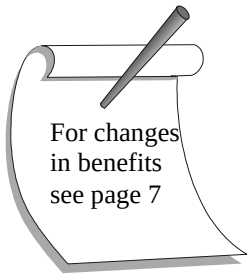
United Healthcare of Ohio, Inc.

www.uhc.com

UnitedHealthcare®
A UnitedHealth Group Company

2002

A Health Maintenance Organization



Serving: *Cincinnati/Dayton/Springfield, Ohio*

Enrollment in this Plan is limited; see page 6 for requirements.

This Plan has full accreditation From the NCQA. See the 2002 Guide for more information On NCQA.

Enrollment codes for this Plan:

3U1 Self Only
3U2 Self and Family

Authorized for distribution by the:

Authorized for distribution by the:

United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

FEHB
Federal Employees
Health Benefits Program

RI 73-608

Table of Contents

Introduction

United Healthcare of Ohio, Inc.
9050 Centre Pointe Drive, Suite 400
West Chester, OH 45069

This brochure describes the benefits of United Healthcare of Ohio, Inc. under our contract (CS 2671) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for 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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means United Healthcare of Ohio, Inc.
- We limit acronyms to one you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personal 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 us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or email us at fehbwebcomments@opm.gov.

Inspector General Advisory

Stop health care fraud!

Fraud increases the cost of health care for everyone. If you suspect that a phyician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same services 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 800-231-2918, Monday- Friday 8:00 A.M.–5:00 P.M. and explain the situation.
- If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

Penalties for Fraud Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

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

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

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

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.

UnitedHealthcare of Ohio Inc. is a health maintenance organization. We contract individually with over 18,000 physicians and 150 hospitals in the state of Ohio to provide care to UnitedHealthcare of Ohio Inc. members. The long list of UnitedHealthcare of Ohio Inc. contracting physicians assures our physicians and health facilities will be conveniently located.

You do not need to select a primary care physician and you do not need to get written referral to see a participating specialist for medical services. The provider must be participating for services to be covered. You must call United Behavioral Health at 1-800-860-1123 to obtain authorization for services to use Mental Conditions/Substance Abuse Benefits. Women may see a Plan gynecologist for their routine examinations.

The Plan's provider directory list primary care doctors with their locations and phone numbers, and note whether or not the doctor is accepting new patients. The directory is updated on a regular basis and is available at time of enrollment or upon calling the Customer Service Department at 800-231-2918 M-F, 8am-5pm, for 3U1/3U2. When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or participation of any one doctor, hospital, or other provider, cannot be guaranteed.

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

Your Rights

OPM requires that all FEHB Plans to provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (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.

If you want more information about us, call 800-231-2918, M-F, 8am-5pm. You may also contact us by fax at 937-436-8813 or visit our website at myuhc.com.

Service Area

To enroll with us, you must live or work in our service area. This is where our providers practice. Our service area is:

Dayton/Springfield/Cincinnati area
Enrollment code: 3U1 Self Only 3U2 Self and Family

The counties of Allen, Auglaize, Boone, Butler, Campbell, Champaign, Clark, Clermont, Clinton, Darke, Greene, Hamilton, Hardin, Highland, Kenton, Logan, Mercer, Miami, Montgomery, Preble, Shelby, and Warren.

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

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

Section 2. How we change for 2002

Program-wide changes

- We increased speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a)

Changes to this Plan

- Your share of the non-Postal premium will increase by 46.0% for Self Only or 42.2% for Self and Family.
- The office visit copayment will increase from $10 to $15 per visit. Members pay no copay after the initial $15 copay for maternity benefits.
- The copay for urgent care services will increase from $10 to $25 per visit.
- The copay for emergency room services will increase from $50 to $75 per emergency room visit.
- The copay for ambulance services will increase from nothing to 20% of charges.
- The copay for outpatient rehabilitation services (physical, speech and occupational) will increase from $10 to $15 per visit
- We no longer limit total blood cholesterol tests to certain age groups. (Section 2(a)
- United Healthcare will be the provider of Dental Benefits rather than Superior Dental Care.
- We now cover certain intestinal transplants. Section 5(b)
- We changed the address for sending disputed claims to OPM. (Section 8)

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your 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 800-231-2918, M-F, 8am-5pm.

Where you get covered care

You get care from "Plan providers" and "Plan facilities". You will only pay copayments, deductibles and/or coinsurances and will not have to file a claim.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website www.myuhc.com.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website, www.myuhc.com.

What you must do to get covered care

You do not need to select a primary care physician and you do not need to get written referral to see a contracted specialist for medical services. The provider must be participating for services to be covered. You must call United Behavioral Health at (800) 860-1123 to obtain authorization for services to use Mental Conditions/Substance Abuse Benefits. A woman may see a Plan gynecologist for her routine examinations.

The Plan's provider directory list primary care doctors (generally family practitioners, pediatricians, and internist), with their locations and phones numbers, and note whether or not the doctor is accepting new patients. The directory is updated on a regular basis and are available at the time of enrollment or upon calling the Customer Service Department at (800) 231-2918 for 3U1/3U2. When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or participation of any one doctor, hospital, or other provider, cannot be guaranteed.

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

- **Primary care**

Your primary care physician can be a *family practitioner, internist or pediatrician*. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

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

- **Specialty care**

You do not need to have a referral to see a participating specialist. If you need the care of a specialist, you may select a specialist from our Provider Directory or call your primary care doctor, who will arrange for you to see a specialist. If your current specialist is a Plan contracted doctor, you may continue to see that doctor without a written referral

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or seriour medical condition, your primary care physician will *work with the Plan* to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when crating your treatment plan (the physician may have to get an authorization or approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk you your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or 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 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 1-800-231-2918. 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 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person.

Circumstances beyond our control

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

Services requiring our prior approval

Your primary care physician must notify us prior to any surgery/treatment. United Healthcare will consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process *prior authorization.* Your physician must obtain prior authorization for services *such as durable medical equipment that costs more than $1000.*

Your primary care physician must notify us prior to any surgery/treatment. United Healthcare will consider if the service is covered, medically necessary, and follows generally accepted medical practice.

The UnitedHealthcare of Ohio Inc. determines "Medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, diagnostic procedures, drug therapies, or devices to be experimental or investigational when one of the following applies (at the time it makes a determination regarding coverage in a particular case): 1) Not approved by the U.S. Food and Drug Administration("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service as appropriate for the proposed use; 2) Subject to review and approval by any Institutional Review Board for the proposed use; 3) The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 Clinical Trial set forth in the FDA regulations, regardless of when the trial is actually subject to FDA oversight; 4) Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition, illness or diagnosis for which its use is proposed. UnitedHealthcare of Ohio Inc. Reserves the right to make final judgement regarding coverage for Experimental, Investigational or Unproven Services.

Section 4. Your costs for covered services

You must share the cost 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: When you see your primary care physician you pay a copayment of $15 per office visit and when you go in the hospital, you pay $100 per admission.

- **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 Plan, you pay 20% for durable medical equipment.

Your castastrophic protection out-of-pocket maximum for deductibles copayments and coinsurance

After your copayments and/or coinsurance total $500 per person or $1000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayment for the following services do not count toward your out-of-pocket maximum and you must continue to pay copayments for these services.

- Orthopedic Devices
- Prosthetic Devices
- Durable Medical Equipment
- Medical Supplies (but not diabetic supplies
- Growth Hormones
- Hospital Emergency Room
- Office Visit, Emergency Room & Urgent Care Copays
- Pharmacy Copays

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

Section 5. Benefits -- OVERVIEW

(See page 7 for how our benefits changed this year and page 49 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 800-231-2918 or at our website at www.myuhc.com

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

IMPORTANT

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 physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office	$15 per office
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Office medical consultations • Second surgical opinion	$15 per office visit Nothing Nothing $15 per office visit $15 per office visit $15 per office visit
At home	$15 per visit
Lab, X-ray and other diagnostic tests	**You pay**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	$15 per office visit

Preventive care, adult	You pay
Routine screenings, such as: • Total Blood Cholesterol – once every three years, • Colorectal Cancer Screening, including ••Fecal occult blood test ••Sigmoidoscopy, screening – every five years starting at age 50	$15 per office visit
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	$15 per office visit
Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnostic and Treatment Services, above.*	$15 per office visit
Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	$15 per office visit
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	$15 per office visit
Preventive care, children	**You pay**
• Childhood immunizations recommended by the American Academy of Pediatrics	$15 per office visit
• Well-child care charges for routine examinations, immunizations and care (under age 22) • Examinations, such as: ••Eye exams through age 17 to determine the need for vision correction. (once every 12 months) ••Ear exams through age 17 to determine the need for hearing correction ••Examinations done on the day of immunizations (through age 22)	$15 per office visit

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see pages 25-27 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). • Internal feedings are covered when they are the sole source of nutrition or is covered by Medicare Complete.	$15 per office visit for initial visit; $100 for facility charges.
• *Not covered: Routine sonograms to determine fetal age, size or sex*	*All charges.*
Family planning	**You pay**
• A broad range of voluntary family planning services, limited to: • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo-provera) • Intrauterine devices (IUDs) • Diaphragms NOTE: We cover oral contraceptives under the prescription drug benefit.	$15 per office visit
• *Not covered: reversal of voluntary surgical sterilization, genetic counseling,*	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: *—intravaginal insemination (IVI)* *—intracervical insemination (ICU)* *—intrauterine insemination (IUI)*	$15 per office visit
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* *—in vitro fertilization* *—empryo transfer, gamete GIFT and ztgote ZIFT* *—Zygote transfer* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*
Allergy care	**You pay**
Testing and treatment Allergy injection	$15 per office visit.
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*
Treatment therapies	**You pay**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 22. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth Hormone Therapy (GHT) NOTE: Growth hormone is covered under the prescription drug benefit at 20% of charges. We will only cover GHT when we preauthorize the treatment. The participating provider must form information that establishes GHT is medically necessary. If the services are not preauthorized or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies.	$15 per office visit

Physical and occupational therapies	You pay
Physical therapy and occupational therapy • 2 months per condition for the services of each of the following: ••qualified physical therapists; ••occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function or functional speech due to illness or injury. Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 36 sessions.	$15 per office visit. Nothing in inpatient.
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges*
Speech therapy	
• 2 months per condition. Note: We only cover Therapy to restore speech when there has been a total or partial loss of functional speech due to illness or injury.	$15 per office visit. Nothing in inpatient.
Not covered: • *Exercise Programs*	*All charges*
Hearing services (testing, treatment, and supplies)	
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see *Preventive care, children*)	$15 per office visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges*
Vision services (testing and treatment and supplies)	**You pay**
• Annual eye refractions (to provide a written lense prescription) • Preventive eye exams (once every 12 months) • Diagnosis and treatment of diseases of the eye	$15 per office visit
Not covered: • *Corrective lenses or frames* • *Eye exercises* • *Contact lenses*	*All charges*

Foot care	You pay
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$15 per office visit.
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All Charges*
Orthopedic and prosthetic devices	**You pay**
• Orthopedic devices such as braces; foot orthotics; medical supplies including colostomy supplies; dressings, catheters and related supplies. • Prosthetic devices such as breast protheses and surgical bras, including necessary replacement following a mastectomy. Plan prior authorization is required for items that cost $100 or more. • Corrective orthopedic appliances for non-dental treatment of temporomamidibalar joint (TMJ) pain dysfunction syndrome.	You pay 20% of the charges.
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *prosthetic replacements provided less than 3 years after the last one we covered*	*All charges*

Durable medical equipment (DME)	You pay
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, we also cover: • wheel chair • hospital beds • blood glucose monitors • insulin pumps • artificial limbs • external lenses following cataract removal • crutches • walkers Plan prior authorization is required for items that cost $1000 or more. Repairs and replacements are covered if needed due to a change in the member's medical condition.	You pay 20% of the charges.
Not covered: • *Hearing Aids* • *Motorized wheel chairs*	*All charges*
Home health services	**You pay**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	$15 per office visit
Not covered: • nursing care requested by, or for the convenience of, the patient or the patient's family, • Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative • services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.	*All charges*
Chiropractic Treatment	**You pay**
• *No Benefit*	*All charges*

Alternative treatments	You pay
Acupuncture – by a doctor of medicine or osteopathy for: anesthesia, pain relief.	$15 per office visit.
Not covered: • *naturopathic services* • *hypnotherapy* • *biofeedback*	*All charges.*
Educational classes and programs	**You pay**
Coverage is limited to: • Diabetes self-management	$15 per office visit.

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

IMPORTANT

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 physicians 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.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES and PRENOTIFICATION OF ALL SURGERIES PRIOR TO RECEIVING THE SERVICE.. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information. • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs). Note: Devices are covered under 5(a). • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay hospital benefits for a pacemaker and surgery benefits for insertion of the pacemaker.	$15 per office visit.

Surgical procedures *(Continued)*	**You pay**
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.* • *Surgical treatment of morbid obesity*	*All charges.*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: —the condition produced a major effect on the member's appearance and —the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: — surgery to produce a symmetrical appearance on the other breast; — treatment of any physical complications, such as lymphedemas; — breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$15 per office visit.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation* • *Removal of birth marks*	*All charges*
Oral and maxillofacial surgery	**You Pay**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • Dental care necessary to release pain in treatment of temporomandibular joint pain dysfunction.	$15 per office visit for spcialist; Nothing for inpatient hospital
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogeneic (donor) bone marrow transplants • 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 • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • United Resource Network (URN – network used for organ tissue transplants) Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-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. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing for inpatient
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**You pay**
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in • Hospital (outpatient) • Skilled nursing facility • Ambulatory surgical center • Office	$15 per office visit

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

IMPORTANT

Here are some important things to remember 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.
- 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 covered in Section 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRIOR NOTIFICATION PRIOR TO HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	You pay
Inpatient Hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and x-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	$100 per admission for facility
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*

Outpatient hospital or ambulatory surgical center	You pay
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Not covered: blood and blood derivatives not replaced by the member	*All charges*

Extended care benefits/skilled nursing care facility benefits	You pay
All necessary services are covered, including: • bed, board and general nursing • drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor • The Plan provides a comprehensive range of benefits for up to 180 days when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan	$100 co-pay per admission for facility charges.
Not covered: custodial care	*All charges*

Hospice care	You pay
• Inpatient Care • Outpatient Care • Family Counseling • Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Note: These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	$100 inpatient admission and nothing for outpatient care.
Not covered: Independent nursing, homemaker services	20% of charges

Ambulance	You pay
• Local professional ambulance service when medically appropriate • Benefits are provided for emergency ambulance transportation ordered or authorized by a Plan doctor.	Nothing.

Section 5 (d). Emergency services/accidents

IMPORTANT

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.
- 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.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:
Emergencies within our service area:

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 48 hours. It is your responsibility to ensure the Plan has been timely notified.

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-participating providers in a medical emergency only if delay in reaching a contracted provider would result in death, disability or significant jeopardy to your condition.
To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Plan pays . . .

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

Emergencies outside our service area:

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care will or can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Plan pays . . .

Reasonable charges for emergency care services to the extent the services would have been covered if received from Plan providers.

What is covered …

- emergency care at a doctor's office or an urgent care center
- emergency care as an outpatient or inpatient at a hospital including doctors' services
- ambulance service if approved by the Plan

What is not covered…

- medical and hospital costs resulting from a normal full-term delivery of a baby outside the Service Area
- elective care or non-emergency care
- emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$15 per office visit $25 per visit. $75 per hospital emergencyroom visit. If the emergency results in admission to a hospital, emergency care copay is waived.
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$15 per office visit $25 per visit $75 per emergency room visit. If the emergency results in admission to a hospital, the emergency care co-pay is waived.
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area.*	*All charges.*
Ambulance	**You pay**
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service. Benefits are provided for emergency ambulance transportation ordered or authorized by a Plan doctor.	20% of charges.
Not covered: air ambulance	*All charges.*

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

IMPORTANT

You may choose to get care Out-of-Network or In-Network. When you receive In-Network care, you must get our approval for services and follow a treatment plan we approve. If you do, cost-sharing and limitations for In-Network mental health and substance abuse benefits will be no greater than for similar benefits for other illness and conditions.

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- 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.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$15 per office visit

Mental health and substance abuse benefits *(Continued)*	**You pay**
• Diagnostic tests	$15 per office visit
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$100 per hospitalization; nothing for outpatient.
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Preauthorization

To be eligible to receive these benefits you must obtain your treatment and follow all the following authorization processes:

Call United Behavioral Health at 800-860-1123 before obtaining care and for a list of participating providers.

Limitation

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

Section 5 (f). Prescription drug benefits

IMPORTANT

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.

IMPORTANT

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

- **Who can write your prescription.** A licensed plan physician must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication
- **We use a formulary.** The Preferred Drug List (PDL) includes brand-name and generic prescription drugs that have been approved by the Food and Drug Administration (FDA). Generic drugs on the PDL are available to you at the lowest copayment. Brand name drugs are also covered on the PDL at a higher copay. If a drug is not on the PDL, it may be covered at a higher copay. Coverage for some drugs may be limited to specific dosage and/or strengths, quantity limits and/or prior authorization. Please refer to your 2002 PDL for specific drug coverage.
- **These are the dispensing limitations.** Prescription drugs prescribed by a contracted or referral doctor and obtained at a contracted pharmacy will be dispensed for up to a 31-day supply or 100-unit supply, whichever is less; 240 milliliters of liquid (8 oz.); 60 grams of ointment, creams or topical preparation; or one commercially prepared unit (e.g., one inhaler, one vial ophthalmic medication or 2 vials of insulin).
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in stringth and dosage to the original brand-name product. Generic cost less than the equivalent brand-name product. The U. S. Food and Drug Administration sets quality standards for generic drugs to ensure that the drugs meet the same standards of quality and stringth as brand-name drugs.
- **When you have to file a claim.** Claims will be filed automatically by the plan pharmacy.

.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through mail order program:	
• Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as not covered.	$10 copay per prescription unit or refill for generic drugs on the Plan's Formulary Drug List. $15 copay per prescription unit or refill for name brand drugs on the Plan's Formulary Drug List. $30 copay per prescription unit or refill for drugs not on the Plan's Formulary Drug List.
• Insulin; copay charge applied every 2 vials	
• Disposable needle and syringes for the administration of covered medication	
• Drugs for sexual dysfunction are limited. Contact the plan for prior authorization and dose limits.	
• Contraceptive drugs and devices that require a perscription	
• Injectible contraceptive drugs, such as Depo-Provera	
• Contraceptive devices and supplies that require a prescription	
• Implanted contraceptive drugs such as Norplant	
• IV fluids and medications	
• Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape, Benedict's solution or equivalents and acetone test tablets.	20% Coinsurance
• Intravenous fluids and medication for home use, implantable drugs, and some injectible drugs are covered under medical and surgical benefits.	
• Prescription drugs prescribed by a plan physician can also be obtained via a mail order program for up to a 90-day supply. To access the mail order program, call 1-800-231-2918 for mail order customer service.	$20 copay per prescription unit or refill for generic drugs on the Plan's Formulary Drug List. and a $30 copay per prescription unit or refill for name brand drugs on the Plan's Formulary Drug List. $60 copay per prescription unit or refill for drugs not on the Plan's Formulary Drug List.

Covered medications and supplies *(continued)*	**You pay**
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins and nutritional substances that can be purchased without a prescription* • *Nonprescription medicine* • *Drug obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Medical supplies such as dressings and anticeptics* • *Drugs to enhance athletic performance* • *Smoking cessation drugs and medication* • *Fertility Drugs* • *Dental prescriptions* • *Appetite suppressants*	*All Charges*

Section 5 (g). Special Features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call Care 24 at 1-877-365-7950 and talk with a registered nurse who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired	For any of your health concerns, 24 hours a day, 7 days a week, you may call Care 24 at 1-800-855-7950 and talk with a registered nurse who will discuss treatment options and answer your health questions
Centers of excellence for transplants/heart surgery/etc	United Resource Network
Travel benefit/ services overseas	Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness. Please refer to Emergency Benefits for coverage details.

Section 5 (h). Dental benefits

IMPORTANT

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.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit	**You pay**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Nothing
Dental Benefits	**You pay**
The following dental services are covered when provided by plan dentists. Contact United Healthcare at 877-816-3596, M-TH, 8:30 a.m. – 8:00 p.m. . Friday, 9:00 a m. – 8:00 p.m.eastern or through the website at myuhc.com.	
Preventive and diagnostic treatment: • Oral Exam (one per six month period) • Prophylaxis (cleaning – two per year) • Fluoride (once per six month period under age 14) • Bitewing x-rays (one set per year) • Complete dental series or panoramic survey (once every 36 months) • Sealants (once per first or second permanent molar every 5 years for covered persons under the age of 16 years) • Space maintenance (once per lifetime, under age of 12)	50% of charges; maximum annual benefit is $500 per person
Emergency treatment (limited to the relief of pain, bleeding, swelling, or other life threatening conditions, but not the cure of disease).	50% of charges
Not Covered: all other dental services not shown as covered.	*All Charges*

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 out-of-pocket maximums.

Wellness Programs

For information pertaining to our wellness programs, please call Customer Service at 1-800-231-2918, M – F, 8am – 5pm.

Medicare Prepaid Plan Enrollment

This plan offers Medicare recipients the opportunity to enroll in the Plan (referred to as UnitedHealthcare of Ohio Inc.'s Medicare Complete) through Medicare. Annuitants and former spouses with FEHB converge and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later re-enroll in the FEHB program. Most federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 800-504-4848 for information on the Medicare prepaid plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 800-504-4848 for information on the benefits available under the Medicare HMO.

Benefits on this page are not part of the FEHB contract

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

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, or condition.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are 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; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

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

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-800-231-2918.

When you must file a claim -- such as for out-of-area care -- 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: UHC of Ohio Claims, Route #2904, P.O. Box 659752, San Antonio, TX 78265-9752

Prescription drugs

Submit your claims to: Paid Prescriptions, LLC, Merck Medco, P.O. Box 2096, Lee's Summit, MO 64063-7096

Other supplies or services

Submit DENTAL claims to: United Healthcare Dental: Claims Division, P.O. Box 30650, Bethesda, MD 20824-0560

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.

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: Write to us within 6 months from the date of our decision; and Send your request to us at: UHC of Ohio, Marketing Dept., P.O. Box 751090, Dayton, OH 45475-1090; and Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E. Street, NW, Washington, DC 20415-3630 Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Section 8. The disputed claims process (continued)

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.

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

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization /prior approval, then call us at 1-800-231-2918 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 can call OPM's Health Benefits Contracts Division 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group health plan or have automobile insurance that pays health care medical 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 and older.
- Some people with disabilities, under 65 years of age.
- People with End-State Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two 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.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Manage Care Plan 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 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. Some things are not covered under Original Medicare, like prescription drugs.

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.

We will not waive any of our copayments or coinsurances.

The Primary Payer Chart begins on page 41.

The following chart illustrates whether Original 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.

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when… a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB. Ask your employing office which of these applies to you.		✓
4) 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),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) 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,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and a) Are an annuitant, or	✓	
b) Are an active employee, or c) Are a former spouse of an annuitant, or d) Are a former spouse of an active employee		✓

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

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.

- 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 claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 800-231-2918.

We waive some costs when you have the Original Medicare – When medicare is the primary care payer, we will not waive any out-of-pocket costs.

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments, coinsurance, or deductibles for your FEHB coverage.

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

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care 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 Managed Care Plan service area.

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium free Part A, we will not ask you to enroll in it.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

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 benefits. You must use our providers.

Medicaid

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

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.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 11.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 11.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Services that are non-health related, such as daily living activities, or services which are health related but do not seek to cure, or services which do not require a trained medical professional.

Deductible

A deductible is a fixed amount of covered expense you must incur for certain covered services and supplies before we start paying benefits for those services.

Experimental or Investigational Services

The UnitedHealthcare of Ohio Inc. determines "Medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, diagnostic procedures, drug therapies, or devices to be experimental or investigational when one of the following applies (at the time it makes a determination regarding coverage in a particular case): 1) Not approved by the U.S. Food and Drug Administration("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service as appropriate for the proposed use; 2) Subject to review and approval by any Institutional Review Board for the proposed use; 3) The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 Clinical Trial set forth in the FDA regulations, regardless of when the trial is actually subject to FDA oversight; 4) Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition, illness or diagnosis for which its use is proposed. UnitedHealthcare of Ohio Inc. Reserves the right to make final judgement regarding coverage for Experimental , Investigational or Unproven Services.

Plan allowance

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

Us/We

Us and we refer to United Healthcare of Ohio

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that 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. 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:

- 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 health 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.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. 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.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

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.

• 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. But, you may be eligible for your own FEHB coverage under the spouse equity law. 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.

• 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.

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. 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, The Plan 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 (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked question. It HIPAA rules, such as a requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and it has information about Federal and State agencies you can contact for more information.

Index

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

Summary of benefits for the United Healthcare of Ohio, Inc. - 2002

- **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: • Diagnostic and treatment services provided in the office	Office visit copay: $15	13
Services provided by a hospital: • Inpatient	$100 per admission copay	24
• Outpatient	*Nothing*	25
Emergency benefits: • In-area	$75 per visit	26
• Out-of-area	$75 per visit	27
Mental health and substance abuse treatment	Regular cost sharing	29
Prescription drugs	$10 (retail) $20 (mailorder) copay per prescription unit or refill for generic drugs and a $15 (retail) $30 (mailorder) copay per prescription unit or refill for name brand drugs on the Plan's Formulary Drug List. $30 (retail) $60 (mailorder) copay per prescription unit or refill for drugs not on the Plan's Formulary Drug List.	31
Dental Care	50% of charges to annual maximum $500 per person	35
Vision Care	$15 office visit	14
Special features	See text for diversity of features	34
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $500/Self Only or $1,000/Family enrollment per year Some costs do not count toward this protection	11

2002 Rate Information for

United Healthcare of Ohio

Non-Postal rates apply to most non-Postal enrollees. 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 special FEHB guides are published for Postal Service Nurses, RI 70-2B; and 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	
		Govt Share	Your Share	Govt Share	Your Share	USPS Share	Your Share
High Option Self Only	3U1	$97.86	$50.90	$212.03	$110.28	115.52	33.24
High Option Self & Family	3U2	$223.41	$118.74	$484.06	$257.27	263.75	78.40

Filename:	22679_FEHB 10.4 final.doc
Directory:	C:\WINDOWS\Desktop
Template:	C:\WINDOWS\Application Data\Microsoft\Templates\Normal.dot
Title:	The Benefit Plan
Subject:	
Author:	Preferred Customer
Keywords:	
Comments:	
Creation Date:	10/2/2001 9:23 AM
Change Number:	83
Last Saved On:	10/5/2001 11:10 AM
Last Saved By:	Larry Mason
Total Editing Time:	196 Minutes
Last Printed On:	10/5/2001 11:11 AM
As of Last Complete Printing	
Number of Pages:	53
Number of Words:	14,331 (approx.)
Number of Characters:	81,689 (approx.)