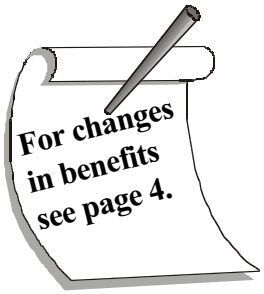
UnitedHealthcare of Ohio, Inc. 2000

A Health Maintenance Organization



Serving: Northeastern, North Central, Central, South Central, Western Ohio, and Northern Kentucky

Enrollment in this plan is limited see page 8 for requirements

This plan has commendable accreditation from the NCQA. See the *200 Guide* for more information on NCQA.

<u>Columbus/Cleveland/Portsmouth area</u>
Enrollment code:
- **VC1 Self Only**
- **VC2 Self and Family**

<u>Dayton/Springfield/Cincinnati/Toledo area</u>
Enrollment code:
- **3U1 Self Only**
- **3U2 Self and Family**

Visit the OPM websiteat http://www.opm.gov/insure
and
Visit this Plan's web page at http://www.uhc.com

Authorized for distribution by the:

United States Office of
Personnel Management
Retirement and Insurance

Federal Employees
Health Benefits Program

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Introduction

UnitedHealthcare of Ohio, Inc., 9200 Worthington Road, Westerville, Ohio 43082-8823

This brochure describes the benefits you can receive from UnitedHealthcare Of Ohio, Inc. HMO under its contract (CS2671) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is 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.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on page 4. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to UnitedHealthcare of Ohio, Inc. HMO as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not re-written the Benefits section of this brochure. You will find new benefits language next year.

How to use this brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. **Health Maintenance Organizations (HMO).** This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.
2. **How we change for 2000.** If you are a current member and want to see how we have changed, read this section.
3. **How to get benefits.** Make sure you read this section; it tells you how to get services and how we operate.
4. **What to do if we deny your claim or request for service.** This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.
5. **Benefits.** Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.
6. **General exclusions – Things we don't cover.** Look here to see benefits that we will not provide.
7. **Limitations – Rules that affect your benefits.** This section describes limits that can affect your benefits.
8. **FEHB FACTS.** Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organizations

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventative care such as routine office visits, physical exams, well-baby care and immunizations, as well as treatment for illness and injury.

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay copayments and coinsurance listed in this brochure.
When you receive emergency services 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. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How we change for 2000

Program-wide changes

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program.

You may review and obtain copies of your medical records on request. You may ask that a physician amend a record that is not accurate, relevant, or complete. If the physician does not amend your record, you may add a brief statement to the record.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

- For enrollment code VC1 or VC2, your share of the Non-Postal premium will increase by 19.8% for Self Only or 18.2% for Self and Family.
- For enrollment code 2U1 or 3U2, your share of the Non-Postal premium will decrease by 5.5% for Self Only or 5.1% for Self and Family.
- Under Prescription Drug Benefit: Drugs are dispensed in accordance with the Plan's drug formulary. See page 16.
- Under Prescription Drug Benefit: The copay increased from $5 to $10 for generic drugs. See page 16.
- Under Prescription Drug Benefit: You pay $15 copay for formulary name brand drugs. See page 16.
- Under Prescription Drug Benefit: You pay $30 copay for non-formulary name brand drugs. See page 16.
- Prescription Drug Benefit: For a 90-day supply through Mail Order Prescription Drug, you pay a $20 copay for generic drugs; you pay a $30 copay for name brand formulary drugs; a $60 copay per for name brand non-formulary drugs. See page 16.
- Medical and Surgical Benefit: The copay increased from $10 up to $15 for specialty care office visits. See page 15.
- Hospital/Extended Care Benefits: A per hospital admission copay is being added. You pay $100 per hospital admission. See page 12.
- **Under Medical and Surgical Benefits, Limited Benefits, coverage for cyrosurgery to treat localized prostate cancer is added. See page 11.**
- **The plan's address changed for codes VC1/VC2 to 9200 Worthington Road, Westerville, Ohio 43082.**
- **The plan's fax number changed for codes VC1/VC2 to 614/410-7399.**

Section 3. How to get benefits

What is this Plan's 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:

Columbus/Cleveland/Portsmouth area
Enrollment Code: VC1 Self Only VC2 Self and Family

The counties of Adams, Ashland, Ashtabula, Athens, Belmont, Brown, Carroll, Columbiana, Coshocton, Crawford, Cuyahoga, Delaware, Erie, Fairfield, Fayette, Franklin, Gallia, Geauga, Guernsey, Harrison, Hocking, Holmes, Huron, Jackson, Jefferson, Knox, Lake, Lawrence, Licking, Lorain, Madison, Mahoning, Marion, Medina, Meigs, Monroe, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Portage, Richland, Ross, Scioto, Seneca, Stark, Summitt, Trumbull, Tuscarawas, Union, Vinton, Washington, Wayne and Wyandot.

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, Grant, Greene, Hamilton, Hardin, Highland, Kenton, Logan, Lucas, Mercer, Miami, Montgomery, Preble, Shelby, Warren, and Wood.

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. We will not pay for any other health care services.

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.

How much do I pay for services?

You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services.

After you pay $500 in copayments or coinsurance for Self Only enrollment or $1,000 for Self and Family enrollment, you do not have to make any further payments for certain services for the rest of the year. This is called a catastrophic limit. However, copayments or coinsurance for your orthopedic devices, prosthetic devices, durable medical equipment, medical supplies (but not diabetic supplies), growth hormones, and hospital emergency room copayments do not count toward these limits and you must continue to make these payments.

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

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Section 3. How to get benefits *continued*

Who provides my health care?

UnitedHealthcare of Ohio, Inc. is a health maintenance organization. We contract individually with over 18,000 physicians and 150 hospitals in our service area to provide care to UnitedHealthcare of Ohio, Inc. members. The long list of UnitedHealthcare of Ohio, Inc. participating physicians assures that 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. You must call United Behavorial 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 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. Directors are updated on a regular basis and are available at the time of enrollment or upon calling the Customer Service Department (614) 442-0503 or (800) 225-7951 for VC1/VC2 or (937) 439-89033 or (800) 231-3918 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 $100 requires prior authorization.

What do I do if my primary care physician leaves the Plan?

Call us. We will help you select a new one.

What do I do if I need to go into the hospital?

Talk to your Plan physician. If you need to be hospitalized, your primary care physician or specialist will make the necessary hospital arrangements and supervise your care.

What do I do if I'm in the hospital when I join this Plan?

First, call our customer service department at 800/231-2918 for 3U1/3U2 and 800/225-7951 for VC1/VC2. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching 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 became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

How do I get 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 participating doctor, you may continue to see that doctor without a written referral.

What do I do if I am seeing a specialist when I enroll?

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.

Section 3. How to get benefits *continued*

What do I do if my 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.

But, what if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

How do you authorize medical services?

Your physician must get our approval before sending you to a hospital for inpatient care unless it is an emergency. If it is an emergency, you should contact the plan with in 48 hours of the emergency admission. Follow up emergency care by a provider who does not contract with us must have an authorization from the Plan. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice.

How do you decide if a service is experimental or investigational?

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. What to do if we deny your claim or request for service

If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing,
2. Refer to specific brochure wording in explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Arrange for a health care provider to give you the service; or
4. Ask for more information

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious or life threatening condition and you haven't responded to my request for service?

Call us for codes 3U1/3U2 at 800-231-2918; 800-225-7951 for codes VC1/VC2 and we will expedite our review.

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM at 202-606-0 755 between 8 a.m. and 5p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.
2. You provided us with additional information we asked for, and we do not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

Section 4. What to do if we deny your claim or request for service *continued*

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

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

If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

Where should I mail my disputed claim?

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contract Division III, P. O. Box 436, Washington, D.C. 20044.

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our 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 or supplies.

What laws apply if I file a lawsuit?

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 made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. BENEFITS

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; you pay up to a $10 office visit copay for **primary care doctor (family, general, and pediatrician)** but no additional copay for laboratory tests and X-rays rendered during the same office visit. **You pay up to a $15 office visit copay for specialist.** For laboratory and X-ray services provided in the doctor's office, without an office visit, you pay up to $10 per visit **for primary care doctor and up to $15 copay for specialist.** Within the service area, house calls will be provided in the judgment of the Plan doctor such care is necessary and appropriate; you pay a $10 copay for a **primary care doctor's** house call and you pay **$15 copay for specialist doctor's house call. You pay** nothing for home visits by nurses and health aides.

The following services are included:

- Preventive care, including well-baby care and periodic check-ups
- Mammograms are covered at a minimum as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures including laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and post-natal care by a Plan doctor (copay waived after first prenatal visit). The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints. For other internally implanted time-release medications, you pay a $10 copay. There is no charge when the device is implanted during a covered hospitalization.
- Cornea, heart/lung, single and double lung/kidney/pancreas, kidney and liver transplants; 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, testicular, mediastinal, retroperitoneal and ovarian germ cell tumors and solid tumors such as breast cancer, multiple myeloma and epithelial ovarian cancer. Related medical and hospital expenses of the donor are covered when the recipient is covered by the Plan.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis
- Chemotherapy, radiation therapy and inhalation therapy
- Surgical treatment of morbid obesity
- Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor who will periodically review the program for continuing appropriateness and need
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers at no additional cost to you.

Section 5. BENEFITS

Medical and Surgical Benefits *continued*

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. Coverage is provided for dental care necessary to release pain in treatment of temporomandibular joint (TMJ) pain dysfunction. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not cover, including any dental care involved in the treatment of temporomandibular joint dysfunction.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery. A patient and her attending physician will decide whether to have breast reconstruction surgery following a mastectomy and whether to have surgery on the other breast in order to produce a symmetrical appearance.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to two months per condition if significant improvement can be expected within two months; you pay a $10 copay per outpatient session. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

Diagnosis and treatment of infertility, as well as artificial insemination, is covered; you pay a $10 copay in a physician's office; nothing in a participating hospital or alternate facility. The following types of artificial insemination are covered: intracervical insemination (ICI) and intrauterine insemination (IUI); cost of donor sperm is not covered. Other assisted reproductive technology (ART) procedures that enable a woman with otherwise untreatable infertility to become pregnant through other artificial conception procedures such as in vitro fertilization and embryo transfer, gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT) are not covered.

Fertility drugs are not covered.

Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infraction, is provided for up to 36 sessions; you pay nothing.

Hearing exams are covered, limited to one per calendar year; you pay a $10 copay per visit.

Cyrosurgery for localized prostate cancer is covered; a Plan preauthorization is necessary.

Durable medical equipment, such as wheel chairs, hospitals beds and glucose monitors, and prosthetic devices, such as artificial limbs and external lenses following cataract removal, are covered. Plan preauthorization is required for items that cost $100 or more. Repairs and replacements are covered if needed due to a change in the member's medical condition. **Orthopedic devices**, such as braces; foot orthotics (excluding shoe inserts); medical supplies, including colostomy supplies, dressings, catheters and related supplies; and growth hormones are also covered. You pay 20% of the charges up to an annual out-of-pocket maximum of $500 per Self Only or $1,000 per Self and Family enrollment. The Plan then pays charges in full. Other charges also apply to these out-of-pocket maximums; see page 5.

Prosthetic devices such as, breast prostheses or surgical bras and their replacements are covered. Plan preauthorization is required for items that cost $100 or more. You pay 20% of the charges up to an annual out-of-pocket maximum of $500 per Self Only or $1,000 per Self and Family enrollment. The Plan then pays charges in full.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment, or insurance, attending school or camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- Transplants not listed as covered
- Hearing aids
- Long-term rehabilitative therapy
- Chiropractic services
- Homemaker services

Section 5. BENEFITS

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay a $100 copay, per admission for facility charges.** All necessary services are covered, including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care.
- Specialized care units, such as intensive care or cardiac care units

Extended care

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. **You pay a $100 copay per admission for facility charges.** 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.

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. **You pay a $100 copay per inpatient admission and you pay nothing for outpatient care.**

Ambulance service

Benefits are provided for emergency ambulance transportation ordered or authorized by a Plan doctor. You pay nothing.

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure, **you pay a $100 copay per admission for facility charges;** the Plan will cover the hospitalization **after copay**, but not the cost of professional dental services. Conditions for which hospitalization would be covered include, hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 15 for nonmedical substance abuse benefits. **You pay a $100 copay per admission for hospitalization**

What is not covered

- Personal comfort items, such as telephone and television
- Blood and blood derivatives (no charge if replacement is arranged by member)
- Custodial care, rest cures, domiciliary or convalescent care

Section 5. BENEFITS

Emergency Benefits

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 the Plan may determine are medical emergencies - what they all have in common is the need for quick action.

Emergencies within the 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 that 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 that 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 participating 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.

You pay . . .
$50 per hospital emergency room visit or $10 per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copay is waived.

Emergencies outside the Service Area

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

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full. **You pay a $100 copay per hospital admission.**

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.

Section 5. BENEFITS

Emergency Benefits *continued*

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

You pay . . .

$50 per hospital emergency room visit or $10 per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copay is waived.

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

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 9.

Section 5. BENEFITS

Mental Conditions/Substance Abuse Benefits

Mental conditions

Members must contact United Behavioral Health at 1-800-860-1123 before obtaining care.

What is covered

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient care
Up to 30 outpatient visits to participating doctors, consultants, or other psychiatric personnel each calendar year; you pay a $10 copay for each covered visit for group therapy, $20 copay for each covered visit for individual therapy - all charges thereafter.

Inpatient care
Up to 30 days of hospitalization each calendar year; you pay nothing for the first 30 days- all charges thereafter. You may exchange one day of inpatient treatment for two days of outpatient day treatment.

What is not covered

- Care for psychiatric condition, that in the professional judgment of plan doctors are not subject to significant improvement through relative short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
- Psychological testing that is not medically necessary to determine the appropriate treatment of a short-term psychiatric condition
- Treatment that is not authorized by a Plan doctor

Substance abuse

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition and, to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient care
Up to 30 outpatient visits to participating providers for treatment each calendar year; you pay a $10 copay for each covered visit for group therapy, $20 copay for each covered visit for individual therapy - all charges thereafter.

Inpatient care

Up to 30 days per calendar year in a substance abuse rehabilitation (intermediate care) program in a participating facility approved by a the Plan; you pay nothing for the first 30 days – all charges after. You may exchange one day of inpatient treatment for two days of outpatient day treatment.

What is not covered

- Treatment that is not authorized by a Plan doctor.

Section 5. BENEFITS

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a participating or referral doctor and obtained at a participating, 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 (i.e., one inhaler, one vial ophthalmic medication or two vials insulin).

You pay a $10 copay per prescription unit or refill for generic drugs. You pay a $15 copay per prescription unit or refill for name brand drugs on the Plan's Formulary Drug List and a $30 Copay per prescription unit or refill for name brand drugs not on the Plan's Formulary Drug List.

Prescription drugs prescribed by a plan or referral doctor can also be obtained via a mail order program for up to a 90-day supply. You pay a $20 copay per prescription unit or refill for generic drugs and a $30 copay per prescription unit or refill for name brand drugs on the Plan's Formulary Drug List and a $60 Copay per prescription unit or refill for brand name drugs not on the Plan's Formulary Drug List. To access the mail order program, call (800) 585-5791 for mail order customer service.

Covered medications and accessories include:

- Drugs for which a prescription is required by Federal law
- Oral contraceptive drugs
- Injectable contraceptive drugs, such as Depo Provera
- Contraceptive devices and supplies that require a prescription
- Implanted contraceptive drugs, such as Norplant
- Diabetic supplies including insulin syringes, needles, glucose test tablets and test tape, Benedict's solution or equivalent and acetone test tablets
- Disposable needle and syringes needed for injecting covered prescribed medication
- Insulin, with a copay charge applied to every two vials;
- Intravenous fluids and medication for home use, implantable drugs, and some injectable drugs are covered under Medical and Surgical Benefits; see page 15

Limited Benefits

- Drugs to treat sexual dysfunction are limited. Contact the plan for dose limits.

What is not covered

- Drugs available without a prescription or for which there is a non-prescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Smoking cessation drugs and medication
- Fertility drugs
- Dental prescriptions
- Appetite suppressants

Section 5. BENEFITS

Other Benefits

Dental care

The following dental services are covered when provided by participating dentists. Contact the Dental Customer Service Department on 800-7623159, for a current participating dental provider directory.

What isuu covered

Preventive and diagnostic treatment; you pay 50 % of charges; maximum annual benefit is $500 per person (combined including basic services):

- Oral exam (two per year)
- Prophylaxis (cleaning - two per year)
- Fluoride (one application per year - under age 12)
- Bitewing (one set each year)
- Complete dental series or panoramic survey (once every five years)
- Up to three periapical x-rays per year

Emergency treatment (limited to the relief of pain, bleeding, swelling, or other life threatening conditions, but not the cure of disease) is also covered. You pay 50% of charges.

Accidental injury benefit

(Covered under Medical/Surgical Benefits.) Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth are covered. The need for these services must result from an accidental injury, not biting or chewing. You pay nothing. Services must be completed within six (6) months of the injury unless medical necessity does not permit.

What is not covered

- All other dental services not shown as covered

Vision care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refractions (to provide a written lens prescription) may be obtained from Plan providers. You pay a $15 copay per visit.

What is not covered

- Corrective lenses or frames
- Eye exercises
- Contact lens fitting

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all enrollees and family members who are members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium and any charges for these services do not count toward any FEHB deductibles or out-of-pocket maximum. These benefits are not subject to the FEHB disputed claims procedures.

OPTUM Care 24- Offers assistance to employees for virtually any type of personal, family, or work-related problem. Through a toll-free, 24 -hour-a-day phone service, or face-to-face consultation, members receive confidential help in coping with family problems, drug abuse, or financial struggles. Master's level counselors will be available to provide you and your family members information and support for a wide variety of concerns 24 hours a day, 365 days a year.

Registered nurses can provide you with helpful information on just about any medical condition 24 hours a day everyday of the week. Nurses can assist you in understanding diagnostic tests, the benefits and side effects of medications, specific dietary regimes, and treatment options. Call Nurseline at (888) 259-3038 or (800) 255-1049 V/TDD.

Car seats for newborns/
Bicycle helmet coupons
(3U1 and 3U2 only)

For information about this benefit, contact newborns/bicycle Customer Service at
(937) 439-8903 or (800) 231-2918.

Wellness programs
(3U1 and 3U2)

Discounts are offered at the following facilities

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. As indicated on page 4, 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 800/711/6089 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 or condition.

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Experimental or investigational procedures, treatments, drugs or devices;
- Procedures, services, drugs and 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;
- Procedures, services, drugs and supplies related to sex transformations;
- Services or supplies you receive from a provider or facility barred from the FEHB Program; and
- Expenses you incurred while you were not enrolled in this Plan.

Section 7. Limitations – Rules that affect your benefits

Medicare

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.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, 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.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800/638-6833. For information on the Medicare+Choice plan offered by this Plan, see page 18.

Other group insurance coverage

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

Section 7. Limitations – Rules that affect your benefits *continued*

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Circumstances beyond our control

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. 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.

TRICARE

TRICARE is the health care program for members, eligible dependents, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we are the primary payer. 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 disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide;
- 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 the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

We do not cover services and supplies that a local, State, or Federal Government agency directly or indirectly pays for.

Section 8. FEHB FACTS

You have a right to information about your HMO.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call 800/231-2918 for code 3U1/3U2 or 800/225-7591 code VC1/VC2 or write to: for codesVC!/VC2, 9200 Worthington Road, Westerville, OH 43802; for codes 3U1/3U2, 6601 Centerville Business Pkwy., Dayton, OH 45459. You may also contact us by fax at 614/410-7399 for codes VC1/VC2 or 937/436-8813 for code 3U1/3U2, or visit our website at www.uhc.com..

Where do I get information about enrolling in the FEHB Program?

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
- The next Open Season for enrollment.

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.

When are my benefits and premiums effective?

The benefits in this brochure are effective on January 1. If you are new to this plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin January 1.

What happens when I 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, which is described later in this section.

What types of coverage are available for my family and me?

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 or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get 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 you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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.

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

Section 8. FEHB FACTS *continued*

Are my medical and claims records 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 coordination 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.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter. If you enrolled through Employee Express you can request a confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

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

When you lose benefits

What happens if my enrollment in this Plan 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 former spouse coverage or Temporary Continuation of Coverage.

What is former spouse 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 more information about your coverage choices.

What is TCC?

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 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.**

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.

Section 8. FEHB FACTS *continued*

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an 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 if individual coverage is available. 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.

Section 8. FEHB FACTS *continued*

How can I get a Certificate of Group Health Plan Coverage?

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may request a certificate from them, as well.

Inspector General Advisory:Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at xxx/xxx-xxxx *(Plan specific)* and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 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 they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Summary of Benefits for UnitedHealthcare of Ohio, Inc. 2000

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.

Benefits		Plan pays/provides	Page
Inpat ient care	**Hospital**	Comprehensive range of medical and surgical services without a dollar or a day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. You pay a $100 copay per admission	12
	Extended care	All necessary services, for up to 180 days in a skilled nursing facility. You pay a $100 copay per admission	12
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. You pay nothing. One inpatient day may be exchanged for two days of outpatient day treatment	15
	Substance abuse	Up to 30 days per year in a substance abuse treatment program. You pay nothing. One inpatient day may be exchanged for two days of outpatient day treatment	15
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. You pay a $10 copay per office visit (copay waived after first prenatal visit); you pay a $10 copay per house call by a doctor; you pay a $15 copay per specialist visit	10
	Home health care	All necessary visits by nurses and health aides. You pay nothing	10
	Mental conditions	Up to 30 outpatient visits per year. You pay a $10 copay per visit for group therapy, $20 copay per visit for individual therapy	15
	Substance abuse	Up to 30 outpatient visits per year. You pay a $10 copay per visit for group therapy, $20 copay per visit for individual therapy	15
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. You pay a $50 copay to the hospital for each emergency room visit or a $10 copay per urgent care center visit and any charges for services that are not covered by this Plan	13-14
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. For retail prescription drugs; you pay a $10 copay for generic drugs, a $15 copay for brand name drugs per prescription unit or refill for drugs on the Plan's Formulary Drug List or $30 copay for brand name drugs per prescription unit or refill for drugs not on the Plan's Formulary Drug List. Maintenance drugs are available by mail; you pay a $20 copay for generic drugs or a $60 copay for brand name drugs not on the Plan's Formulary Drug List for a 90-day supply	16
Dental care		Accidental injury benefit; you pay nothing. Preventive dental care; you pay 50% of charges	17
Vision care		One eye exam for refractions per calendar year. You pay a $15 copay per visit	17
Out-of-pocket limit		Copayments and coinsurance are required for a few benefits. However, they will not be required for the following benefits for the remainder of the calendar year after your out-of-pocket expenses (excluding office visit copays) for these services provided or arranged by the Plan reach $500 per Self Only enrollment or $1,000 per Self and Family enrollment: orthopedic devices; prosthetic devices; durable medical equipment; medical supplies (but not diabetic supplies); growth hormones and emergency room copayments.	5

2000 Rate Information for
UnitedHealthcare 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 most career U.S. Postal Service employees. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee but not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees" RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Cincinnati/Dayton/Springfield/Toledo, Ohio									
Self Only	**3U1**	**$78.83**	**$28.13**	**$170.80**	**$60.95**	**$93.06**	**$13.90**	**$93.26**	**$13.70**
Self and Family	**3U2**	**$175.97**	**$70.04**	**$381.27**	**$151.75**	**$207.74**	**$38.27**	**$201.02**	**$44.99**
Central/South Central Ohio,									
Self Only	**VC1**	**$78.83**	**$32.53**	**$170.80**	**$70.48**	**$93.06**	**$18.30**	**$93.26**	**$18.10**
Self and Family	**VC2**	**$175.97**	**$80.15**	**$381.27**	**$173.66**	**$207.74**	**$48.38**	**$201.02**	**$55.10**