

Union Health Service

www.unionhealth.org

Member Service 312 423-4200 extension 3285



2018

A Health Maintenance Organization (High Option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details. This plan is accredited. See page 11.

IMPORTANT

- Rates: Back Cover
- Changes for 2018: Page 13
- Summary of benefits: Page 69

Serving: Chicago and Suburban Area

Enrollment in this plan is limited: You must live or work in our geographic service area to enroll. See page 12 for requirements.

Enrollment code for this Plan:

- 761 Self Only
- 763 Self Plus One
- 762 Self and Family



Authorized for distribution by the:



United States
Office of Personnel Management

Healthcare and Insurance
<http://www.opm.gov/insure>

RI 73-026

**Important Notice from Union Health Service About
Our Prescription Drug Coverage and Medicare**

The Office of Personnel Management (OPM) has determined that the Union Health Service's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug 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 Medicare D 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 will 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 (October 15 through December 7) 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 800-772-1213 (TTY 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 800-MEDICARE 800-633-4227, TTY 877-486-2048.

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Introduction

This brochure describes the benefits of Union Health Service under our contract (CS 1571) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 312-423-4200 ext. 3285 or through our website: www.unionhealth.org. The address for Union Health Service administrative offices is:

Union Health Service, Inc.
1634 West Polk Street
Chicago, Illinois 60612

This brochure is the official statement of benefits. No 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. If you are enrolled in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2018, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2018, and changes are summarized on page 14. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provisions for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means Union Health Service.
- 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.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

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) statements that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 312-423-4200 ext. 3262 and explain the situation.
 - If we do not resolve the issue:

**CALL - THE HEALTH CARE FRAUD HOTLINE
877-499-7295**

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

**You can also 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).
 - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).
- 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 (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination Is Against the Law

Union Health complies with applicable Federal civil rights laws to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, Union Health does not discriminate, exclude people, or treat them differently on the basis because of race, color, national origin, age, disability, or sex.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. 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. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks. 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 take notes, 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 and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have such as latex.
- 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 your pharmacist about the medication 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.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

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

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic 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 or clinic.

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 reactions to anesthesia, and any medications you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- http://www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/. 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.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a health care facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error. If "Never Events" or "Serious Reportable Events" should ever occur and appear on a provider billing, UHS will automatically and directly communicate with the billing provider to remove the charges.

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.
- **Minimum essential coverage (MEC)** Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.
- **Minimum value standard** Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.
- **Where you can get information about enrolling in the FEHB Program** See www.opm.gov/healthcare-insurance 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 that 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 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
- 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. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family** Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 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 or Self Plus One 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 Plus One or 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 Plus One or 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 are married.

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 of changes in family member status including your marriage, divorce, annulment, or when your child reaches age 26.

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.

If you have a qualifying life event (QLE) – such as marriage, divorce, or the birth of a child – outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

• **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26 th birthday.
Foster children	Foster children are eligible for coverage until their 26 th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but NOT their spouse or their own children) are covered until their 26 th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26 th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay

You can find additional information at www.opm.gov/healthcare-insurance.

• **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 Plus One or 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 in for Self Plus One or 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 Plus One or Self and Family coverage, as appropriate, 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 Plus One or Self and Family, as appropriate, 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 Plus One or Self and Family, as appropriate 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. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

• **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2018 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 2017 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.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance 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).

- **Upon divorce**

If you are divorced from a Federal employee, Tribal employee, or an 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 additional information about your coverage choices. You can also visit OPM's website at www.opm.gov/healthcare-insurance/healthcare/plan-information/
- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. If you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

You may elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premium. Visit www.HealthCare.gov to compare plans and see what your premium deductible and out-of-pocket would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.
- **Converting to Individual Coverage**

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing 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 contact us in writing 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, a waiting period will not be imposed and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 312 423-4200 extension 3285 or visit our website at www.unionhealth.org.
- **Health Insurance Marketplace**

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this HMO plan works

This Plan is a (health maintenance organization (HMO)) plan. OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Union Health Service holds the following accreditation

- Accreditation Association for Ambulatory Health Care (www.aaahc.org);

To learn more about this plan's accreditation(s), please visit the following websites: www.aaahc.org

For the most recent copy of the provider directory go to: www.unionhealth.org; or contact the Plan's member service department at 312-423-4200 extension 3285 or 3291.

Union Health Service emphasizes preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury.

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

You should join Union Health Service because you prefer the plans 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

Preventive care services

Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles or annual limits when received from network providers.

How we pay providers

UHS is a Staff Model Group Practice Plan that employs individual physicians, owns and operates medical centers and contracts with hospitals to provide the benefits in this brochure. Most physicians are salaried employees. Other Plan providers accept a negotiated payment from us. You will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

All physicians are either Board Certified or Eligible in their specialties and are affiliated with contracted area hospitals.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, to no more than \$7,350 for Self Only enrollment, and \$14,700 for Self Plus One or Self and Family.

Health education resources and account management tools.

Your rights and responsibilities

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 website (www.opm.gov/healthcare-insurance/) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Union Health Service is a state-certified HMO that was established in 1955.
- Union Health Service is a staff model not-for-profit Health Maintenance Organization.
- Union Health Service has been in operation for over 60 years.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, Union Health Service at www.unionhealth.org. You can also contact us to request that we mail a copy to you.

If you want more information about us, call our Member Service Department 312-423-4200 ext. 3285, 3291 or write to Union Health Service, 1634 West Polk Street Chicago, IL 60612. You may also visit our website at www.unionhealth.org.

By law, you have the right to access your personal health information (PHI). For more information regarding access to PHI, visit our website at www.unionhealth.org to obtain a Notice of our Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

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: the Chicago, Illinois area located in Cook, DuPage, Kane, Will and Kendall counties.

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

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. Change for 2018

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

Changes to this Plan

- Your share of the non-Postal and Postal premiums will increase for Self Only, Self Plus One and Self and Family. See page 70.
- Infertility benefits for Gamete intrafallopian tube transfer (GIFT) and Zygote intrafallopian transfer (ZIFT) will no longer be covered. See page 27.
- Your copay of the prescription drug benefit for Tier II, Preferred will increase to \$45 (30-day supply) and \$112.50 (90-day supply). See page 45.
- Your copay of the prescription drug benefit for Tier III, Non-Preferred will increase to \$80 (30-day supply) and \$200 (90-day supply). See Page 45.
- There will not be a copayment for pre-authorized Statin Drugs for adults aged 40 to 75 years with no history of cardiovascular disease (CVD), 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater. See page 45.
- Your copay for emergency care is \$50 per visit when directed by UHS to an urgent care center and will increase to \$125 per visit as an outpatient at a hospital or when not directed by UHS to an urgent care center. See page 40.
- There will no longer be a copayment for voluntary sterilization (tubal ligation). See page 26.
- Your annual catastrophic out-of-pocket expenses for covered services, including deductibles and copayments will increase to \$7,350 for Self Only enrollment, and \$14,700 for Self Plus One or Self and Family enrollment.

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 our Member Service Department at 312-423-4200 ext. 3285 or write to us at 1634 West Polk Street, Chicago, IL 60612.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance and you will not have to file a claim as long as you receive care from a network provider.

- **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 website: www.unionhealth.org

- **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 website at www.unionhealth.org

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a UHS primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. The UHS Physicians Directory lists all primary care physicians and specialists. The UHS Member Service Department can assist you if you have questions.

- **Primary care**

Your primary care physician can be a family practitioner, internist, pediatrician, or Obstetrician/Gynecologist (OB-GYN). Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, a woman may see her Plan obstetrician/gynecologist without a referral.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our UHS physicians and our contracting providers when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

- Your primary care physician will create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - terminate our contract with your specialist for other than cause;
 - 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 Medical Management Department immediately at 312-423-4200 ext. 3231. 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;
- 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.

You need prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services*.

You must get prior approval for services outside of the Plan. Failure to do so will result in you being responsible for the service.

<ul style="list-style-type: none"> • Inpatient hospital admission 	<p>Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.</p>
<ul style="list-style-type: none"> • Other services 	<p>Your primary care physician has authority to refer you for most services. For certain services however, services outside of our network your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.</p>
	<p>Our Medical Director must approve your referral to an outside specialist (physicians who are not in our current network) before you receive treatment. When you receive a referral from your primary care physician to an outside specialist, you must return to the primary care physician after the consultation. Your primary care physician must provide or authorize all follow-up care. On outside referrals, your primary care physician will give specific instructions to the specialist as to what services are authorized. If the specialist suggests additional services or visits, you must check with your primary care physician for approval and authorization. Do not go to the outside specialist (outside of UHS facilities) unless your primary care physician has arranged for and the Plan has issued an authorization for the referral in advance.</p>
<p>How to request precertification for an admission or get prior authorization for Other services</p>	<p>First, your physician, your hospital, you, or your representative, must call us at 312-423-4200 ext. 3231 before admission or services requiring prior authorization are rendered.</p>
	<p>Next, provide the following information:</p> <ul style="list-style-type: none"> • enrollee’s name and Plan identification number; • patient’s name, birth date, identification number and phone number; • reason for hospitalization, proposed treatment, or surgery; • name and phone number of admitting physician; • name of hospital or facility; and • number of days requested for hospital stay.
<ul style="list-style-type: none"> • Non-urgent care claims 	<p>For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.</p>
	<p>If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.</p>
<ul style="list-style-type: none"> • Urgent care claims 	<p>If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.</p>

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or calling us at 312 423-4200 ext. 3262. You may also call OPM's Health Insurance III at 202 606-0755 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 312 423-4200 ext. 3262. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

Concurrent care claims

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

Precertification for maternity care is coordinated in the same manner as all inpatient and outpatient services.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

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

Care at non-network facilities except in a medical emergency is not covered.

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.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.

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

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

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

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

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

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

Example: When you see your primary care physician you pay a copayment of \$15 per office visit.

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

UHS has a deductible for orthopedic and prosthetic devices and durable medical equipment of \$100 per member per calendar year with a maximum of \$300 for Family.

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

Coinsurance Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your deductible.

Example: In our Plan, you pay 20% of our allowance for orthopedic and prosthetic devices and durable medical equipment.

Your catastrophic protection out-of-pocket maximum After your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total \$7,350 for Self Only, or \$14,700 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for approved covered services under this contract. ***The maximum annual limitation on cost sharing listed under Self Only of \$7,350 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

Example Scenario: Your plan has a \$7,350 Self Only maximum out-of-pocket limit and a \$14,700; Self Plus one or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of \$7,350 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of \$14,700, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of \$7,350 for the calendar year before their qualified medical expenses will begin to be covered in full.

However, copayments and coinsurance if applicable 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:

- Eyeglasses or contact lenses
- Expenses for utilizing out-of-network providers

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

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic 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 expense 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 then covered expenses according to this years benefit, benefit changes are effective January 1.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Benefits

See page 14 for how benefits changed this year. Page 72 is a benefit summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5(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 an ambulatory surgical center or the outpatient department of a hospital.
- Plan has a deductible for prosthetic and orthopedic devices and durable medical equipment.
- 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	High Option
Professional services of physicians <ul style="list-style-type: none"> • In physician's office • In an urgent care center • Office medical consultations • Second surgical opinion • At home • Advance care planning 	\$15 per visit
<ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	No copay
<i>Not covered:</i> <ul style="list-style-type: none"> • Telehealth services 	<i>All charges</i>
Lab, X-ray and other diagnostic tests	High Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	\$15 per visit

Benefit Description	You pay
Preventive care, adult	High Option
<p>Routine annual physical includes:</p> <p>Routine screenings, such as:</p> <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 - Colonoscopy screening – every ten years starting at age 50 	Nothing
<p>Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older</p>	Nothing
<p>Well woman care; based on current recommendations such as:</p> <ul style="list-style-type: none"> • Cervical cancer screening (Pap smear) • Human Papillomavirus (HPV) testing • Chlamydia/Gonorrhea screening • Osteoporosis screening • Breast cancer screening • Counseling for sexually transmitted infections • Counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence 	Nothing
<p>Routine mammogram – covered for women.</p>	Nothing
<p>Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC); based on the Advisory Committee on Immunization Practices (ACIP) schedule.</p>	Nothing
<p>Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible.</p> <p>Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/</p> <p>HHS: www.healthcare.gov/preventive-care-benefits/</p> <p>CDC: www.cdc.gov/vaccines/schedules/index.html</p> <p>Women’s preventive services:</p> <p>www.healthcare.gov/preventive-care-women/</p> <p>For additional information: healthfinder.gov/myhealthfinder/default.aspx</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.</i> 	<i>All charges</i>

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	High Option
<ul style="list-style-type: none"> Immunizations, boosters, and medications for travel or work-related exposure. 	All charges
Preventive care, children	High Option
<ul style="list-style-type: none"> Well-child visits examinations, and immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics 	Nothing
<ul style="list-style-type: none"> Childhood immunizations recommended by the CDC 	Nothing
<p>Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventative listing of services will be subject to the applicable member copayments, coinsurance, and deductible.</p> <p>Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/</p> <p>HHS: www.healthcare.gov/preventive-care-benefits/</p> <p>CDC www.cdc.gov/vaccines/schedules/index.html</p> <p>For additional information: healthfinder.gov/myhealthfinder/default.aspx</p> <p>Note: For a complete list of the American Academy of Pediatrics Bright Future Guidelines go to brightfutures.aap.org/Pages/default.aspx</p>	Nothing
Maternity care	High Option
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> Prenatal care Screening for gestational diabetes for pregnant women after 24 weeks. Delivery Postnatal care 	<p>Nothing for prenatal care</p> <p>Nothing for delivery</p> <p>Nothing for first postpartum care office visit, \$15 per visit for all postpartum care visits thereafter.</p>
Breastfeeding support, supplies and counseling for each birth	Nothing
<p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> You do not need to precertify for your vaginal delivery; see page 18 for other circumstances, such as extended stays for you or your baby. You may remain in the hospital up to 48 hours after a vaginal 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 Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits apply to circumcision. We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. 	Nothing

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	High Option
<ul style="list-style-type: none"> Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). <p>Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Routine sonograms to determine fetal age, size, or sex.</i> <i>Medical cost resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges</i>
Family planning	High Option
<p>Contraceptive counseling on an annual basis</p> <p>Voluntary sterilization (tubal ligation)</p>	Nothing
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> Voluntary sterilization (See Surgical procedures Section 5 (b)) Surgically implanted contraceptives Injectable contraceptive drugs (such as Depo provera) Intrauterine devices (IUDs) Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	\$15 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Reversal of voluntary surgical sterilization</i> <i>Genetic testing and counseling</i> 	<i>All charges</i>
Infertility services	High Option
<p>Diagnosis, testing and treatment of infertility such as:</p> <ul style="list-style-type: none"> Artificial insemination: <ul style="list-style-type: none"> In vitro fertilization (IVF) Intracytoplasmic sperm injection (ICSI) Donor sperm and eggs (medical cost) Procedure utilized to retrieve oocytes or sperm and subsequent procedures used to transfer the oocytes or sperm to the covered recipient Associated donor expense medical expenses, including but not limited to physical examination, laboratory screening, psychological screening, and prescription drugs are covered if established as prerequisites to donation by the insurer Fertility Drugs as mandated by the State of Illinois 	\$15 per visit

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	High Option
<p>Note: The State of Illinois has limitations on the number of assisted reproductive technology (ART) procedures. The following are the limitations according to the State of Illinois. To receive infertility services, members must live in Illinois, have been unable to conceive after one year of unprotected sexual intercourse or unable to sustain a successful pregnancy; have a medical condition that renders conception impossible through unprotected sexual intercourse; efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.</p> <p>Note: Benefits for advanced procedures such as IVF and ICSI are covered only after you have been unable to sustain a successful pregnancy through reasonable less costly medically appropriate infertility treatments.</p> <p>Note: Fertility drugs are covered under medical benefits and oral fertility drugs covered under prescription drug benefits.</p> <p>Note: The benefits for advanced procedures required by the law are four completed oocyte retrievals per lifetime of the individual, unless a live birth is achieved as a result of an artificial reproductive transfer of oocytes. In that case, two additional oocyte retrievals will be covered.</p>	\$15 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>Gamete intrafallopian tube transfer (GIFT)</i> - <i>Zygote intra-fallopian transfer (ZIFT)</i> • <i>Costs for services rendered to a surrogate.</i> • <i>Cost incurred for reversing a tubal ligation or vasectomy</i> • <i>Cost for preserving and storing sperm, eggs and embryos</i> • <i>Costs for an egg or sperm donor which are not medically necessary</i> • <i>Experimental treatments</i> 	<i>All charges</i>
Allergy care	High Option
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	\$15 per visit
Allergy serum	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 	<i>All charges</i>

Benefit Description	You pay
Treatment therapies	High Option
<ul style="list-style-type: none"> Chemotherapy and radiation therapy <p>Note; High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 35.</p> <ul style="list-style-type: none"> Respiratory and inhalation therapy Dialysis – hemodialysis Intravenous (IV) Infusion Therapy – Home IV and antibiotic therapy Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder (ABA) therapy coverage per state of Illinois mandate.) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Other Services under You need prior Plan approval for certain services</i> in Section 3.</p>	<p>\$15 per visit</p>
Peritoneal dialysis	Nothing
Physical and occupational therapies	High Option
<p>60 visits for the services of each of the following:</p> <ul style="list-style-type: none"> Qualified physical therapists Occupational therapists Habilitative services for dependents up to age 26 (per state of Illinois mandated guidelines) <p>Note: We only cover therapy when a provider orders the care.</p> <p>Note: Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.</p> <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 30 sessions.</p>	<p>\$15 per outpatient visit</p> <p>Nothing per visit during covered inpatient admission</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Long-term rehabilitative therapy</i> <i>Exercise programs</i> 	<p><i>All charges</i></p>
Speech therapy	High Option
<p>60 visits per condition upon approval of the Plan's Medical Director.</p>	<p>\$15 per outpatient visit</p> <p>Nothing per visit during covered inpatient admission.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Therapy that will not result in improvements to your condition within 60 visits.</i> 	<p><i>All charges</i></p>

Benefit Description	You pay
Hearing services (testing, treatment, and supplies)	High Option
<ul style="list-style-type: none"> For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or Audiologist Implanted hearing device, such as a cochlear implant <p>Note: For routine hearing screening performed during a child's preventive care visit, see Section 5 (a) <i>Preventive care, children</i>.</p> <p>Note: For benefit devise see Section 5(a) <i>Orthopedic and prosthetic devices</i></p>	\$15 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Testing and examinations for hearing aids</i> <i>Hearing aids</i> <i>Hearing services that are not shown as covered</i> 	<i>All charges</i>
Vision services (testing, treatment, and supplies)	High Option
<p>In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, you may obtain an annual eye refraction (which includes the written lens prescription).</p> <ul style="list-style-type: none"> One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) Eye exam to determine the need for vision correction for children through age 17 (see <i>Preventive care, children</i>) Annual eye refractions <p>Note: See <i>Preventive care, children</i> for eye exams for children.</p>	\$15 per 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	High Option
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts.</p>	\$15 per 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	High Option
<ul style="list-style-type: none"> • Artificial limbs and eyes; • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Speech generating device (electro larynx - electronic speech aid also known as an artificial larynx). • Implanted hearing-related devices, such as cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. <p>Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.</p>	<p>\$15 per office visit</p> <p>20% of charges after you pay the calendar year deductible.</p> <p>\$100 deductible per member per calendar year with a maximum of \$300 for Family (no further deductible for family members after three deductibles have been satisfied)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Replacement of an otherwise covered prostheses before (1) any evidence of a manufacturing defect is known or (2) normal wear and tear with proper use for which either condition causes the prior prostheses to become unusable for its intended purpose.</i> • <i>External hearing aids</i> 	<p><i>All charges</i></p>
Durable medical equipment (DME)	High Option
<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 • Insulin pumps <p>Note: Call our Medical Management Department at 312 423-4200 ext. 3231 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>20% of charges after you pay the calendar year deductible</p> <p>\$100 deductible per member per calendar year with a maximum of \$300 for Family (no further deductible for family members after three deductibles have been satisfied)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Motorized wheelchairs.</i> 	<p><i>All charges</i></p>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	High Option
<ul style="list-style-type: none"> • <i>Equipment that is not medically necessary</i> • <i>Audible prescription reading devices</i> • <i>Hearing aids</i> 	<i>All charges</i>
Home health services	High Option
<p>Home health care is provided for homebound members at their home when prescribed by a Plan physician.</p> <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 <p>Note: Our Medical Management Department will monitor all home health care</p>	\$15 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<i>All charges</i>
Chiropractic	High Option
<p>Your UHS Orthopedic physician may refer you for a chiropractic consultation or chiropractic care.</p> <p>Note: You must receive prior approval from the Plan's Medical Director to receive chiropractic services. The Plan's medical director will review your chiropractor's treatment plan after you receive your consultation. (See section 3 for services requiring prior approval)</p>	\$15 per visit
Alternative treatment	High Option
No benefit	<i>All charges</i>
Educational classes and programs	High Option
<p>Coverage is provided for:</p> <ul style="list-style-type: none"> • Tobacco cessation program, including individual/group/telephone counseling, and for over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. 	<p>Nothing for counseling for up to two quit attempts per year</p> <p>Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence</p>
<ul style="list-style-type: none"> • Diabetes Nutrition Therapy Classes • Childhood obesity education 	\$15 per 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 physician must provide or arrange your care.
- Plan has deductibles for prosthetic and orthopedic devices and durable medical equipment.
- 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 services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Surgical procedures	High Option
<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) -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. • Insertion of internal prosthetic devices. See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization (e.g. vasectomy) See Section 5 (a) Family planning for tubal ligation • Treatment of burns <p>Note:</p> <ul style="list-style-type: none"> • Surgery for morbid obesity should be performed only as a last resort, when the member's health is endangered and more conservative medical measures, including prescription drugs such as appetite suppressants, have not been successful 	<p>Inpatient: Nothing</p> <p>Outpatient: \$15 per visit</p>

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	High Option
<ul style="list-style-type: none"> 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 	Inpatient: Nothing Outpatient: \$15 per visit
Not covered: <ul style="list-style-type: none"> <i>Reversal of voluntary sterilization</i> <i>Routine treatment of conditions of the foot; (see Foot care)</i> 	<i>All charges</i>
Reconstructive surgery	High Option
<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>	\$15 per visit
Not covered: <ul style="list-style-type: none"> <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> 	<i>All charges</i>
Oral and maxillofacial surgery	High Option
Oral surgical procedures, limited to: <ul style="list-style-type: none"> Reduction of fractures of the jaws or facial bones; Surgical correction of cleft lip, cleft palate or severe functional malocclusion; Removal of stones from salivary ducts; Excision of leukoplakia or malignancies; Excision of cysts and incision of abscesses when done as independent procedures; Other surgical procedures that do not involve the teeth or their supporting structures. 	\$15 per visit
Not covered: <ul style="list-style-type: none"> <i>Oral implants and transplants</i> 	<i>All charges</i>

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay
Oral and maxillofacial surgery (cont.)	High Option
<ul style="list-style-type: none"> • Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) • Shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, and any other dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	All charges
Organ/tissue transplants	High Option
<p>These solid organ transplants are covered. Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Intestinal transplants • Isolated small intestine • Small intestine with the liver • Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-Pancreas • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis <p>These tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan. Refer to <i>Other services</i> in Section 3 for prior authorization procedures.</p> <ul style="list-style-type: none"> • Autologous tandem transplants for <ul style="list-style-type: none"> - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) <p>Note: These solid organ, tandem blood or marrow stem cell transplants are subject to medical necessity and experimental/investigational review by the Plan. Refer to <i>Other services</i> in Section 3 for prior authorization procedures.</p>	Nothing
<p>Blood or marrow stem cell transplants</p> <p>The Plan extends coverage for the diagnoses as indicated below.</p>	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	High Option
<p>Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. Refer to <i>Other services</i> in Section 3 for prior authorization procedures:</p> <ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g. Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Epithelial ovarian cancer - Multiple myeloma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal and ovarian germ cell tumors <p>Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan.</p> <p>Refer to <i>Other services</i> in Section 3 for prior authorization procedures:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) 	Nothing

Benefit Description	You pay
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Neuroblastoma - Amyloidosis <p>These blood or marrow stem cell transplants are covered only in a Plan-designated center of excellence and if approved from the Plan's medical director in accordance with the Plan's protocols.</p> <p>If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not covered by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.</p> <ul style="list-style-type: none"> • Autologous Transplants for <ul style="list-style-type: none"> - Advanced Childhood kidney cancers - Advance Ewing sarcoma - Aggressive non-Hodgkin lymphomas limited to procedures performed in clinical trial - Breast Cancer limited to procedures performed in clinical trial - Childhood rhabdomyosarcoma - Epithelia Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.</p>	<p>Nothing</p>
<i>Not covered:</i>	<i>All charges</i>

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> • <i>Donor screening tests and donor search expenses except as shown above</i> 	<i>All charges</i>
Anesthesia	High Option
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) • Skilled nursing facility 	Nothing
Professional services provided in – <ul style="list-style-type: none"> • Hospital outpatient department • Ambulatory surgical center • Office 	\$15 per visit

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.
- Plan has a \$100 deductible per member/\$300 deductible per family for prosthetic and orthopedic devices and durable medical equipment.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 (services requiring our approval) to be sure which services require precertification.

Benefit Description	You pay High Option
Inpatient hospital	
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations • General nursing care • 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>	Nothing
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • 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 (Note: calendar year deductible applies to durable medical equipment and prosthetic and orthopedic devices) 	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care 	All charges

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	High Option
<ul style="list-style-type: none"> • Hospital cost resulting from a normal full-term delivery of a baby outside the service area 	<i>All charges</i>
Outpatient hospital or ambulatory surgical center	High Option
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • 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>	Nothing
Extended care benefits/Skilled nursing care facility benefits	High Option
<p>We provide a comprehensive range of benefits for up to 60 days per calendar year when full time nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan.</p> <ul style="list-style-type: none"> • Bed, board and general nursing • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility (SNF) when prescribed by a Plan doctor and managed by our Medical Management Department. 	Nothing
<i>Not covered: Custodial care</i>	<i>All charges.</i>
Hospice care	High Option
<p>We cover supportive and palliative care for a terminally ill member in the home or hospice facility. Services include inpatient and outpatient care, end of life care and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.</p>	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges</i>
End of Life Care	High Option
Covered through Hospice Care	Nothing
Ambulance	High Option
Local professional ambulance service when medically appropriate	Nothing

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

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

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please call the Plan's 24-hour emergency number immediately at 312-423-4200. The Plan has doctors on call 24 hours a day, seven days a week. Directed urgent care is obtained when contacting UHS emergency number at 312 423-4200. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 48 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been notified in a timely fashion. If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full. Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

Emergencies outside our service area: Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness. If you need 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 the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefit Description	You pay
Emergency within our service area	High Option
<ul style="list-style-type: none"> • Emergency care at a UHS office • Emergency care (when directed by the Plan) to an urgent care center • Emergency care as an outpatient at a hospital, including doctors services. <p>Note: We waive the ER copay if you are admitted to the hospital.</p> <p>Note: Directed Urgent care is obtained when contacting UHS emergency number at 312 423-4200. Any other visits to urgent care are considered undirected.</p>	<p>\$15 per visit</p> <p>\$50 per visit (when directed by the Plan) to an urgent care center</p> <p>\$125 per visit at a hospital or (non-directed) urgent care center</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>

Benefit Description	You pay
Emergency outside our service area	High Option
<ul style="list-style-type: none"> Emergency care (when directed by the Plan) at an urgent care center Emergency care at a outpatient hospital, including doctors services <p>Note: We waive the ER copay if you are admitted to the hospital.</p> <p>Note: Directed Urgent care is obtained when contacting UHS emergency number at 312 423-4200. Any other visits to urgent care are considered undirected.</p>	<p>\$50 per visit (when directed by the Plan) to an urgent care center</p> <p>\$125 per visit at a hospital or (non-directed) urgent care center</p>
<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>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges</i>
Ambulance	High Option
<p>Professional ambulance service when medically appropriate.</p> <p>Note: See 5(c) for non-emergency service.</p>	Nothing
<i>Not covered: Air ambulance</i>	<i>All charges</i>

Section 5(e). Mental health and substance misuse disorder benefits

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay
Professional services	High Option
<p>When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance misuse disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.</p> <p>Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:</p> <ul style="list-style-type: none"> • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug misuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost-sharing responsibilities are no greater than for other illnesses or conditions.</p> <p>\$15 per visit</p>
Diagnostics	High Option
<p>Diagnostic tests when ordered by a Plan doctor</p> <ul style="list-style-type: none"> • Outpatient diagnostic tests provided and billed by a licensed mental health and substance misuse disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility 	<p>\$15 per visit</p>

Benefit Description	You pay
Inpatient hospital of other covered facility	High Option
<p>Inpatient services provided and billed by an approved hospital or other covered facility</p> <ul style="list-style-type: none"> • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services 	\$15 per visit
Outpatient hospital or other covered facility	High Option
<p>Outpatient services provided and billed by an approved hospital or other covered facility</p> <ul style="list-style-type: none"> • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment 	\$15 per visit
Not covered	High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services deemed not medically necessary</i> 	<i>All charges</i>
<p>Note: The Plan emergency number, 312-423-4200, can be accessed 24-hours a day 7 days a week.</p> <ul style="list-style-type: none"> • Referrals will be written by the Plan Primary Care Physicians to network mental health and substance abuse providers. • Please refer to <i>Section 3</i> for information on which services require precertification or prior approval. • Upon initial consultation an authorized treatment plan will be determined and structured. • Inpatient services will be precertified through the Plan's case managers • Review and discharge planning are all through the Plan case managers 	

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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.
- Members must make sure their physicians obtain prior approval/authorization for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications
- 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 physician, dentist, or licensed practitioner (as allowed by law) and in states allowing it, a licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them** - You must fill the prescription at a plan pharmacy. Certain maintenance prescriptions can be mailed to your home according to Food and Drug Administration Guidelines and from the UHS Polk Street Pharmacy. Contact the UHS Pharmacy at 312-423-4260 to make arrangements.
- **We use a formulary** – Drugs are prescribed by licensed doctors and covered in accordance with the Plan's drug formulary. The Plan's formulary does not exclude medications from coverage, but requires a higher copayment for non-preferred drugs. We continually review new and existing medications to ensure the formulary remains responsive to the needs of our members and health professionals. Criteria used to evaluate drug selection for the formulary includes, but is not limited to: safety, efficacy and cost-effectiveness data, as well as a comparison of relevant benefits of similar prescription or over-the counter (OTC) agents while minimizing potential duplications.
- **There are dispensing limitations** – Prescription drugs will be dispensed for up to a 90-day supply for Tier I, II, and III. An additional copay applies for each increment of 30 days (i.e. 30 days = single copay, 60 days = double copay and 90 days = 2.5 ratio). In addition, there is a copay applied to each unit of commercially prepared medications (i.e. one inhaler, one vial of ophthalmic drops or insulin, etc.)
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **Why use generic drugs?** Generic drugs are lower-priced drugs in which the therapeutic ingredient is chemically equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U. S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.
- **Preferred drug** - Preferred prescription drugs are drugs that are effective for treating specific condition and are more cost-effective than equivalent non-preferred drugs. Often there is a choice of medications you can take for the same condition. One or more of these medications may be a preferred drug under this plan.
- **Non-preferred drug** - Non-preferred drugs are drugs that are less cost-effective than preferred drugs, but not more therapeutically effective than preferred brand name or generic drugs. Non-preferred drugs require a higher copayment. Depending on your personal health care needs, there may be times when non-preferred drugs are right for you. In these situations, you will need to pay the non-preferred copayment.
- **Specialty drug** - Specialty drugs are high-cost injectable, infused, oral, or inhaled drugs that generally require special storage or handling and close monitoring of the patient's drug therapy.

- **When you do have to file a claim.** You will not have to file a claim unless you receive covered prescription drugs during an out of area emergency. See Section 7 for information on how to file your claim

Benefit Description	You pay
Covered medications and supplies	High Option
<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 • Diabetic supplies limited to: <ul style="list-style-type: none"> - Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction when medically necessary (contact the Plan pharmacy for limits) • Fertility drugs are covered under infertility benefits see Section 5 (a) Infertility services • Intravenous fluids and medication for home use, implantable drugs, and some injectible drugs are covered see Section 5 (a) Home Health • Growth hormone therapy (GHT) <p>Note: – We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Other Services under You need prior Plan approval for certain services</i> in Section 3.</p>	<p><u>30-day supply</u></p> <ul style="list-style-type: none"> • Tier I - Generic \$15 • Tier II - Preferred \$45 • Tier III - Non-Preferred \$80 • Tier IV - Specialty (20% of payment up to \$2,500 per member per year) <p><u>90-day supply</u></p> <ul style="list-style-type: none"> • Tier I - Generic \$40 • Tier II - Non-Preferred \$112.50 • Tier III - Non-Preferred \$200
Women's contraceptive drugs and devices	Nothing
Preventive care medications	High Option
<p>Medications to promote better health as recommended by ACA.</p> <p>The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a health care professional and filled at a network pharmacy.</p> <ul style="list-style-type: none"> • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements (prescription) for children age 6 months-1 year • Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 • Pre-authorized Statin Drugs for adults aged 40 to 75 years with no history of cardiovascular disease (CVD), 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater <p>Note: To receive this benefit a prescription from a doctor must be presented to pharmacy.</p>	Nothing

Preventive care medications - continued on next page

Benefit Description	You pay
Preventive care medications (cont.)	High Option
<p>Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a health care professional and filled by a network pharmacy. These may include some over-the counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to /www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations</p>	Nothing
Not covered:	High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Fertility drugs not mandated by the State of Illinois</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them.</i> • <i>Drugs available without a prescription or for which there is a nonprescription equivalent available</i> <p>Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See <i>Section 5 (a)</i>. Educational classes and Programs</p>	All charges

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. Plan dentists must provide or arrange your care.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentist must provide or arrange your care.
- 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	High Option
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	\$15 per visit
Dental benefits	High Option
<i>We have no other dental benefits.</i>	<i>All charges</i>

Section 5(h). Wellness and Other Special Features

Feature	Description
Flexible benefit option	<p>Under the flexible benefit option we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternative to regular contract benefits as a less costly alternative. 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 in addition to other terms as necessary. 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 do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely our and except as expressly provided in the agreement, we may withdraw at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the state time period (unless circumstances change). You may request an extension of the time period, but regular contract benefit 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 claim process. However, if at this time we make a decision regarding alternative benefits, we also decide that regular contract benefits, are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (See Section 8).
Not for Profit Organization	UHS is a not-for-profit organization managed by a Board composed of members representing Unions, physicians, and community leaders.
24 Hour Emergency Line	Emergencies - 24 hours a day, 7 days a week, you may call 312-423-4200
Centers of excellence for transplants/heart surgery/etc.	Affiliated with major medical centers and guided by National Transplant Program
High risk pregnancies	Affiliated with major medical centers
Translation Services	Extensive translation skills among staff and physicians. Translation phone service is available to cover all languages.
Extended Hours	UHS offers extended clinic hours at several facilities during the week and weekends.
Continuity of Care	UHS has low physician and employee turnover.
Electronic Medical Records	UHS has utilized electronic medical records (EMR) since 2002. The EMR provides your PCP tools to coordinate care with other physicians, including specialists, who are part of the UHS team.

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 Union Health member service at 312 423-4200 extension 3285 or visit our website at www.unionhealth.org

Vision Care

One annual refraction (which includes the written lens prescription) may be obtained from a UHS optometrist. The services are available by appointment at the UHS Eye Care Centers 312-423-4200 ext. 3320 or 6500 located at 1634 West Polk Street, Chicago, IL 60612 and 2800 West 87th Street, Chicago, IL 60652.

UHS searches for the best arrangement with Optical Providers for Plan members to receive a discount that is better than what is available to the public. Members are encouraged to call the UHS Eye Care Center for further information 312-423-4200 ext. 3320.

Benefits on this page are not part of the FEHB contract

Section 6. General Exclusions - services, drugs and supplies we do not 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 it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, see Section 3 *When you need prior Plan approval for certain services*.**

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 you receive from a provider or facility barred from the FEHB Program
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. 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 CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call us at 312-423-4200 ext. 3262.

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

- Covered member's name, ID number, date of birth, address and phone 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 payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

Union Health Service Insurance Department
1634 West Polk Street
Chicago, Illinois 60612
312-423-4200 ext. 3262

Prescription drugs

Submit out-of-area and emergency prescription drug reimbursement claims to:

Union Health Service Pharmacy
1634 West Polk Street
Chicago, Illinois 60612
312-423-4200 ext. 3260

Other supplies or services

All other claims for supplies or service should be sent to the following department for review and processing. Submit your claims to:

Union Health Service Insurance Department
1634 West Polk Street
Chicago, Illinois 60612
312-423-4200 ext. 3262

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.
Post-service claims procedures	<p>We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.</p> <p>If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.</p> <p>If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.</p>
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice Requirements	<p>If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.</p> <p>Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.</p>

Section 8. The disputed claims process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.unionhealth.org or call 312-423-4200 ext. 3262.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing: Union Health Service Insurance Department, 1634 West Polk Street, Chicago, Illinois 60612 or calling 312-423-4200 ext. 3262.

Our reconsideration will take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgement (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgement and who was not involved in making the initial decision.

Our reconsideration will not take in account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claim adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">a) Write to us within 6 months from the date of our decision; andb) Send your request to us at: UHS Medical Director, 1634 West Polk Street; Chicago, IL 60612 andc) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andd) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. <p>We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.</p>
	<p>In the case of a post-service claim, we have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none">a) Pay the claim or

2	<p>b) Write to you and maintain our denial or</p> <p>c) Ask you or your provider for more information</p> <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. We will write to you with our decision.</p>
3	<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; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information <p>Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 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; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p> <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. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.</p> <p>Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.</p>
4	<p>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.</p> <p>If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, 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.</p> <p>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.</p> <p>You may not file a lawsuit 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.</p>

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 you did not indicate that your claim was a claim for urgent care, then call us at 312-423-4200 ext. 3262. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance III at (202)-606-0755 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about the plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Program if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.unionhealth.org

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

• 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 (or a covered family member) 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

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefit payments and on the provision of benefits under our coverage.

If you have received benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgement, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgement, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fee or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone 1-877-888-3337 (TTY 1-877-889-5680), 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.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention detection or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When You have Medicare

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;
- 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 (1-800-633-4227), (TTY 1-877-486-2048) 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 do not offer a Medicare Advantage plan, however we do have a Medicare Health Care Prepayment Plan (HCPP) call us at 312 -423-4200 ext. 3285. 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. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB drug coverage and Medicare. The notice is on the first inside page of this brochure. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 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 800-772-1213, (TTY 1-800-325-0778) 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 do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

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.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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

Claims process when you have the Original Medicare Plan – You 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 payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 312-423-4200 ext.3262.

We waive some costs if the Original Medicare Plan is your primary payor– We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other health care professionals.

Please review the following table. It illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

Benefit Description	Member Cost without Medicare	Member Cost with Medicare Part B
Deductible	\$100 deductible for orthopedic and prosthetic devices and durable medical equipment and 20% of charges after deductible	\$0
Out of Pocket Maximum	\$7,350 self only/\$14,700 family	\$7,350 self only/\$14,700 family
Primary Care Physician	\$15 per visit	\$0
Specialist	\$15 per visit	\$0
Inpatient Hospital	\$0	\$0
Outpatient Hospital	\$0	\$0
Rx 30 day supply	Tier 1 Generic \$15 Tier 2 -Preferred \$45 Tier 3 - Non-Preferred \$80 Tier 4 – Specialty 20% of payment up to \$2,500 per member per year	Tier 1 - Generic \$15 Tier 2 - Preferred \$45 Tier 3 -Non-Preferred \$80 Tier 4 – Specialty 20% of payment up to \$2,500 per member per year
Rx – 90 day supply	Tier 1 - Generic \$40 Tier 2 - Preferred \$112.50 Tier 3 - Non-Preferred \$200	Tier 1 - Generic \$40 Tier 2 - Preferred \$112.50 Tier 3 - Non-Preferred \$200

You can find more information about how our plan coordinates benefits with Medicare from the Member Service Department at 312-423-4200 ext. 3285.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **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) (TTY 1-877-486-2048) 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:

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).

However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

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

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, 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 payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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 Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payor 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 payor before eligibility due to ESRD (for 30 month coordination period)		✓
• Medicare was the primary payor 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.

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.
Clinical Trials Cost Categories	<p>An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.</p> <ul style="list-style-type: none">• Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient’s condition whether the patient is in a clinical trial or is receiving standard therapy• Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient’s routine care• Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by clinical trials. This plan does not cover these costs.
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 19.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 19.
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	Treatment or services that are designed mainly to help the patient with daily living activities. 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 19.
Experimental or investigational service	If a medical treatment, procedure, drug, device, or biological product is FDA approved, the Plan will use this as a basis for providing coverage. If it lacks FDA’s approval, the Plan will make a policy decision based on specific statements from specialty societies or medical organizations such as the American Cancer Society, the American College of Surgeons, and the American Medical Society.
Group health coverage	Health care coverage that a member is eligible for because of employment by, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies.
Health care professional	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.
Medical necessity	A Medically Necessary service is a service that is (1) consistent with the Enrollee’s condition, disease, ailment or injury, (2) appropriate with regard to standards of good medical practice, (3) not solely for the convenience of the Enrollee or provider, and (4) the most appropriate supply or level of service which can be safely rendered to the Enrollee.

When specifically applied to an inpatient, it further means that the Enrollee's medical symptoms or condition require that the diagnosis or treatment cannot be effectively, safely and economically provided to the Enrollee in an outpatient setting. Your Primary Care Physician, in accordance with the above standards adopted by Union Health Service, will determine when a service is medically necessary.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suggested an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier health benefits plan.

Us/We

Us and We refer to Union Health Service

Urgent care claims

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, you should notify us when you submit the claim. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care. Please mail to UHS Director of Claims; 1634 West Polk Street, Chicago, IL 60612 or fax to 312-423-4321 or call 312-423-4200 extension 3262.

You

You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no Government contribution.

Important information about four 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. Participating employees save an average of about 30% on products and service they 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.

Fourth, the **Federal Employees' Group Life Insurance Program (FEGLI)** can help protect your family from burdensome funeral costs and the unexpected loss of your income.

What is an FSA?

It is tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$100. The maximum annual election for a health care flexible spending account (HCFSAs) or a limited expense health care spending account (LEX HCFSAs) is \$2,600 per person. The maximum annual election for a dependent care flexible spending account (DCFSAs) is \$5,000 per household.

- **Health Care FSA (HCFSAs)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, and **physician prescribed** over-the-counter medications, over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26). FSAFEDS offer paperless reimbursement for your HCFSAs through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSA FEDS will automatically reimburse your eligible out-of-pocket expenses based on the claims information it receives from your plan.
- **Limited Expense Health Care FSA (LEX HCFSAs)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSAs)** – Reimburses you for eligible non-medical day care expenses for your children 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 DCFSAs.

- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSa or LEX HCFSa and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS, 877-372-3337 (TTY, 1-866-353-8058), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time.

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

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

All dental plans provide a comprehensive range of services, including:

- 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 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia but it may be limited. Review your FEDVIP dental plan's brochure for information on this benefit.**

Vision Insurance

All 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/dental and www.opm.gov/vision. These sites also provide 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, 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 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 such as Alzheimer's disease. Long term care can be received in your home, in a nursing home, in an assisted living facility or in adult day care. You must apply, answer health questions (called underwriting) and be approved for enrollment. Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Your qualified relatives can apply even if you do not. 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. For more information, call 800-LTC-FEDS 800-582-3337, (TTY 800 843-3557) or visit www.ltcfeds.com .

The Federal Employees' Group Life Insurance Program - FEGLI

Peace of Mind for You and Your Family

The Federal Employees' Group Life Insurance Program (FEGLI) can help protect your family from burdensome funeral costs and the unexpected loss of your income. You can get life insurance coverage starting at one year's salary to more than six times your salary and many options in between. You can also get coverage on the lives of your spouse and unmarried dependent children under age 22. You can continue your coverage into retirement if you meet certain requirements. For more information, visit www.opm.gov/life.

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

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Summary of benefits for the High Option for 2018

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

High Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$15	23
Services provided by a hospital:		
• Inpatient	Nothing	38
• Outpatient	Nothing	39
Emergency benefits:		
• In-area	\$15 copay at a UHS office \$50 copay per visit (when directed by UHS) to an urgent care center \$125 copay per visit at a hospital or (non-directed) urgent care center	40
• Out-of-area	\$125 copay per visit at a hospital or urgent care center	41
Mental health and substance misuse disorder treatment:	\$15 copay	42
Prescription drugs:	30-day supply: Generic \$15, Preferred \$45, Non-Preferred \$80, Specialty 20% of payment up to \$2,500 per member per year 90-day supply: Generic \$40, Preferred \$112.50, Non-Preferred \$200	44
Dental care:	Accidental Injury	47
Vision care:	One annual eye refraction, medical and surgical for diagnosis and treatment of diseases,	25, 29, 49
Special features:	Not for Profit Organization, 24-Hour Emergency Line, High Risk Pregnancies, Centers for Excellence for Transplants/Heart Surgery/etc., Translation services, Urgent Care, Continuity of Care, Staff Model, Evening and Weekend Hours, Electronic Medical Records	48
Protection against catastrophic costs:	Nothing after your out-of-pocket expenses \$7,350 for Self Only, or \$14,700 Self Plus One or Self and Family.	11, 19

2018 Rate Information

For 2018 FEHB plan premium information, please see:

<https://www.opm.gov/healthcare-insurance/tribal-employers/benefits-premiums/> or contact your tribal employer's Human Resources department.