

# CDPHP Universal Benefits, Inc.

Formerly Capital District Physicians' Health Plan, Inc. (CDPHP)

[www.cdphp.com](http://www.cdphp.com)

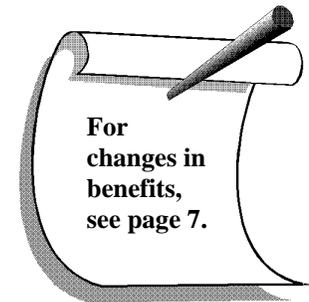


## 2006

### A Prepaid Comprehensive Medical Plan (High and Standard Option)

**Serving:** Upstate, Hudson Valley, and Central New York

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 6 for requirements.



**Enrollment codes for this Plan:**

**High Option - SG1 Self Only**

**High Option - SG2 Self and Family**

**Standard Option – SG4 Self Only**

**Standard Option – SG5 Self and Family**

**Special Notice:**

This Plan is offering a Standard Option for the first time under the Federal Employees Health Benefits Program during the 2006 Open Season. To enroll in the Standard Option you must make a positive election during Open Season.



Federal Employees  
Health Benefits Program

Authorized for distribution by the:



**United States  
Office of Personnel Management**

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

RI 73-549

## Notice of the United States Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.
- OPM has the right to use and give out your personal medical information to administer the FEHB Program. For example:
  - To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
  - To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accountability Office when conducting audits.
- OPM may use or give out your personal medical information for the following purposes under limited circumstances:
  - For Government health care oversight activities (such as fraud and abuse investigations),
  - For research studies that meet all privacy law requirements (such as for medical research or education), and
  - To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at [www.opm.gov/insure](http://www.opm.gov/insure) on the Web. You may also call 202-606-0745 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints  
United States Office of Personnel Management  
P.O. Box 707  
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

## **Important Notice from CDPHP UBI About Our Prescription Drug Coverage and Medicare**

OPM has determined that CDPHP UBI's prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

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

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

### **Please be advised**

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

#### **Medicare's Low Income Benefits**

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

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

- Visit [www.medicare.gov](http://www.medicare.gov) for personalized help,

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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## Introduction

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

### CDPHP UBI

Patroon Creek Corporate Center  
1223 Washington Avenue  
Albany, NY 12206

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2006, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2006, and changes are summarized on page 7. Rates are shown at the end of this brochure.

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## Plain Language

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

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

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

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## Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at (518) 641-3228 and explain the situation.

If we do not resolve the issue:

**CALL — THE HEALTH CARE FRAUD HOTLINE  
202-418-3300**

**OR WRITE TO:**

**United States Office of Personnel Management  
Office of the Inspector General Fraud Hotline  
1900 E Street NW Room 6400  
Washington, DC 20415-1100**

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

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## Preventing medical mistakes

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

- 1. Ask questions if you have doubts or concerns.**
  - Ask questions and make sure you understand the answers.
  - Choose a doctor with whom you feel comfortable talking.
  - Take a relative or friend with you to help you ask questions and understand answers.
- 2. Keep and bring a list of all the medicines you take.**
  - Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
  - Tell them about any drug allergies you have.
  - Ask about risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
  - Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
  - Read the label and patient package insert when you get your medicine, including all warnings and instructions.
  - Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- 3. Get the results of any test or procedure.**
  - Ask when and how you will get the results of tests or procedures.
  - Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
  - Call your doctor and ask for your results.
  - Ask what the results mean for your care.
- 4. Talk to your doctor about which hospital is best for your health needs.**
  - Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
  - Be sure you understand the instructions you get about follow-up care when you leave the hospital.
- 5. Make sure you understand what will happen if you need surgery.**
  - Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
  - Ask your doctor, "Who will manage my care when I am in the hospital?"
  - Ask your surgeon:
    - Exactly what will you be doing?
    - About how long will it take?
    - What will happen after surgery?
    - How can I expect to feel during recovery?
  - Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

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

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## Section 1. Facts about this prepaid plan

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

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

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

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

### General Features of our High and Standard Options

The High and Standard Options cover the same services and participating providers but differ in the out-of-pocket costs and premium rates. The Standard Option is offered for the first time during the 2006 Open Season.

### How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

### Your Rights

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

- CDPHP Universal Benefits, Inc. (CDPHP UBI) is licensed under Article 43 in New York State.
- CDPHP UBI is an affiliate of Capital District Physicians' Health Plan, Inc. (CDPHP), a health plan that has been in existence for 21 years.
- CDPHP UBI is a non-profit health services corporation.

If you want more information about us, call 1-877-269-2134, or write to CDPHP UBI, Patroon Creek Corporate Center, 1223 Washington Ave., Albany, NY 12206. You may also contact us by fax at (518) 641-5005 or visit our Web site at [www.cdphp.com](http://www.cdphp.com).

### Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is: Albany, Broome, Chenango, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Hamilton, Herkimer, Madison, Montgomery, Oneida, Orange, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Tioga, Ulster, Warren, and Washington counties.

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

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

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## Section 2. How we change for 2006

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

### Changes to this Plan

- Your share of the non-Postal High-Option premium will increase by 26.4% for Self Only and by 31.1% for Self and Family, see page 60.
- You must obtain precertification for certain services. The list has been modified from 2005. Your share of the cost will increase if you do not obtain prior approval for certain services, see page 9.
- A participating specialty pharmacy vendor is used for certain prescription drugs, see page 34.
- CDPHP UBI will offer two options. The High Option enrollment code will be SG1 and SG2. The Standard Option enrollment code will be SG4 and SG5. You will remain in the High Option plan unless you make an open season enrollment change.

### The following benefit changes apply to the High Option:

- The urgent care copayment will change to \$20 per provider per visit, see page 16.
- Electrocardiograms and EEGs will be \$20 per visit, see page 17.
- Preventive care for adults: There is no copay for one routine annual physical exam, routine gynecological exam, standard testing for prostate cancer and routine Pap tests, see page 17.
- Anesthesia professional services performed in the doctor's office will be covered in full, see page 27.
- For self coverage, inpatient hospital copays are limited to two per calendar year. For Self and Family coverage, inpatient hospital copays are limited to three per calendar year, see page 28.
- Local professional ambulance and air ambulance when medically appropriate will change to \$50 per trip, see page 29.
- Outpatient hospital or ambulatory surgical center copay will increase to \$75 copay per visit, see page 29.
- Eyeglasses and contact lenses necessitated by certain medical conditions such as aphakia or following intraocular surgery will change to a 20% coinsurance, see page 21.
- Home infusion therapy is covered under home care with no copay, see page 23.
- Infertility drugs are covered up to six cycles per pregnancy attempt subject to the prescription drug copayments, see page 35.

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## Section 3. How you get care

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### Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-877-269-2134 or write to us at Patroon Creek Corporate Center, 1223 Washington Ave., Albany, NY 12206. You may also request replacement cards through our Web site at [www.cdphp.com](http://www.cdphp.com).

### Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments and/or coinsurance, and you will not have to file claims.

#### • Plan providers

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

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

#### • Plan facilities

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

### What you must do to get covered care

It depends on the type of care you need. You can go to any participating provider you want, but we must approve some care in advance.

#### • Primary care

Because all covered services must be provided or arranged by CDPHP UBI participating providers, you are encouraged to select a personal doctor within the network to coordinate your care. Your primary care provider can be an internist, family practitioner, general practitioner, or pediatrician (for children). Alternate primary care providers are obstetricians and gynecologists.

#### • Specialty care

- Participating specialists are listed in our CDPHP UBI directory and in Find-A-Doc at our Web site at [www.cdphp.com](http://www.cdphp.com).
- No referral is necessary to visit a participating specialist.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - Terminate our contract with your specialist for other than cause; or
  - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
  - Reduce our service area and you enroll in another FEHB Plan, you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist

until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-877-269-2134. If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92<sup>nd</sup> day after you become a member of this Plan, whichever happens first.

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

## **How to get approval for...**

- **Your hospital stay**

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

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

- **How to precertify an admission**

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

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

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

- **Maternity care**

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

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

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

With the exception of emergency care, you must obtain prior authorization for providers and facilities that do not participate with us. The number to call is 1-800-274-2332.

**Circumstances beyond our control**

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

**Other services requiring our prior approval**

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

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

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

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

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

Prior approval is also required for the following services:

Mental health services – You must contact the mental health contractor, Value Options at 1-800-700-4824 for information or pre-certification before you access mental health services.

Substance abuse – You must contact the substance abuse and dependency contractor, St. Peter's Behavioral Health Management, at 1-800-427-9025 for information or pre-certification before you access substance abuse services.

Certain Prescription drugs – You or your physician must obtain prior approval for coverage of certain prescription drugs. The request for services can be made by contacting CDPHP's Pharmacy Department by mail, fax (518-641-3208), or by calling 1-877-269-2134. The prior approval request must contain clinical information that is reviewed against established criteria for medical

necessity. If necessary your physician may be contacted by a pharmacist to obtain clinical information to support the request. The Plan's Medical Director makes final determinations.

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

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

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

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## Section 4. Your costs for covered services

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

### **Copayments**

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

Example: For the High Option when you see your primary care physician you pay a copayment of \$20 per office visit and when you go in the hospital, you pay \$100 per day, up to a maximum of \$500 per confinement.

### **Deductible**

We do not have a deductible.

### **Coinsurance**

Coinsurance is the percentage of our negotiated fee that you must pay for your care. Example: In our High Option Plan, you pay 20 percent of our allowance for durable medical equipment.

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

High Option—The High Option does not have a catastrophic protection out-of-pocket maximum.

Standard Option—If the total amount of out-of-pocket expenses for covered inpatient facility charges (inpatient acute or rehabilitation hospital or skilled nursing facility) and inpatient professional services (physician hospital visits, surgery, anesthesia, lab, and X-ray, etc.) exceed \$4,000 per person or \$5,000 per family enrollment under the standard option in any calendar year, you do not have to pay any more for these inpatient-related services. However, out-of-pocket expenses for other than inpatient-related facility and professional services do not count toward your catastrophic protection limit, and you must continue to pay out-of-pocket for these services. Note: Penalty charges for not following the precertification process and any expenses in excess of the Plan allowance or benefit maximums do not count toward your catastrophic protection out-of-pocket maximum.

**High and Standard Option Benefits**

See page 7 for how our benefits changed this year. Page 58 and 59 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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### Section 5 High and Standard Option Benefits Overview

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

The High and Standard Option Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain more information about High and Standard Options benefits, contact us at 1-877-269-2134 or at our Web site at [www.cdphp.com](http://www.cdphp.com).

Each option offers unique features.

#### **High Option**

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

#### **Standard Option**

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

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care. You pay all charges for non-participating providers.
- A facility copay applies to services that appear in this section but are performed in the ambulatory surgical center or the outpatient department of a hospital.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
	High Option	Standard Option
<b>Diagnostic and treatment services</b>		
Professional services of physicians		
<ul style="list-style-type: none"> <li>• In physician’s office</li> </ul>	\$20 per office visit	\$25 per visit for primary care \$40 per visit for specialist
Professional services of physicians		
<ul style="list-style-type: none"> <li>• In an urgent care center</li> </ul>	\$20 per visit	\$40 per visit
<ul style="list-style-type: none"> <li>• During a hospital stay</li> <li>• In a skilled nursing facility</li> </ul>	Nothing	10% of the Plan allowance
<ul style="list-style-type: none"> <li>• Office medical consultations</li> <li>• Second surgical opinion/inpatient consultation</li> </ul>	\$20 per office visit	\$25 per visit for primary care \$40 per visit for specialist  10% of the Plan allowance for inpatient services
At home	\$20 per visit	\$25 per visit for primary care
<i>Not covered:</i>	<i>All charges.</i>	<i>All charges.</i>
<ul style="list-style-type: none"> <li>• <i>Surgery primarily for cosmetic purposes</i></li> <li>• <i>Homemaker services</i></li> </ul>		

*Diagnostic and treatment services – continued on next page*

## High and Standard Option

Lab, X-ray and other diagnostic tests	You pay	
	High Option	Standard Option
Tests, such as: <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine Mammograms</li> <li>• CAT Scans/MRI</li> <li>• Ultrasound</li> </ul>	Nothing if you receive these services at a preferred facility; otherwise, \$20 per office visit	Nothing if you receive these services at a preferred facility; otherwise, \$40 per office visit  10% of the Plan allowance for inpatient services
<ul style="list-style-type: none"> <li>• Electrocardiogram and EEG</li> </ul>	\$20 copay per provider per visit	\$40 per provider per visit  10% of the Plan allowance for inpatient services
<ul style="list-style-type: none"> <li>• Non-routine Pap tests</li> </ul>	\$20 per office visit	\$40 per office visit
Preventive care, adult	High Option	Standard Option
One routine annual physical exam (non-gynecological ) per calendar year	Nothing	Nothing
Routine screenings, such as but not limited to: <ul style="list-style-type: none"> <li>• Total Blood Cholesterol—Once every five years</li> <li>• Colorectal Cancer Screening, including               <ul style="list-style-type: none"> <li>– Fecal occult blood test – every five years starting at age 50</li> <li>– Sigmoidoscopy, screening – every five years starting at age 50</li> <li>– Double contrast barium enema—every five years starting at age 50</li> <li>– Colonoscopy—once every 10 years starting at age 50.</li> </ul> </li> </ul>	\$20 per office visit	\$40 per office visit
Standard diagnostic testing for prostate cancer including but not limited to digital rectal examinations and prostate specific antigen tests.	Nothing	Nothing
One routine gynecological exam per calendar year	Nothing	Nothing
Routine Pap test	Nothing	Nothing
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> <li>• From age 35 through 39, one during this five year period</li> <li>• From age 40 through 49, one every one to two calendar years</li> <li>• From age 50 to 70, annually</li> <li>• Over age 71, as indicated</li> </ul>	Nothing	Nothing
Routine immunizations included but not limited to: <ul style="list-style-type: none"> <li>• Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations)</li> <li>• Influenza vaccine, annually</li> <li>• Pneumococcal vaccine, age 65 and older</li> </ul>	Nothing for immunization; office visit copay applies	Nothing for immunization; office visit copay applies
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>	<i>All charges.</i>

## High and Standard Option

Preventive care, children	You pay	
	High Option	Standard Option
<ul style="list-style-type: none"> <li>Childhood immunizations recommended by the American Academy of Pediatrics</li> </ul>	Nothing	Nothing
<ul style="list-style-type: none"> <li>Well-child care charges for routine examinations, immunizations and care (up to age 22). Visits covered at 2 weeks, 1 month, 2 months, 4 months, 6 months, 12 months, 15 months, and 18 months, then annually to age 22.</li> </ul>	Nothing	Nothing
<ul style="list-style-type: none"> <li>Examinations (other than well-child care), such as:                             <ul style="list-style-type: none"> <li>Eye exams to determine the need for vision correction. Limited to one every 24 months.</li> <li>Ear exams determine the need for hearing correction</li> </ul> </li> </ul>	\$20 per office visit	\$40 per office visit
Maternity care	High Option	Standard Option
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> <li>Prenatal care</li> <li>Delivery</li> <li>Postnatal care</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>You do not need to precertify your normal delivery; see page 10 for other circumstances, such as extended stays for you or your baby.</li> <li>You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.</li> <li>We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment.</li> </ul> <p>We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). See Special Features (Section 5g) for childbirth education reimbursement program.</p>	\$20 per office visit for the initial diagnosis. You pay nothing thereafter.	\$40 per office visit for the initial diagnosis. You pay nothing thereafter.  10% of the Plan allowance for inpatient services.
<i>Not covered: Elective sonograms to determine fetal sex.</i>	<i>All charges.</i>	<i>All charges.</i>
Family planning	High Option	Standard Option
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>Voluntary sterilization (See Surgical procedures Section 5 (b))</li> <li>Genetic counseling when approved</li> <li>Visits to insert or implant covered contraceptive devices</li> </ul>	\$20 per office visit	\$25 per visit for primary care \$40 per visit for specialist  10% of the Plan allowance for inpatient services
<p>Note: We cover FDA approved contraceptives under the prescription drug benefit. Please refer to Section 5(f).</p>		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Reversal of voluntary surgical sterilization</i></li> </ul>	<i>All charges.</i>	<i>All charges.</i>

## High and Standard Option

Infertility services	You pay	
	High Option	Standard Option
Diagnosis and treatment of infertility such as: <ul style="list-style-type: none"> <li>• Artificial insemination:               <ul style="list-style-type: none"> <li>– <i>intra</i>vaginal insemination (IVI)</li> <li>– <i>intra</i>cervical insemination (ICI)</li> <li>– <i>intra</i>uterine insemination (IUI)</li> </ul> </li> <li>• Fertility drugs</li> </ul> Note: Members must be at least 21 years of age but no more than 44 years old to be covered for infertility services. Note: We cover fertility drugs under the prescription drug benefit for up to six cycles per pregnancy. See Section 5(f).	\$20 per office visit  Nothing for inpatient services	\$40 per visit for specialist  10% of the Plan allowance for inpatient services
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> <li>– <i>in vitro</i> fertilization</li> <li>– <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i></li> </ul> </li> <li>• <i>Services and supplies related to ART procedures</i></li> <li>• <i>Cost of donor sperm</i></li> <li>• <i>Leuprolide Acetate when used for cessation of ovulation.</i></li> <li>• <i>Items such as ovulation predictor kits and home pregnancy kits.</i></li> <li>• <i>IVIG when utilized for infertility or pregnancy loss.</i></li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Allergy care</b>		
<ul style="list-style-type: none"> <li>• Testing and treatment</li> </ul>	\$20 per office visit	\$25 per visit for primary care \$40 per visit for specialist  10% of the Plan allowance for inpatient services
<ul style="list-style-type: none"> <li>• Allergy injections</li> <li>• Allergy serum</li> </ul>	Nothing	Nothing
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges.</i>	<i>All charges.</i>

## High and Standard Option

Treatment therapies	You pay	
	High Option	Standard Option
<ul style="list-style-type: none"> <li>Chemotherapy and radiation therapy</li> </ul> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 28.</p> <ul style="list-style-type: none"> <li>Respiratory and inhalation therapy</li> </ul>	\$20 per office visit	\$25 per office visit for chemotherapy \$40 per office visit all other therapies 10% of the Plan allowance for inpatient services
<ul style="list-style-type: none"> <li>Dialysis – hemodialysis and peritoneal dialysis</li> </ul>	\$20 per office visit if received as an outpatient. Covered in full if part of home care.	\$25 per office visit if received as an outpatient. Covered in full if part of home care.
<ul style="list-style-type: none"> <li>Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</li> </ul>	\$20 per office visit if received as an outpatient. Covered in full if part of home care.	\$40 per office visit if received as an outpatient. Covered in full if part of home care.
Home dialysis – equipment and supplies	\$20 per month	\$40 per month
<ul style="list-style-type: none"> <li>Growth hormone therapy (GHT)</li> </ul> <p>Note: Please refer to Section 5(f) for coverage for prescription drugs. Prescription drugs for GHT are only covered when prior approved. See <i>Services requiring prior approval</i> in Section 3.</p>	\$20 per office visit	\$40 per office visit
Physical and occupational therapies	High Option	Standard Option
<p>Physical and occupational therapy are limited to one course each for two consecutive months for each specific diagnosis and related conditions per calendar year:</p> <ul style="list-style-type: none"> <li>qualified physical therapists and</li> <li>occupational therapists</li> </ul> <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <ul style="list-style-type: none"> <li>Medically necessary cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction.</li> </ul> <p>Note: These services require prior approval. See Section 3.</p>	\$20 per office visit \$20 per outpatient visit Nothing per visit during covered inpatient admission	\$40 per office visit \$40 per outpatient visit 10% of the Plan allowance for inpatient services
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>Long-term rehabilitative therapy</li> <li>Exercise programs</li> <li>Continuous ECG monitoring and Thallium stress tests</li> <li>Services for chronic or maintenance phase of cardiac rehabilitation</li> </ul>	<i>All charges.</i>	<i>All charges.</i>
Speech therapy	High Option	Standard Option
<p>Speech therapy is limited to one course for two consecutive months for each specific diagnosis and related conditions per calendar year. Note: Please refer to Section 3 for services requiring prior approval.</p>	\$20 per office visit \$20 per outpatient visit Nothing per visit during covered inpatient admission.	\$40 per office visit \$40 per outpatient visit 10% of the Plan allowance for inpatient services

## High and Standard Option

<b>Speech therapy (continued)</b>	<b>You pay</b>	
	<b>High Option</b>	<b>Standard Option</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Care beyond treatment period.</i></li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Hearing services (testing, treatment, and supplies)</b>	<b>You pay</b>	
	<b>High Option</b>	<b>Standard Option</b>
<ul style="list-style-type: none"> <li>• Hearing examinations and testing</li> </ul>	\$20 per office visit	\$40 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Purchase and fitting of a hearing aid</i></li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Vision services (testing, treatment, and supplies)</b>	<b>High Option</b>	<b>Standard Option</b>
<ul style="list-style-type: none"> <li>• Eyeglasses or contact lenses necessitated by certain medical conditions such as aphakia, keratoconus, or endocrine exophthalmos or following intraocular surgery. Replacement reviewed based on medical necessity.</li> </ul>	20% of the Plan allowance	50% of the Plan allowance
<ul style="list-style-type: none"> <li>• Routine eye exam and eye refractions once every 24 months</li> <li>• Eye exercises and orthoptics when approved</li> </ul>	\$20 per office visit	\$40 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Eyeglasses or contact lenses</i></li> <li>• <i>Radial keratotomy and other refractive surgery</i></li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Foot care</b>	<b>High Option</b>	<b>Standard Option</b>
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	\$20 per office visit	\$25 for primary care office visit \$40 per visit for specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <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></li> <li>• <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></li> </ul>	<i>All charges.</i>	<i>All charges.</i>

## High and Standard Option

Orthopedic and prosthetic devices	High Option	Standard Option
<ul style="list-style-type: none"> <li>Artificial limbs and eyes</li> <li>Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy</li> </ul>	20% of the Plan allowance. Must be preauthorized if cost is over \$500	50% of the Plan allowance. Must be preauthorized if cost is over \$500
<ul style="list-style-type: none"> <li>Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device.</li> </ul>	Nothing	Nothing
<ul style="list-style-type: none"> <li>Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.</li> <li>Approved lumbosacral supports</li> </ul>	20% of the Plan allowance. Must be preauthorized if cost is over \$500	50% of the Plan allowance. Must be preauthorized if cost is over \$500
<ul style="list-style-type: none"> <li>Hair prosthesis. CDPHP provides benefits for the purchase of one medically necessary cranial prosthesis, wig, or toupee per lifetime per member for replacement of hair loss as a result of injury, disease, or treatment of a disease. Coverage is limited to a maximum amount of \$200 per prosthesis, wig or toupee. This limitation is applied to the balance remaining after the member's payment of the coinsurance.</li> </ul>	20% of the Plan allowance	50% of the Plan allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Orthopedic and corrective shoes</i></li> <li><i>Arch supports</i></li> <li><i>Foot orthotics</i></li> <li><i>Heel pads and heel cups</i></li> <li><i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i></li> <li><i>Prosthetic replacements provided less than 3 years after the last one we covered unless medically indicated</i></li> <li><i>Stump hose</i></li> </ul>	<i>All charges.</i>	<i>All charges.</i>
Durable medical equipment (DME)	High Option	Standard Option
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: <ul style="list-style-type: none"> <li>Hospital beds;</li> <li>Wheelchairs</li> <li>Crutches</li> <li>Walkers</li> </ul>	20% of the Plan allowance. Must be preauthorized if cost is over \$500 or item is rented	50% of the Plan allowance. Must be preauthorized if cost is over \$500 or item is rented
<ul style="list-style-type: none"> <li>Blood glucose monitors; and</li> <li>Insulin pumps.</li> </ul> Your Plan physician will call us for authorization of this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment. Note: See "Services requiring our prior approval" in Section 3.	\$20 per item, must be preauthorized if cost is over \$500 or item is rented	\$25 per item, must be preauthorized if cost is over \$500 or item is rented
<i>Not covered: Motorized wheelchairs.</i>	<i>All charges.</i>	<i>All charges.</i>

## High and Standard Option

Home health services	High Option	Standard Option
<ul style="list-style-type: none"> <li>Home health care ordered by a Plan physician, approved by the Plan’s medical director, and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. Some services include: home infusion therapy, medical supplies, drugs and medications. Please refer to Section 3, “Services requiring our prior approval.”</li> </ul>	Nothing	Nothing
<ul style="list-style-type: none"> <li>Oxygen therapy</li> </ul>	20% of the Plan allowance	50% of the Plan allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>Nursing care requested by, or for the convenience of, the patient or the patient’s family;</li> <li>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</li> <li>Rest cures</li> </ul>	<i>All charges.</i>	<i>All charges.</i>
Chiropractic	High Option	Standard Option
<ul style="list-style-type: none"> <li>Medically necessary care for spinal manipulation</li> </ul>	\$20 per office visit	\$40 per office visit
Alternative treatments	High Option	Standard Option
No benefit	<i>All charges</i>	<i>All charges</i>
Educational classes and programs	High Option	Standard Option
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> <li>Smoking Cessation – Provided at no cost to you through CDPHP UBI’s wellness program.</li> <li>Peak Asthma Performance – Members are encouraged to call toll-free for telephonic education about asthma. Members who participate may receive a semi-annual newsletter and materials including a peak flow meter, a video on asthma, a daily diary, and medication spacer.</li> <li>PressureWise – An interactive program for members identified as hypertensive. Members attending program receive a blood pressure monitor and information on taking their blood pressure at home.</li> </ul>	Nothing	Nothing

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

	<p><b>Here are some important things you should keep in mind about these benefits:</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Plan physicians must provide or arrange your care. You pay all charges for non-participating providers.</li> <li>• Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.</li> <li>• The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).</li> <li>• <b>YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.</b> Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.</li> </ul>	
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Benefit Description	You pay	
Surgical procedures	High Option	Standard Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care by the surgeon</li> <li>• Correction of amblyopia and strabismus</li> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies (see Reconstructive surgery)</li> <li>• Surgical treatment (bariatric surgery) of morbid obesity, a condition in which you weigh 100 pounds or 100% over your normal weight according to current underwriting standards; there is documented failure of a non-surgical attempt; and your body mass index is 40 or higher (or 35 or higher and you have severe co-morbidities). Note: This procedure requires preauthorization. Please call the Plan at 1-877-269-2134 for further information.</li> <li>• Insertion of internal prosthetic devices. See 5(a), <i>Orthopedic and prosthetic devices</i> for device coverage information</li> <li>• Voluntary sterilization (e.g., Tubal ligation, Vasectomy)</li> <li>• Surgically implanted contraceptive and intrauterine devices (IUDs). Note: Devices are covered under 5(f) Prescription drug coverage.</li> <li>• Treatment of burns</li> <li>• Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done.</li> </ul>	<p>\$20 per office visit</p> <p>Nothing at outpatient or inpatient facility</p>	<p>\$25 per primary care office visit</p> <p>\$40 per visit for specialist care</p> <p>Nothing at outpatient facility</p> <p>10% of the Plan allowance for inpatient services</p>

## High and Standard Option

Benefit Description	You pay	
<b>Surgical procedures</b>	<b>You pay</b>	
	<b>High Option</b>	<b>Standard Option</b>
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• Reversal of voluntary sterilization</li> <li>• Routine treatment of conditions of the foot; see Foot care</li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Reconstructive surgery</b>	<b>High Option</b>	<b>Standard Option</b>
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if:               <ul style="list-style-type: none"> <li>– the condition produced a major effect on the member’s appearance and</li> <li>– the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as:               <ul style="list-style-type: none"> <li>– surgery to produce a symmetrical appearance of breasts;</li> <li>– treatment of any physical complications, such as lymphedemas;</li> <li>– breast prostheses and surgical bras and replacements (see Prosthetic devices)</li> </ul> </li> </ul> <p>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>	\$20 per office visit; nothing at outpatient or inpatient facility	\$40 per office visit; 10% of the Plan allowance for inpatient services
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• 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</li> <li>• Surgeries related to sex transformation</li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Oral and maxillofacial surgery</b>	<b>High Option</b>	<b>Standard Option</b>
Oral surgical procedures, limited to: <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;</li> <li>• Removal of stones from salivary ducts;</li> <li>• Excision of leukoplakia or malignancies;</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures; and</li> <li>• Other surgical procedures that do not involve the teeth or</li> </ul>	\$20 per office visit; nothing at outpatient or inpatient facility	\$40 per office visit; 10% of the Plan allowance for inpatient services

## High and Standard Option

Benefit Description	You pay	
their supporting structures.		
<b>Oral and maxillofacial surgery</b> <i>(continued)</i>	You pay	
	High Option	Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Oral implants and transplants</li> <li>• Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</li> <li>• Dental work related to TMJ</li> </ul>	<i>All charges.</i>	<i>All charges.</i>
<b>Organ/tissue transplants</b>	High Option	Standard Option
<p>Limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Kidney</li> <li>• Kidney/Pancreas</li> <li>• Liver</li> <li>• Lung: Single – Double</li> <li>• Pancreas</li> <li>• Allogenic donor bone marrow transplants</li> <li>• Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors</li> <li>• Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas when medically necessary.</li> <li>• National Transplant Program (NTP) – CDPHP UBI facilitates organ transplants at a CDPHP UBI approved transplant center</li> </ul> <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p> <p>Note: Please see Section 3 for “Services requiring our prior approval.”</p>	\$20 per office visit; nothing at outpatient or inpatient facility	\$40 per office visit; 10% of the Plan allowance for inpatient services
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Donor screening tests and donor search expenses, except those performed for the actual donor</li> <li>• Implants of artificial organs</li> <li>• Transplants not listed as covered</li> </ul>	<i>All charges.</i>	<i>All charges.</i>

## High and Standard Option

Benefit Description	You pay	
<b>Anesthesia</b>	<b>You pay</b>	
	<b>High Option</b>	<b>Standard Option</b>
Professional services provided in – • Hospital (inpatient)	Nothing	10% of the Plan allowance for inpatient services
• Hospital outpatient department	Nothing	Nothing
• Skilled nursing facility	Nothing	10% of the Plan allowance for inpatient services
• Ambulatory surgical center Professional services provided in – • Office	Nothing	Nothing

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility. You pay all charges for non-participating providers.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay	
	High Option	Standard Option
<p><b>Inpatient hospital</b></p> <p>Room and board, such as</p> <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations;</li> <li>• General nursing care; and</li> <li>• Meals and special diets.</li> </ul> <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	<p>\$100 copay per day up to a maximum of \$500 per admission. For individual coverage, inpatient copays are limited to two per calendar year. For family coverage, inpatient copays are limited to three per calendar year. The copayment does not apply to hospital inpatient charges for newborn nursery care.</p>	<p>\$500 per admission plus 10% of the Plan allowance. For individual coverage, inpatient copays are limited to two per calendar year. For family coverage, inpatient copays are limited to three per calendar year. The copayment does not apply to hospital inpatient charges for newborn nursery care.</p>
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests and X-rays</li> <li>• Administration of blood and blood products</li> <li>• Blood or blood plasma, if not donated or replaced</li> <li>• Dressings, splints, casts, and sterile tray services</li> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics, including nurse anesthetist services</li> <li>• Take-home items</li> <li>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home</li> </ul>	<p>Nothing</p>	<p>10% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Custodial care</li> <li>• Non-covered facilities, such as nursing homes, schools</li> <li>• Personal comfort items, such as telephone, television, barber services, guest meals and beds</li> <li>• Private nursing care except when medically necessary in the hospital when ordered and approved by a CDPHP UBI participating physician</li> </ul>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

## High and Standard Option

Benefit Description	You pay	
<b>Outpatient hospital or ambulatory surgical center</b>	<b>You pay</b>	
	<b>High Option</b>	<b>Standard Option</b>
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma, if not donated or replaced</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> </ul> <p>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>	\$75 per visit	\$100 per visit
Services not associated with a medical procedure being done on the same day: Outpatient hospital diagnostic x-ray and laboratory tests.	Nothing if you receive these services at a preferred facility; otherwise, \$20 per visit	Nothing if you receive these services at a preferred facility; otherwise, \$40 per visit
<i>Not covered: Blood and blood derivatives not replaced by the member. Storage of blood and blood derivatives, except in the case of autologous blood donations required for a scheduled surgical procedure.</i>	<i>All charges.</i>	<i>All charges.</i>
<b>Extended care benefits/Skilled nursing care facility benefits</b>	<b>High Option</b>	<b>Standard Option</b>
Skilled nursing facility (SNF): up to 90 days in lieu of hospitalization.	Nothing	10% of the Plan allowance
<i>Not covered: Custodial care</i>	<i>All charges.</i>	<i>All charges.</i>
<b>Hospice care</b>		
Up to 210 days combined inpatient and outpatient	Nothing	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges.</i>	<i>All charges.</i>
<b>Ambulance</b>		
<ul style="list-style-type: none"> <li>• Local professional ambulance service when medically appropriate. Air ambulance if medically appropriate and approved.</li> </ul>	\$50 per trip	\$100 per trip
<i>Not covered: Transportation for convenience</i>	<i>All charges.</i>	<i>All charges.</i>

**Section 5(d) Emergency services/accidents**

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

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

**What is a medical emergency?**

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

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

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

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

**Emergencies outside our service area:** If you have an emergency outside of CDPHP UBI’s service area, simply go to the nearest hospital emergency room. If you are required to pay for services at the time of treatment, please request an itemized bill. Send the bill along with your name and member ID number to CDPHP’s Member Services Department, Patroon Creek Corporate Center, 1223 Washington Ave., Albany, NY 12206.

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

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

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

## High and Standard Option

Benefit Description	You pay	
Emergency outside our service area	You pay	
	High Option	Standard Option
<ul style="list-style-type: none"> <li>Emergency care at a doctor's office</li> </ul>	\$20 per visit	\$25 per visit primary care \$40 per visit specialist
<ul style="list-style-type: none"> <li>Emergency care at an urgent care center</li> </ul>	\$20 per visit	\$40 per visit for specialist
<ul style="list-style-type: none"> <li>Emergency care as an outpatient or inpatient at a hospital, including doctors' services</li> </ul> <p>Note: If the emergency results in admission to a hospital, the emergency room copay is waived. Please refer to Section 5c for inpatient hospital coverage.</p>	\$50 per visit	\$100 per visit
Ambulance		
<p>Local professional ambulance service when medically appropriate</p> <p>Air ambulance if medically appropriate and approved.</p> <p>Note: See 5(c) for non-emergency service.</p>	\$50 per trip	\$100 per trip
<i>Not covered: Non-emergency or routine transport</i>	<i>All charges.</i>	<i>All charges.</i>

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

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below. Participating providers must provide all care.

Benefit Description	You pay	
	High Option	Standard Option
<p><b>Mental health and substance abuse benefits</b></p> <p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> <li>• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</li> <li>• Medication management</li> </ul>	<p>\$20 per visit</p>	<p>\$40 per visit</p>
<ul style="list-style-type: none"> <li>• Diagnostic tests</li> </ul>	<p>\$20 per visit or test</p>	<p>\$40 per visit or test</p>
<ul style="list-style-type: none"> <li>• Services provided by a hospital or other facility                             <ul style="list-style-type: none"> <li>—Mental health</li> <li>—Chemical abuse</li> </ul> </li> <li>• Services in approved alternative care settings such as partial hospitalization, halfway house and residential treatment, full-day hospitalization, facility based intensive outpatient treatment</li> </ul>	<p>\$20 per outpatient visit</p> <p>\$20 per outpatient visit</p> <p>\$100 copay per day up to a maximum of \$500 per admission. For individual coverage inpatient copays are limited to two per calendar year. For family coverage, inpatient copays are limited to three per calendar year.</p>	<p>\$40 per outpatient visit</p> <p>\$25 per outpatient visit</p> <p>\$500 per admission plus 10% of the Plan allowance. For individual coverage, inpatient copays are limited to two per calendar year. For family coverage, inpatient copays are limited to three per calendar year.</p>

## High and Standard Option

Mental health and substance abuse benefits <i>(continued)</i>	You pay	
	High Option	Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Services we have not approved.</i></li> </ul> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All charges.</i>	<i>All charges.</i>

### Preauthorization

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

#### Mental Health Care

You have direct access to in-network mental health care. A direct access toll-free telephone number, 1-800-700-4824, to ValueOptions, will connect you to a qualified mental health clinician who will assist and arrange for treatment. For your convenience, the telephone number for mental health services is imprinted on your CDPHP UBI ID card.

#### Alcohol/Substance Abuse Benefits

You have access to alcohol and substance abuse care. These benefits are coordinated by St. Peter's Behavioral Health Management (SPBHM). CDPHP UBI members can contact SPBHM directly at 1-800-427-9025.

### Limitation

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

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## Section 5(f) Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
  - All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
  - 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.
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**There are important features you should be aware of. These include:**

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

There are different copayments for generic and brand name prescriptions. A generic will be dispensed whenever possible. If there is no generic equivalent available, you will still be responsible for the brand name copayment.

- **Why use generic drugs?** Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your plan less money than brand name drugs.
- **When you do have to file a claim.** You do not have to submit claims.

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

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*Prescription drug benefits begin on the next page*

## High and Standard Option

Benefit Description	You pay	
	High Option	Standard Option
<p><b>Covered medications and supplies</b></p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> <li>• Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>.</li> <li>• Self-administered injectable drugs</li> <li>• Drugs for sexual dysfunction within applicable limits. Please call the Plan for information.</li> <li>• Prescription contraceptive drugs and devices</li> <li>• Smoking cessation prescriptions up to a 12-week supply</li> <li>• Nutritional supplements for the therapeutic treatment of phenylketonuria (PKU).</li> <li>• Infertility prescriptions available for members between 21 and 44 years of age, up to six cycles per pregnancy attempt.</li> <li>• Prescription drugs for certain inherited disease of amino acid and organic acid metabolism shall include modified sold food products that are low protein or which contain modified protein which are medically necessary for up to 12 months. Benefit limit of \$2,500.</li> </ul>	<p>\$10 generic/\$25 formulary brand/\$40 non-formulary for a 30-day supply</p> <p>\$20 generic/\$50 formulary brand/\$80 non-formulary for a 90-day supply by mail order</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>	<p>\$10 generic/\$30 formulary brand/\$50 non-formulary for a 30-day supply</p> <p>\$20 generic/\$60 formulary/\$100 non-formulary for a 90-day supply by mail order</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>
<ul style="list-style-type: none"> <li>• Insulin, oral agents to control blood sugar, needles, test strips, lancets, and visual reading and urine test strips</li> </ul>	<p>\$20 per item</p>	<p>\$25 per item</p>
<ul style="list-style-type: none"> <li>• Durable medical equipment for insulin dependent persons, preauthorization needed only if over \$500.</li> </ul>	<p>\$20 per item</p>	<p>\$25 per item</p>
<ul style="list-style-type: none"> <li>• Non-insulin disposable needles and syringes for the administration of covered medication</li> </ul>	<p>20% of the Plan allowance</p>	<p>50% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Drugs and supplies for cosmetic purposes</li> <li>• Vitamins, nutrients, and food supplements that can be purchased without a prescription</li> <li>• Nonprescription medicines</li> <li>• Weight loss prescriptions</li> <li>• Drugs to enhance athletic performance</li> <li>• Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</li> </ul>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

**Section 5(g) Special features**

Feature	Description
<p><b>On-line tools</b></p>	<p>Easy-to-use Internet-based tools to help you manage your own health and make smarter decisions that may reduce health care costs.</p> <p><b>Heathcare Advisor™</b> –</p> <p>You will have the ability to:</p> <ul style="list-style-type: none"> <li>• Research medical conditions and illnesses</li> <li>• Understand treatments</li> <li>• Locate questions to ask your doctors</li> <li>• Compare hospitals, using a variety of criteria, providing necessary or desired treatments or services</li> </ul> <p><b>My Online Wellness<sup>SM</sup></b>–</p> <ul style="list-style-type: none"> <li>• Self-Care Centers- Focus on information specific to certain disease entities such as arthritis, asthma, hypertension, diabetes and others.</li> <li>• Rx Corner- Integrates your prescription drug benefits with drug news and tools.</li> </ul> <p>These programs are available to members through <a href="http://www.cdphp.com">www.cdphp.com</a>.</p>
<p><b>Flexible benefits option</b></p>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> <li>• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit.</li> <li>• Alternative benefits are subject to our ongoing review.</li> <li>• By approving an alternative benefit, we cannot guarantee you will get it in the future.</li> <li>• The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits.</li> <li>• Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</li> </ul>
<p><b>Non-emergency care for full-time students out of the area</b></p>	<p>If you are away at school and need medical care (non-preventive) for an illness or injury, coverage is available. When a medical situation develops, call 1-800-274-2332 prior to seeking care and request that CDPHP UBI authorize coverage of necessary treatment by a practitioner in the area.</p>
<p><b>Services for deaf and hearing impaired</b></p>	<p>The telephone system also includes a TDD system. Members may call 1-877-261-1164 for services.</p>

## High and Standard Option

Feature	Description
<b>Childbirth Education Reimbursement Program</b>	CDPHP UBI will reimburse expectant mothers 50 percent of the cost, up to \$30 per year, for participating in and completing childbirth education classes. Once you complete the class, send the receipt and certificate of completion to CDPHP UBI, Patroon Creek Corporate Center, 1223 Washington Ave., Albany, NY 12206, for reimbursement.
<b>Centers of excellence</b>	CDPHP facilitates care at approved transplant centers for medically necessary, non-experimental treatment.

**Section 5(h) Dental benefits**

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

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

<b>Accidental injury benefit</b>	<b>You pay</b>	
	<b>High Option</b>	<b>Standard Option</b>
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	\$20 per visit	\$40 per visit

**Dental benefits**

We have no other dental benefits.

Section 5(i) 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.

“The Road to Good Health” Wellness Workshops

Through a series of wellness workshops, you can learn how the combined power of good nutrition, regular exercise, and stress management can help you move toward optimal health and well-being. A schedule of wellness programs appears on our Web site, [www.cdphp.com](http://www.cdphp.com), and in *SmartMoves*, CDPHP’s quarterly member newsletter. All wellness programs are free to members.

Complementary and Alternative Medicine (CAM) Program

CDPHP will be offering at no charge, an easy way to research and obtain reputable, top-quality Complementary and Alternative Medicine (CAM) services and products. The program is being provided to CDPHP members through a partnership with American WholeHealth, Inc., a nationwide group of more than 28,000 credentialed practitioners of acupuncture, massage, chiropractic, and other CAM disciplines. The CAM program features discounts on a wide variety of non-covered services, including: vitamins, massage therapy, fitness centers, spas, personal trainers, Tai Chi classes, health magazine subscriptions, and more. Members may access it by logging in through CDPHP’s secure Web site function, Online Health™ using member ID and PIN. Areas that can be navigated include:

- Healing Centers—Look up home remedies to supplement the care your physician provides.
- Reference Library—Learn about dozens of different natural therapies.
- Healing Kitchen—Review healthy recipes and nutrition information.
- News and Perspectives—Read updates from the medical literature.
- Expert Opinions—See how the experts answer frequently asked questions.
- Find A Practitioner—Locate a participating massage therapist, acupuncturist, or holistic practitioner near you.
- Smoking Cessation—Program provided at no cost to you through CDPHP’s wellness program.
- Peak Asthma Performance—Members are encouraged to call a toll-free number to CDPHP’s Wellness Line for telephonic education. They may receive a semi-annual newsletter about asthma and a kit including a peak flow meter, a video on asthma, a daily diary, and a medication spacer.
- Pressure Wise—An interactive program for members identified as hypertensive. Members attending the program receive a blood pressure monitor and information on taking their blood pressure at home.

Disease Management Programs

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

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The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under *Services Requiring Our Prior Approval* on page 9.**

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;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies required for obtaining or continuing employment or insurance, attending schools or camp, or travel; or
- Services, drugs, or supplies you receive without charge while in active military service.

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## Section 7. Filing a claim for covered services

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

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

### **Medical, hospital, and drug benefits**

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

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

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

**Submit your claims to:** CDPHP Universal Benefits, Inc.  
Patroon Creek Corporate Center  
1223 Washington Avenue  
Albany, NY 12206

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

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

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

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

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## Section 8. The disputed claims process

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

Step	Description
<b>1</b>	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none"><li>Write to us within 6 months from the date of our decision; and</li><li>Send your request to us at: CDPHP UBI, Patroon Creek Corporate Center, 1223 Washington Ave., Albany, NY 12206; and</li><li>Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and</li><li>Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</li></ol>
<b>2</b>	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none"><li>Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or</li><li>Write to you and maintain our denial – go to step 4; or</li><li>Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.</li></ol>
<b>3</b>	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
<b>4</b>	<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"><li>90 days after the date of our letter upholding our initial decision; or</li><li>120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or</li><li>120 days after we asked for additional information.</li></ul> <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, DC 20415-3630</p>

## The disputed claims process (*continued*)

Send OPM the following information:

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

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

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

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

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

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

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

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

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

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

If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or

You may call OPM's Health Insurance Group 2 at (202) 606-3818 between 8 a.m. and 5 p.m. eastern time.

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## Section 9. Coordinating benefits with other coverage

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### When you have other health coverage

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

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

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

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

### What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or older.
- Some people with disabilities under 65 years of age.
- 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. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We, CDPHP UBI, do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about our prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

### • Should I enroll in Medicare?

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

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you

don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

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

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

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

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

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

**Claims process when you have the Original Medicare Plan** – You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at (518) 641-3140 or 1-877-269-2134 or see our Web site at [www.cdphp.com](http://www.cdphp.com).

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

- **Medicare Advantage (Part C)**

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

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

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

**Suspended FEHB coverage to enroll in a Medicare Advantage plan:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the

next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

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

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

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

<b>Primary Payer Chart</b>		
<b>A. When you - or your covered spouse - are age 65 or over and have Medicare and you...</b>	<b>The primary payer for the individual with Medicare is...</b>	
	<b>Medicare</b>	<b>This Plan</b>
1) Have FEHB coverage on your own or through your spouse who is also an active employee		✓
2) Have FEHB coverage through your spouse who is an annuitant or through your spouse who is an annuitant	✓	
3) 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 #1 above	✓	
4) 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	✓	
5) 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)	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓ *	
<b>B. When you or a covered family member...</b>		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		✓
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (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...		✓ for 30-month coordination period
• This Plan was the primary payer before eligibility due to ESRD		
• Medicare was the primary payer before eligibility due to ESRD	✓	
<b>C. When either you or your spouse are eligible for Medicare solely due to disability and you...</b>		
Have FEHB coverage on your own or through your spouse who is also an active employee		✓
Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
<b>D. When you are covered under the FEHB Spouse Equity provision as a former spouse</b>		
	✓	

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

## **TRICARE and CHAMPVA**

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

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

## **Workers' Compensation**

We do not cover services that:

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

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

## **Medicaid**

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

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

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

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

## **When others are responsible for injuries**

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

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

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

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<b>Calendar year</b>	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
<b>Coinsurance</b>	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 12.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services. See page 12.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Custodial care</b>	Custodial care is care that does not have a direct medical benefit such as house cleaning, preparing meals, personal hygiene. Custodial care that lasts 90 days or longer is sometimes known as long-term care.
<b>Deductible</b>	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before the plan starts paying for those services. Note: We do not have a deductible.
<b>Experimental or investigational services</b>	A procedure that is not approved by the Federal Food and Drug Administration and/or the National Institute of Health Technology Assessment.
<b>Group health coverage</b>	Medical benefits such as hospital, surgical, and preventive care that are purchased on an employer-sponsored basis.
<b>Medical necessity</b>	A service or treatment which is appropriate and consistent with the diagnosis and accepted standards in the medical community.
<b>Plan allowance</b>	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance by the average community charges. Our providers accept the allowances as payment in full.
<b>Us/We</b>	Us and We refer to CDPHP Universal Benefits, Inc., an affiliate of Capital District Physicians' Health Plan, Inc. (CDPHP).
<b>You</b>	You refers to the enrollee and each covered family member.

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## Section 11. FEHB Facts

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### Coverage information

- **No pre-existing condition limitation**

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

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

See [www.opm.gov/insure](http://www.opm.gov/insure). Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

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

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

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

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

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

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

- **Children's Equity Act**

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

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

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2006 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 2005 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

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

### **When you lose benefits**

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage**

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

- **Temporary Continuation of Coverage (TCC)**

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

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

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

- **Converting to individual coverage**

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

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

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

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

- **Getting a Certificate of Group Health Plan Coverage**

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

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

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## Section 12. Two Federal Programs complement FEHB benefits

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### Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

### The Federal Flexible Spending Account Program – *FSAFEDS*

#### • What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

#### Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$5,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$5,000 each (\$10,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

#### Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return and who is mentally or physically incapable of self care.
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive.

#### • Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2006 FEHB Open Season. Even if you enrolled during 2004, you must make a new election to continue participating in 2006. Enrollment is easy!

- Online: visit [www.FSAFEDS.com](http://www.FSAFEDS.com) and click on Enroll.
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, from 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

#### What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

## Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAFEDS accounts. *However, if you enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), you are not eligible to participate in an HCFSA.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

*Note:* FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

## • How much should I contribute to my FSA?

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “Use-it-or-Lose-it” rule. FSAFEDS has adopted the “grace period” permitted by the IRS. You now have an additional 2 1/2 months to incur eligible expenses and reduce any potential forfeitures. In addition, you will have until May 31, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through March 15 of the following year. For example, if you enrolled in FSAFEDS for the 2005 Plan Year, you will have from January 1, 2005 until March 15, 2006 to incur eligible expenses and you may submit claims for those expenses through May 31, 2006.

The [FSAFEDS Calculator](http://www.FSAFEDS.com) at [www.FSAFEDS.com](http://www.FSAFEDS.com) will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

## • What can my HCFSA pay for?

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 12 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under this plan, typical out-of-pocket expenses include: inpatient hospital copayments, coinsurance for durable medical equipment, office visit copays, prescription drug copays, dental services, and eyeglasses.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. Since Publication 502 is primarily meant to help on preparing your Federal income tax return, there are two important differences to note. ***Note:*** **While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes. In addition, over-the-counter medicines and products ARE an eligible expense under your HCFSA, and this is not included in Publication 502.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at <https://www.FSAFEDS.com/fsafeds/eligibleexpenses.asp>. If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

## • Tax savings with an FSA

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

<b>Annual Tax Savings Example</b>	<b>With FSA</b>	<b>Without FSA</b>
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
<b>Your tax savings:</b>	<b>\$576</b>	<b>-\$0-</b>

**Note:** This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424—a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

- **Health care expenses**

You *cannot* claim expenses on your Federal Income Tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

**Paperless Reimbursement**—This plan does not participate in the FSAFEDS paperless reimbursement program.

- **Dependent care expenses**

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit [www.FSAFEDS.com](http://www.FSAFEDS.com) and download the Dependent Care Tax Credit Worksheet from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance during your period of coverage for the Plan Year, plus 2 1/2 month grace period resulting in the forfeiture of funds remaining in your account (the IRS "Use-it-or-Lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at [www.fsafeds.com](http://www.fsafeds.com), or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9 a.m. until 9 p.m. Eastern Time.

- E-mail: [FSAFEDS@shps.net](mailto:FSAFEDS@shps.net)
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

## The Federal Long Term Care Insurance Program

- **It's important protection**

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” 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. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To request an Information Kit and application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit [www.ltcfeds.com](http://www.ltcfeds.com).

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

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## Summary of benefits for the High Option of CDPHP UBI - 2006

- **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.

Benefits	You pay	Page
Medical services provided by physicians: <ul style="list-style-type: none"> <li>• Diagnostic and treatment services provided in the office .....</li> </ul>	Office visit copay: \$20 primary care; \$20 specialist	16
Services provided by a hospital: <ul style="list-style-type: none"> <li>• Inpatient .....</li> <li>• Outpatient .....</li> </ul>	\$100 copay per day up to a maximum of \$500 per admission. For individual coverage, inpatient copays are limited to two per calendar year. For family coverage, inpatient copays are limited to three per calendar year.  \$20 per visit  \$75 for outpatient surgery	28  29
Emergency benefits <ul style="list-style-type: none"> <li>• In-area .....</li> <li>• Out-of-area .....</li> </ul>	\$50 per visit to hospital emergency room; \$20 per visit to urgent care center  \$50 per visit to hospital emergency room	30  31
Mental health and substance abuse treatment .....	Regular cost sharing	32
Prescription drugs .....	\$10 generic/\$25 formulary brand/\$40 non-formulary for a 30-day supply  \$20 generic/\$50 formulary brand/\$80 non-formulary for a 90-day supply by mail order	34
Dental care .....	\$20 per visit for accidental injury benefit	38
Vision care .....	\$20 per visit for one refraction every 24 months	21
Special features: <ul style="list-style-type: none"> <li>Flexible benefits option</li> <li>Non-emergency medical care for full-time students attending school out of the area</li> <li>Services for the deaf and hearing impaired</li> <li>Childbirth Education Reimbursement Program</li> <li>Centers of Excellence for transplants/heart surgery</li> </ul>		36
Protection against catastrophic costs  (your out-of-pocket maximum).....	We do not have an out-of-pocket maximum for the High Option.	12

## Summary of benefits for the Standard Option of CDPHP UBI - 2006

- **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.

Benefits	You pay	Page
Medical services provided by physicians: <ul style="list-style-type: none"> <li>• Diagnostic and treatment services provided in the office .....</li> </ul>	Office visit copay: \$25 primary care; \$40 specialist	16
Services provided by a hospital: <ul style="list-style-type: none"> <li>• Inpatient .....</li> <li>• Outpatient .....</li> </ul>	\$500 copay per admission plus 10% of the Plan allowance. For individual coverage, inpatient copays are limited to two per calendar year. For family coverage, inpatient copays are limited to three per calendar year.  \$40 per visit  \$100 for outpatient surgery	28  29
Emergency benefits <ul style="list-style-type: none"> <li>• In-area .....</li> <li>• Out-of-area .....</li> </ul>	\$100 per visit to hospital emergency room; \$40 per visit to urgent care center  \$100 per visit to hospital emergency room	30  31
Mental health and substance abuse treatment .....	Regular cost sharing	32
Prescription drugs .....	\$10 generic/\$30 formulary brand/\$50 non-formulary for a 30-day supply.  \$20 generic/\$60 formulary brand/\$100 non-formulary for a 90-day supply by mail order	34
Dental care .....	\$40 per visit for accidental injury benefit	38
Vision care .....	\$40 per visit for one refraction every 24 months.	21
Special features: <ul style="list-style-type: none"> <li>Flexible benefits option</li> <li>Non-emergency medical care for full-time students attending school out of the area</li> <li>Services for the deaf and hearing impaired</li> <li>Childbirth Education Reimbursement Program</li> <li>Centers of Excellence for transplants/heart surgery</li> </ul>		36
Protection against catastrophic costs (your out-of-pocket maximum).....	Nothing after \$4,000/Self Only or \$5,000/family enrollment per year for certain services.	12

## 2006 Rate Information for CDPHP UBI

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

**Postal rates** apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

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

High Option Self Only	SG1	\$139.18	\$49.10	\$301.56	\$106.38	\$164.31	\$23.97
High Option Self & Family	SG2	\$316.08	\$128.26	\$684.84	\$277.90	\$373.15	\$71.19
Standard Option Self Only	SG4	\$123.79	\$41.26	\$268.21	\$89.40	\$146.48	\$18.57
Standard Option Self & Family	SG5	\$309.48	\$103.16	\$670.54	\$223.51	\$366.22	\$46.42