lafayette, Platte, and Ray.

St. Louis, Jefferson City and Springfield , MO (Enrollment code B91 and B92):

Illinois Counties of : Bond, Calhoun, Clinton, Greene, Jersey, Macoupin, Madison, Monroe, Montgomery, Randolph, Saint Clair, and Williamson.

Missouri Counties of: Barry, Boone, Butler, Calloway, Camden, Carter, Christian, Chariton, Cole, Cooper, Crawford, Dade, Dallas, Dent, Douglas, Franklin, Gasconade, Greene, Howard, Iron, Jasper, Jefferson, Laclede, Lawrence, Lincoln, Macon, Madison, Maries, McDonald, Miller, Moniteau, Montgomery, Monroe, Morgan, Newton, Osage, Perry, Pettis, Phelps, Pike, Polk, Pulaski, Randolph, Reynolds, Ripley, Saint Charles, Saint Francois, Saint Louis, Saint Louis City, Sainte Geneviev, Saline, Stone, Taney, Texas, Warren, Washington, Wayne, Webster and Wright.

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

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

Section 2. How we change for 2009

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

Changes to this Plan

- Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 69.
- **Primary Care Physician (PCP) visits for children through age 17:** The copayment for primary care physician visits for children through age 17 will decrease to \$0. See page 15.
- **Primary Care office visits:** The copayments will increase to \$20 for primary care physician visits for ages 18 and up. See page 15.
- **Specialty pharmacy:** Members are no longer required to use the specialty pharmacy to fill medications that treat rare, unusual or complex diseases. See page 40.
- **Outpatient hospital or ambulatory surgical center:** The copayment for outpatient surgical facility charge will increase to \$200. See page 32.
- **Prescription drugs:** You will now pay the applicable copay for the Tier drug purchased without an ancillary charge. See page 38.
- **Catastrophic out-of-pocket maximum:** The catastrophic out-of-pocket maximum has increased to \$3,000 per person or \$6,000 per family. See page 11.

Section 3. How you get care

- Identification cards** We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.
- If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-877-835-9861, or write to us at United Healthcare of the Midwest, Inc., Federal Employees Health Benefits (FEHB) Program, at P.O. Box 30432, Salt Lake City, UT 84130-0432. You may also print temporary cards and request replacement cards through our web site www.myuhc.com.
- Where you get covered care** You get care from “Plan providers” and “Plan facilities”. You will only pay copayments, and/or coinsurance. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.
- **Plan providers** Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.
- We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site www.uhcfeds.com.
- **Plan facilities** Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site www.uhcfeds.com.
- What you must do to get covered care** **You do not need to select a primary care physician and you do not need to get written referrals to see a contracted specialist for medical services.** The provider must be participating for services to be covered. You must call Customer Service 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 \$1,000 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.
- **Primary care** Your primary care physician (PCP) can be a family practitioner, internist, or pediatrician. Your primary care physician (PCP) will provide most of your health care
 - **Specialty care** **You do not need to have a referral to see a participating specialist.** If you need the care of a specialist, you may select a specialist from our provider directory, or call your PCP who will assist you in locating an appropriate participating provider. If your current specialist is a Plan provider, you may continue to see that doctor without a written referral unless the provider is a mental health/substance abuse specialist. You must call Customer Service at 1-800-558-7868 to obtain authorization for services to use mental health/substance abuse benefits.
- Here are some other things you should know about specialty care:
- If you are seeing a specialist when you enroll in our Plan, check with the specialist to verify that the specialist is participating with the Plan. If the specialist is contracted with the Plan, you may continue to see the provider. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
 - Reduce our service area and you enroll in another FEHB Plan,

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

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

• **Hospital care**

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

• **If you are 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 1-877-835-9861. 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 92nd day after you become a member of this Plan, whichever happens first.

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

Circumstances beyond our control

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

Services requiring our prior approval

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

- Mental health and substance abuse benefits. See page 36.
- Orthopedic and prosthetic devices over \$1,000. See page Durable medical equipment over \$1,000. See page 21.
- Durable medical equipment over \$1,000. See page 21.
- Growth hormone therapy (GHT). See page 19.
- Magnetic resonance imaging (MRI) and/or Magnetic resonance angiogram (MRA) See page 15.
- Pet scans and/or Computed tomography (CT) scans. See page 15.
- Nuclear medicine studies including nuclear cardiology. See page 15.
- Clinical trials. See page 28.

Section 4. Your costs for covered services

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

Copayments	<p>A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.</p> <p>Example: When you see your primary care physician you pay a copayment of \$20 per office visit and when you go in the hospital, you pay \$150 per day up to 3 days per admission.</p>
Cost-Sharing	<p>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.</p>
Deductible	<p>We do not have a deductible.</p>
Coinsurance	<p>Coinsurance is the percentage of our allowance that you must pay for your care.</p> <p>Example: In our Plan, you pay 50% of our allowance for durable medical equipment</p>
Your catastrophic protection out-of-pocket maximum	<p>After your (copayments and coinsurance) total \$3,000 per person or \$6,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:</p> <ul style="list-style-type: none">• Orthopedic devices• Prosthetic devices• Durable medical equipment• Medical supplies (excluding diabetic supplies)• Growth hormones• Hospital emergency room• Office visit, emergency room, and urgent care copays• Pharmacy copays• Refractive eye exams <p>Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.</p>
Carryover	<p>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.</p>
When Government facilities bill us	<p>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.</p>

High Option Benefits

See page 8 for how our benefits changed this year.

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Summary of benefits for the High Option of the United Healthcare of the Midwest, Inc. - 200962

Section 5. High Option Benefits Overview

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

The High Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about High Option benefits, contact us at 1-877-835-9861, or at our Web site at www.uhcfeds.com.

Our benefit package offers the following unique features:

High Option Benefits	You pay
Medical services provided by physicians:	
Diagnostic and treatment services provided in the office	\$20 per visit to you Primary Care Physician office (PCP) ages 18 and up, nothing for children through age 17. \$30 per specialist visit
Services provided by a hospital:	
• Inpatient	\$ 150 per day up to 3 days per admission
• Outpatient Services • Outpatient Surgical	Nothing \$200 per visit outpatient surgical facility charge
Emergency benefits:	
• In or out-of-area	\$100 per visit
Mental health and substance abuse treatment:	Regular cost sharing
Prescription drugs:	
• Plan retail pharmacy and Specialty Pharmaceuticals Note: Please see page 40 for information on specialty medications.	Tier 1: \$7 Tier 2: \$30 Tier 3: \$50
• Plan mail order for up to a 90-day fill	Tier 1: \$17.50 Tier 2: \$75 Tier 3: \$125
Dental care:	Please refer to page 45 for a description of our non-FEHB dental benefits.
Vision care:	\$30 copayment for eye refraction exam every other year
Special features:	Flexible Benefits Option, Care 24, Transplant Centers of Excellence, Cancer Resource Services, Healthy Pregnancy Program, Health and Wellness Programs and Bariatric Resource Services.

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • Office medical consultations • Second surgical opinion 	\$20 per visit to your Primary Care Physician (PCP) ages 18 and up, nothing for children through age 17 \$30 per specialist visit
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility 	Nothing
At home	Nothing
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI/ MRA • Ultrasound • Electrocardiogram and EEG 	Nothing if you receive these services during your office visit; otherwise, \$30 per specialist visit

Benefit Description	You pay
Preventive care, adult	
Routine physical every other year which includes: Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening , including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 	\$20 per visit to your Primary Care Physician (PCP) \$30 per specialist visit \$200 per outpatient surgical visit
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	\$20 per visit to your Primary Care Physician (PCP) \$30 per specialist visit
Routine Pap test Note: You do not pay a separate copay for a Pap test performed during your routine annual physical; see <i>Diagnostic and treatment services</i> , on page 15.	\$20 per visit to your Primary Care Physician (PCP) ages 18 and up nothing for children through age 17. \$30 per specialist visit
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	\$20 per visit to your Primary Care Physician (PCP) \$30 per specialist visit
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):	\$20 per visit to your Primary Care Physician (PCP) \$30 per specialist visit
<i>Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges</i>
Preventive care, children	
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	\$20 per visit to your Primary Care Physician (PCP) ages 18 and up, nothing for children through age 17 \$30 per specialist visit
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics (birth to age 5) • Hepatitis A – ages 12 to 23 months • Influenza vaccine – ages 6 months to age 5 • Rotavirus vaccine – infants ages 8 to 32 weeks 	Nothing
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (up to age 22) 	\$20 per visit to your Primary Care Physician (PCP) ages 18 and up, nothing for children through age 17

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	
<ul style="list-style-type: none"> • Examinations, such as: <ul style="list-style-type: none"> - Eye exams through age 17 to determine the need for vision correction - Hearing exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22) 	<p>\$20 per visit to your Primary Care Physician (PCP) ages 18 and up, nothing for children through age 17</p> <p>\$30 per specialist visit</p>
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 31 for other circumstances, such as extended stays for you or your baby. • Routine care includes office visits, one office sonogram (as part of prenatal care) and laboratory work. Copays will continue to apply to specialized scanning, any specialist not the member's current OB/GYN, durable medical equipment, prescription drugs, chiropractic and acupuncture services, emergency room visits, urgent care visits, or inpatient hospital copayments as these services are not considered routine. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to a circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	<p>\$30 per specialist office visit for initial visit only</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex.</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Administration of injectable contraceptive drugs (such as Depo provera) • Insertion and removal of intrauterine devices (IUDs) • Diaphragms and fitting for diaphragms • Genetic counseling <p>Note: We cover oral and injectable contraceptives under the prescription drug benefit.</p>	<p>\$20 per visit to your Primary Care Physician (PCP)</p> <p>\$30 per specialist visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> 	<p><i>All charges</i></p>
Infertility services	
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) 	<p>\$20 per visit to your Primary Care Physician (PCP)</p> <p>\$30 per specialist visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> • <i>in vitro fertilization</i> • <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> • <i>Fertility drugs</i> 	<p><i>All charges</i></p>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	<p>\$20 per visit to your Primary Care Physician (PCP) ages 18 and up, nothing for children through age 17</p> <p>\$30 per specialist visit</p>
<p>Allergy serum</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 	<p><i>All charges</i></p>

Benefit Description	You pay
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 26.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: We only cover GHT when prior authorization is obtained for the treatment by your participating provider who notifies the Plan that the GHT is medically necessary. Prior authorization is required for GHT before you begin treatment; otherwise, we will only cover GHT services from the date your provider submits the information. If your provider does not 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>\$20 per visit to your Primary Care Physician (PCP) ages 18 and up, nothing for children through age 17</p> <p>\$30 per specialist visit</p>
Physical and occupational therapies	
<p>Up to two consecutive months per condition per year of visits for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 36 sessions per calendar year.</p> <p>Pulmonary rehabilitation is provided for up to 20 visits per calendar year.</p>	<p>\$30 per specialist visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs 	<p><i>All charges</i></p>

Benefit Description	You pay
Speech therapy	
Up to two consecutive months per condition per calendar year	\$30 per specialist visit
<i>Not covered: Exercise programs</i>	<i>All charges</i>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17, which include; (see <i>Preventive care, children</i>) 	\$30 per specialist visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> • <i>Hearing aids, testing and examinations for them</i> 	<i>All charges</i>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Initial pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Eye refraction exams every other year <p>Note: See <i>Preventive care, children</i> for eye exams for children.</p> <p><i>Replacement glasses or contact lenses are not covered after the initial pair.</i></p>	\$30 per specialist office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses, except as shown above</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges</i>
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	\$30 per specialist visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<i>All charges</i>

Benefit Description	You pay
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Orthopedic devices such as braces, medical supplies including colostomy supplies, dressings, catheters and related supplies • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome <p>Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device.</p> <p>Note: Benefits limited to \$2,500 per calendar year excluding prosthetic arms and legs. Plan prior authorization required for items that cost \$1,000 or more.</p>	<p>Nothing up to \$2,500 then 100%</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Prosthetic replacements provided less than 3 years after the last one we covered</i> 	<p><i>All charges</i></p>
Durable medical equipment (DME)	
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Blood glucose monitors; and • Insulin pumps. 	<p>50% of charges up to \$2,500 then 100%</p>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	
<p>Note: Benefits are limited to \$2,500 per calendar year. Plan prior authorization is required for items that cost \$1,000 or more. Repairs and replacements are covered if needed due to a change in the member's medical condition.</p>	50% of charges up to \$2,500 then 100%
<p><i>Not covered: Motorized wheelchairs.</i></p>	<p><i>All charges</i></p>
Home health services	
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<p><i>All charges</i></p>
Chiropractic	
<ul style="list-style-type: none"> • Diagnosis and related services for the manipulation of the spine and extremities to remove nerve interference or its effects. Limited to one treatment per day up to 26 visits per calendar year <p>Note: The interference must be the result of, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.</p>	\$30 per specialist visit
Alternative treatments	
<p>Acupuncture – by a doctor of medicine or osteopathy for:</p> <ul style="list-style-type: none"> • anesthesia • pain relief 	\$30 per specialist visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Naturopathic services</i> • <i>Hypnotherapy</i> • <i>Biofeedback</i> 	<p><i>All charges</i></p>

Benefit Description	You pay
Educational classes and programs	
Coverage is limited to: <ul style="list-style-type: none">• Smoking cessation• Diabetes self management	\$20 per visit to your Primary Care Physician (PCP) ages 18 and up. \$30 per specialist visit

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see <i>Reconstructive surgery</i>) • Surgical treatment of morbid obesity (bariatric surgery) <ul style="list-style-type: none"> - Eligible members must be age 22 or over; - have a minimum Body Mass Index (BMI) of 40, or 35 with at least 2 co-morbid conditions present) and - must have completed a 6-month Plan physician supervised weight loss program ; and - must complete a pre-surgical psychological evaluation; and - Individuals must weigh 100 pounds or 100% over his or her normal weight according to current underwriting standards. • Insertion of internal prosthetic devices . See 5 (a) <i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) 	<p>Nothing for surgery subject to the applicable office visit and facility charge copayments; see sections 5(a) and 5(c)</p>

Benefit Description	You pay
Surgical procedures (cont.)	
<ul style="list-style-type: none"> Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	Nothing for surgery subject to the applicable office visit and facility charge copayments; see sections 5(a) and 5(c)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Reversal of voluntary sterilization Routine treatment of conditions of the foot; see Foot care 	<i>All charges</i>
Reconstructive surgery	
<ul style="list-style-type: none"> Surgery to correct a functional defect Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> The condition produced a major effect on the member’s appearance; and The condition can reasonably be expected to be corrected by such surgery. Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> surgery to produce a symmetrical appearance of breasts; treatment of any physical complications, such as lymphedemas; breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	Nothing for surgery subject to the applicable office visit and facility charge copayments; see sections 5(a) and 5(c)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury Surgeries related to sex transformation 	<i>All charges</i>

Benefit Description	You pay
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Dental care necessary to release pain in treatment of temporomandibular joint pain dysfunction; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>Nothing for surgery subject to the applicable office visit and facility charge copayments; see sections 5(a) and 5(c)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<p><i>All charges</i></p>
Organ/tissue transplants	
<p>Solid organ transplants 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"> • Cornea • Heart • Heart/lung • Kidney • Single, double or lobar lung • Kidney • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas 	<p>Nothing for surgery subject to the applicable office visit and facility charge copayments; see sections 5(a) and 5(c)</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnosis.</p> <ul style="list-style-type: none"> • Allogeneic transplants for: 	<p>Nothing for surgery subject to the applicable office visit and facility charge copayments; see sections 5(a) and 5(c)</p>

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

Benefit Description	You pay
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> • Autologous transplants for: <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Ependyoblastoma - Ewing’s sarcoma - Medulloblastoma - Pineoblastoma - Waldenstrom's macroglobulinemia 	<p>Nothing for surgery subject to the applicable office visit and facility charge copayments; see sections 5(a) and 5(c)</p>
<p>Mini-transplants (non-myeloblative, reduced intensity conditioning) for covered transplants: Subject to medical necessity</p>	
<p>Tandem transplants for covered transplants: Subject to medical necessity</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"> • Allogeneic transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Myelodysplasia/Myelodysplastic syndromes - Multiple myeloma - Multiple sclerosis • Nonmyeloablative allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Myelodysplasia/myelodysplastic syndromes - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma 	<p>Nothing for surgery subject to the applicable office visit and facility charge copayments; see sections 5(a) and 5(c)</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay
<p>Organ/tissue transplants (cont.)</p> <ul style="list-style-type: none"> - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas • Autologous transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Small cell lung cancer - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis - Scleroderma-SSc (severe, progressive) <p>National Transplant Program (NTP) - OptumHealth Care Solutions (URN) used for organ tissue transplants</p> <p>Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute - or National Institutes of Health - approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>Nothing for surgery subject to the applicable office visit and facility charge copayments; see sections 5(a) and 5(c)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered • All services related to non-covered transplants • All services associated with complications resulting from the removal of an organ from a non-member 	<p><i>All charges</i></p>

Benefit Description	You pay
Anesthesia	
Professional services provided in – <ul style="list-style-type: none">• Hospital (inpatient)• Hospital outpatient department• Skilled nursing facility• Ambulatory surgical center• Office	Nothing

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay
Inpatient hospital	
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	\$ 150 per day up to 3 days per admission
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care unless medically necessary</i> 	<i>All charges</i>

Benefit Description	You pay
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	\$200 per outpatient surgical facility charge
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges</i>
Extended care benefits/Skilled nursing care facility benefits	
<ul style="list-style-type: none"> • Room and board in a semi-private room • General nursing • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor • Benefits up to 60 days when full time skilled nursing care is necessary and confinement is medically appropriate. 	Nothing
<i>Not covered: Custodial care</i>	<i>All charges</i>
Hospice care	
<ul style="list-style-type: none"> • Inpatient care • Outpatient care • Family counseling • Supportive and palliative care for a terminally ill member is covered in the home or hospice <p>Note: Benefits are limited to up to three months per benefit period with a lifetime maximum of three benefit periods. These services are provided under the direction of the Plan doctor who certifies that the patient is in the terminal stages of illness, with the life expectancy of approximately six months.</p>	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges</i>

Benefit Description	You pay
Ambulance	
Non-emergency local professional ambulance service when medically appropriate with a network provider and when ordered or authorized by a Plan doctor.	Nothing

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within or outside our service area

If you are in an emergency situation, please call your Primary Care Physician. In extreme emergencies, if you are unable to contact your physician, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan or Primary Care Physician within 48 hours, unless it was not reasonably possible to notify us within that time. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify us within that time. If you are hospitalized in a non-Plan facility and Plan physicians believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full. Plan physician or health care practitioner would result in death, disability or significant jeopardy to your condition. To be covered by this Plan, any follow-up care recommended by non-Plan physicians or health care practitioners must be approved by the Plan or provided by Plan physicians or health care practitioners.

Benefit Description	You pay
Emergency within or outside our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office 	\$20 per visit to you Primary Care Physician (PCP) ages 18 and up, nothing for children through age 17 \$30 per specialist visit
<ul style="list-style-type: none"> • Emergency care at an urgent care center 	\$50 per visit
<ul style="list-style-type: none"> • Emergency care as an outpatient at a hospital, including doctors’ services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	\$100 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <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> 	<i>All charges</i>

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

Benefit Description	You pay
Emergency within or outside our service area (cont.)	
<ul style="list-style-type: none"> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	All charges
Ambulance	
<ul style="list-style-type: none"> • Professional ambulance service when medically appropriate. • Air ambulance service when medically appropriate. <p>Note: See Section 5(c) for non-emergency service.</p>	Nothing

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

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when a deductible does not 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.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$20 per visit to your Primary Care Physician (PCP) ages 18 and above, nothing for children through age 17</p> <p>\$30 per specialist office visit</p> <p>Nothing per outpatient hospital visit</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>\$20 per visit to your Primary Care Physician (PCP) ages 18 and up, nothing for children through age 17</p> <p>\$30 per specialist office visit</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>\$20 per visit to your Primary Care Physician (PCP) ages 18 and up, nothing for children through age 17</p> <p>\$30 per specialist office visit</p> <p>\$150 per day up to 3 days per inpatient hospital admission</p> <p>Nothing per outpatient hospital visit</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>	<p><i>All charges</i></p>

Mental Health and substance abuse benefits

**Mental Health and
substance abuse benefits**

- Preauthorization** To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes: Call Customer Service at 1-800-558-7868 to obtain prior authorization before utilizing services or for a list of Plan participating providers.
- Limitation** We may limit your benefits if you do not obtain a treatment plan and obtain prior authorization.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescription medications, as described in the chart beginning on the next page. 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. Some prescription medications have Quantity Level Limits (QLL) and Quantity per Duration Limits (QD). Please see page 39 for more information.
- We have no deductible
- 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.
- **We use a Prescription Drug List (PDL).**Our PDL Management Committee creates this 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.

The PDL consists of Tiers 1, 2, and 3.

- **Tier 1** is your **lowest** copayment option (\$7 for up to a 31-day supply or \$17.50 for up to a 90-day supply through mail order), 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 mail order), 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 mail order), 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 Tier level for all covered medications and supplies may occur 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 \$7 if it is a Tier 1 medication. This is our network contracting policy, however, only a few retail pharmacies apply this policy. You will never pay more than the appropriate copayment for a medication. Contact our Customer Service 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 \$7 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. You may purchase maintenance medications through retail pharmacy or mail order. You will pay the applicable Tier copayment for each 31-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 \$17.50 through mail order, Tier 2 would be \$75 through mail order and Tier 3 would be \$125 through mail order.
- **Contraceptives** - You pay one copay for up to maximum of a 90-day supply of contraceptive medications, subject to QLL and QD limitations.
- **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, injectable medications 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 to filling prescription medications for members covered under the FEHB if:
 - You are called to active duty, or
 - You are officially called off-site as a result of a national or other emergency, 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 or call 1-877-471-1860.
- **Specialty Pharmacy Program.** Our Specialty Pharmacy Program includes high cost medications to 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 90-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
 - Free supplies such as syringes and needles
 - Educational materials as well as support and development of a necessary care plan.

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
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin with a copayment charge applied every 2 vials • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction • Oral and injectable contraceptive drugs <p>Note: Intravenous fluids and medications for home use, implantable drugs, and some injectable drugs are covered under <i>Medical services and supplies Section (5a)</i> or <i>Surgical and anesthesia services Section (5b)</i>.</p>	<p>Plan retail pharmacy up to a maximum of a 31 day supply:</p> <p>Tier 1- \$ 7</p> <p>Tier 2- \$ 30</p> <p>Tier 3- \$ 50</p> <p>Plan mail order pharmacy for up to a maximum of up to a 90-day supply:</p> <p>Tier 1- \$ 17.50</p> <p>Tier 2- \$ 75</p> <p>Tier 3- \$ 125</p>
<ul style="list-style-type: none"> • Diabetic supplies limited to insulin syringes, needles, glucose test tape, Benedict’s solution or equivalents and acetone test tablets. • Implanted contraceptive drugs and devices such as Norplant 	<p>50% of charges</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay
<p>Covered medications and supplies (cont.)</p> <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Medications used for cosmetic purposes • Any product dispensed for the purpose of appetite suppression and other weight loss products • Drugs to enhance athletic performance • Medical supplies such as dressings and antiseptics • Artificial insemination fertility drugs except Clomid (clomiphene) • Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies • Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed • Vitamins, nutrients and food supplements that can be purchased without a prescription • Nonprescription medicines • 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 • Compound drugs that do not contain at least one covered ingredient that requires a Prescription Order or Refill • Alcohol swabs and bio-hazard disposable containers 	<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 FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We have no deductible.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Accidental injury benefit	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Nothing

Dental benefits

Please refer to page 45 for a description of our non-FEHB dental benefits.

Section 5(h). Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services. For example:</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Care24	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-888-887-4114 and talk with a registered nurse with an average of 15 years of experience who will discuss treatment options and answer your health questions. Members may learn self-care for minor illnesses and injuries; understand diagnosed conditions; manage chronic diseases; discover and evaluate possible benefits and risks of various treatment options; learn about specific medications; prepare questions for doctor visits; develop and maintain healthful living habits; and connect with community support groups.</p>
Transplant Centers of Excellence	<p>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 at 1-888-936-7246 to discuss information about transplants and physicians.</p>
Cancer Resource Services	<p>Cancer is one of the most prevalent conditions in medicine. Cancer Resource Services (CRS) provides unparalleled clinical and economic value in managing complex cancers-providing patients with access to expertise at leading cancer centers throughout the country. Call 1-866-936-6002 to discuss information about cancer centers and physicians.</p>
Healthy Pregnancy Program	<p>With our Healthy Pregnancy Program, United Healthcare 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, and 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 www.healthy-pregnancy.com.</p>
Health and Wellness Educational Information	<p>You can find healthy living article and general information on www.myuhc.com Health and wellness topic categories include the following and much more:</p> <ul style="list-style-type: none"> • Addiction • Family • Fitness and Nutrition • Healthy Aging

	<ul style="list-style-type: none"> • Healthy Pregnancy • Preventive Medicine • Relationships
ParentSteps	<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 www.urnparentsteps.com or call 1-866-774-4626.</p>
Congenital Heart Disease Resource Service (CHDRS)	<p>Members 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 www.urnweb.com.</p>
Kidney Resource Services (KRS)	<p>Kidney Resource Services provides access to top-performing dialysis centers and nurse consulting services to support the management of kidney disease. Kidney transplantation candidates have access to the Transplant Centers of Excellence Network and Transplant Resources Service nurse consulting services. Please call a KRS nurse at 1-888-936-7246 for all inquiries and notifications related to End Stage Renal Disease, including dialysis or vascular access for dialysis. Information is also available at www.urnweb.com.</p>
Bariatric Resource Services (BRS)	<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, 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, at 1-888-936-7246 to enroll in the program. Information is also available at www.urnweb.com.</p>

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket 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 1-877-835-9861 or visit their website at www.uhcfeds.com.

PPO Dental Plan

UnitedHealthcare provides a PPO Basic Dental plan to our Federal members enrolled in this plan. There is no additional premium for this benefit that includes many restorative procedures as well as comprehensive preventive benefits. Enrollment is automatic when you enroll in this UnitedHealthcare FEHB health plan. See the 2009 Federal Employees Health Benefits Summary

UnitedHealth Wellness SM

As a comprehensive portfolio of wellness programs and services offered through UnitedHealthcare, UnitedHealth Wellness can help improve your total health and well-being. UnitedHealth Wellness is not insurance. Instead, it is our commitment to bring you more ways than ever to stay healthy. For more information also visit us on the web at www.unitedhealthwellness.com. 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: Trackers to monitor your weight and exercise programs; exercise recommendations; calculators for body mass index, healthy weight, calorie burn and heart rate; strength exercise demonstrations, quizzes to help you advance through the program; motivational support and much, much more! To access the program, log on to www.myuhc.com, click "Health and Wellness", then "Your Personal Health Center" on the right side of the screen.

Discounts on wellness products and services : You can get discounts on wellness products and health care services not covered by your 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 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. The online Personal Health Manager helps you manage your health information all in one place. You can securely record your current health status or conditions, document your medical contacts, create an emergency medical wallet card and store information from doctors visits and print reports.

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

Health and Wellness Library Get the latest information on a variety of health and wellness topics, including: content personalized based upon your condition, life stage or life style; clinical information on a wide range of diseases, conditions, tests, procedures, treatments, therapies and drugs; exclusive articles to help you make sense of the latest health news and trends and daily articles on consumer health news. Log onto www.myuhc.com and click "Health&Wellness", then "ConditionsAtoZ"

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** (see specifics regarding transplants).

We do not cover the following:

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

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, 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 30555, Salt Lake City, UT 84130-0555.

Prescription drugs

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

International Claims

In the event that emergency services were required while traveling, **submit international claims to:** UnitedHealthcare, PO Box 30555, Salt Lake City, UT 84130-0555.

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3.

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: United Healthcare Federal Employees Health Benefits (FEHB) Program Appeals, P.O. Box 30573, Salt Lake City, Utah 84130-0573 ; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial - go to step 4; orAsk you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group III, 1900 E Street, NW, Washington, DC 20415-3630.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none">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; andYour daytime phone number and the best time to call. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p>

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

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

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

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

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

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

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

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-877-835-9861 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group III at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member 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, 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. You will not need to do anything. To find out if you need to do something to file your claim, call us at 1-877-835-9861 or see our Web site at www.uhcfeds.com.

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

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

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

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

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

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

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

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

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

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

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one dental/vision plan, coverage provided under your FEHB Plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 11.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 11.
Cost-Sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g. deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Services that are non-health related, such as daily living activities, or services which are health related but do not seek to cure, or services which do not require a trained medical professional. Custodial care that lasts 90 days or more is sometimes known as long term care.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 11.
Experimental or investigational service	United Healthcare of the Midwest, Inc. determines “Medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, diagnostic procedures, drug therapies, or devices to be experimental or investigational when one of the following applied (at the time it makes a determination regarding coverage in a particular case): <ul style="list-style-type: none">• Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service as appropriate for the proposed use;• Subject to review and approval by any Institutional Review Board for the proposed use;• The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 Clinical Trial set forth in the FDA regulations, regardless of when the trial is actually subject to FDA oversight;• Not demonstrated through the prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition, illness or diagnosis for which its use is proposed.
Medical necessity	Services which are reasonably necessary in the exercise of good medical practice in accordance with professional standards accepted in the United States for the treatment of an active illness or injury. We determine medical necessity.
Us/We	Us and We refer to United Healthcare of the Midwest, Inc.
Plan Allowance	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. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense
You	You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage information

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal 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 or has a change in marital status, divorce, or when your child under age 22 marries.

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

When you retire

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

When you lose benefits

When FEHB coverage ends

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

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

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

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

Upon divorce

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

Temporary Continuation of Coverage (TCC)

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

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

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

Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Section 12. Three Federal Programs complement FEHB benefits

Important information

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

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money 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 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 Insurance

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/dentalvision. This site also provides links to each plan’s website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

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

The Federal Long Term Care Insurance Program – *FLTCIP*

It’s important protection

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

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Summary of benefits for the High Option of the United Healthcare of the Midwest, Inc.- 2009

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

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	\$20 per visit to your Primary Care Physician (PCP) ages 18 and up, nothing for children through age 17 \$30 per specialist visit	15
Services provided by a hospital:		
• Inpatient	\$ 150 per day up to 3 days per admission copay	31
• Outpatient Services • Outpatient Surgical	Nothing \$200 per visit	32
Emergency benefits:		
• In or out-of-area	\$100 per emergency room visit	34
Mental health and substance abuse treatment:	Regular cost sharing	36
Prescription drugs:		38
• Plan Retail pharmacy and Specialty Pharmaceuticals	Tier 1: \$7 Tier 2: \$30 Tier 3: \$50	40
• Plan mail order for up to a 90-day fill	Tier 1: \$17.50 Tier 2: \$75.00 Tier 3: \$125	40
Dental care:	Please refer to page 45 for a description of our non-FEHB dental benefit.	42
Vision care:	\$30 copayment for eye refraction exam every other year	20
Special features:	Flexible Benefits Option, Care 24, Transplant Centers of Excellence, Cancer Resource Services, Healthy Pregnancy Program, Bariatric Resource Services, Health and Wellness Programs	43
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$3,000/ Self Only or \$6,000 for Self and Family enrollment per year Some costs do not count toward this protection	11

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2009 Rate Information for - United Healthcare of the Midwest, Inc.

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

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

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

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

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

St. Louis, MO

High Option Self Only	B91	\$155.66	\$52.37	\$337.26	\$113.47	\$179.45	\$28.58
High Option Self and Family	B92	\$348.58	\$116.19	\$755.25	\$251.75	\$402.03	\$62.74

Kansas City, KS

High Option Self Only	GX1	\$155.66	\$76.73	\$337.26	\$166.25	\$179.45	\$52.94
High Option Self and Family	GX2	\$352.56	\$193.53	\$763.88	\$419.32	\$406.42	\$139.67

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