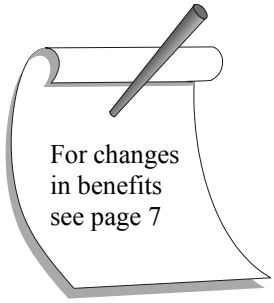
United Healthcare of Ohio, Inc.

UnitedHealthcare®
A UnitedHealth Group Company

www.uhc.com

2004

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 2004 Guide for more information On NCQA.

Enrollment codes for this Plan:

3U1 Self Only
3U2 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

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

FEHB
Federal Employees
Health Benefits Program

RI 73-608

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this 2004 Federal Employees Health Benefits (FEHB) Program plan brochure. The brochure describes the benefits this plan offers you for 2004. Because benefits vary from year to year, you should review your plan's brochure every Open Season – especially Section 2, which explains how the plan changed.

It takes a lot of information to help a consumer make wise healthcare decisions. The information in this brochure, our FEHB Guide, and our web-based resources, make it easier than ever to get information about plans, to compare benefits and to read customer service satisfaction ratings for the national and local plans that may be of interest. Just click on www.opm.gov/insure!

The FEHB Program continues to be an enviable national model that offers exceptional choice, and uses private-sector competition to keep costs reasonable, ensure high-quality care, and spur innovation. The Program, which began in 1960, is sound and has stood the test of time. It enjoys one of the highest levels of customer satisfaction of any healthcare program in the country.

I continue to take aggressive steps to keep the FEHB Program on the cutting edge of employer-sponsored health benefits. We demand cost-effective quality care from our FEHB carriers and we have encouraged Federal agencies and departments to pay the full FEHB health benefit premium for their employees called to active duty in the Reserve and National Guard so they can continue FEHB coverage for themselves and their families. Our carriers have also responded to my request to help our members to be prepared by making additional supplies of medications available for emergencies as well as call-up situations and you can help by getting an Emergency Preparedness Guide at www.opm.gov. OPM's *HealthierFeds* campaign is another way the carriers are working with us to ensure Federal employees and retirees are informed on healthy living and best-treatment strategies. You can help to contain healthcare costs and keep premiums down by living a healthy life style.

Open Season is your opportunity to review your choices and to become an educated consumer to meet your healthcare needs. Use this brochure, the FEHB Guide, and the web resources to make your choice an informed one. Finally, if you know someone interested in Federal employment, refer them to www.usajobs.opm.gov.

Sincerely,

Kay Coles James
Director

Notice of the Office of Personnel Management's Privacy Practices

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

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

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

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government health care oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

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

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

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any

information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.

- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

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

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

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

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

Table of Contents

Introduction

This brochure describes the benefits United Healthcare of Ohio, Inc. under our contract (CS 2671) with the United States Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for United Healthcare of Ohio, Inc. administrative offices is:

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2004, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2004, and changes are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means United Healthcare of Ohio, Inc.
- We limit acronyms to one you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States 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 OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Insurance Services Program, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - If the provider does not resolve the matter, call us at 1-800-231-2918 and explain the situation.
  - Call the provider and ask for an explanation. There may be an error.
  - If we do not resolve the issue:

CALL -- THE HEALTH CARE FRAUD HOTLINE
202-418-3300
OR WRITE TO:
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child over age 22 (unless he/she is disabled and incapable of self support).

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing Medical Mistakes

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

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

Want more information on patient safety?

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

Section 1. Facts about this HMO plan

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

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

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You 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. 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 at 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:

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

The Kentucky counties of Boone, Campbell, and Kenton

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 2004

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

Program-wide changes

- We added information regarding two new Federal Programs that complement FEHB benefits, the Federal Flexible Spending Account Program — *FSAFEDS* and the Federal Long Term Care Insurance Program. See pages 49-52.
- We added information regarding Preventing Medical Mistakes. See page 4.
- We added information regarding enrolling in Medicare. See page 40-41.
- We revised the Medicare Primary Payer Chart. See page 42.

Changes to this Plan

- Your share of the non-Postal premium will increase by 11.0% for Self Only or 11.1% for Self and Family.

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. You may also request replacement cards through our website at www.uhc.com.

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 or by looking in our website at www.myuhc.com. 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 serious 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. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

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 $250 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. Coinsurance doesn't begin until you meet your deductible. Example: In our Plan, you pay 20% of our allowance 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 54 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 claim 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 visit
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	Not covered
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 $250 inpatient admission and nothing for outpatient care.

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
Routine 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 vaccine annually • 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 • Postnatal care • Delivery 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. Surgical benefits, not maternity benefits, apply to circumcision if this is the case. • 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; $250 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 (see Surgical procedures section 5(b) • Surgically implanted contraceptives • 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 zygote 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 – 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. NOTE: We will only cover GHT when we preauthorize the treatment. Your participating provider should call 800-635-6882 for preauthorization. We will ask your participating provider to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date your information is submitted. If you do not ask or if we determine GHT is not medically necessary, will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	$15 per office visit
Not covered:	*All charges.*

Physical and occupational therapies	You pay
2 months visits per condition per year for the services of each of the following: — qualified physical therapists and — occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 36 sessions	$15 per office visit $15 per outpatient visit Nothing per visit during covered inpatient admission
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges*
Speech therapy	
2 months per condition per year. 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 per visit during covered inpatient admission
Not covered: • *Exercise Programs*	*All charges*
Hearing services (testing, treatment, and supplies)	
• Hearing 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 lens 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 and orthoptics* • *Contact lenses* • *Radial Keratotomy and other refractive surgery*	*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**
• Artificial limbs and eyes; stump hose • Orthopedic devices such as braces; 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 $1000 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). • Voluntary sterilization (e.g. tubal ligation, vasectomy) • 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.*	*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 of 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 specialist; 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 a National Cancer Institute- or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. 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 • Skilled nursing facility • Ambulatory surgical center • Office	 Nothing Nothing Nothing $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	$250 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	$250 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.	$250 copay per inpatient admission and nothing for outpatient care.
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	**You pay**
• Local professional ambulance service when medically appropriate and with a network service. • Benefits are provided for non-emergency ambulance transportation ordered or authorized by a Plan doctor.	20% of charges

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 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

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 emergency room 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 with a network service. NOTE: 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:

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

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	$250 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.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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 2004 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). Plan members called to active military duty (or member in time of national emergency) who need to obtain prescribed medications should call our Customer Service Department at 800-231-2918.
- **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 strength 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 strength 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:	$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.
• 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.	Same as above.
• Insulin; copay charge applied every 2 vials	Same as above.
• Disposable needle and syringes for the administration of covered medication	Same as above.
• Drugs for sexual dysfunction are limited. Contact the plan for prior authorization and dose limits.	Same as above.
• Compound drugs that contain at least one ingredient requiring a Prescription Order or Refill.	Same as above.
• Contraceptive drugs , devices and supplies that require a prescription.	Same as above.
• Injectible contraceptive drugs	Same as above.
• 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.
• Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape, Benedict's solution or equivalents and acetone test tablets.	20% Coinsurance
• Implanted contraceptive drugs such as Norplant	20% Coinsurance
• Intravenous fluids and medication for home use, implantable drugs, and some injectible drugs are covered under medical and surgical benefits.	Refer to Home Health Services, Section 5a

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 1-800-855-2880 and talk with a registered nurse who will discuss treatment options and answer your health questions.
Centers of excellence	United Resource Network
Cancer Resource Services	Speak with a nurse consultant, at 1-866-936-6002 from 7am to 7pm EST, Monday – Friday, to discuss information about cancer centers and physicians.
United Naturally	Simple-to-use discount program that lets you access a network of credentialed complementary care practitioners for acupuncture, massage therapy, naturopathy and nutrition counseling. Show your United Healthcare ID card and save 20% on services at participating network provider locations.
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.
- Accidental dental is covered under the medical plan. Contact customer service at 1-800-231-2918, M-F, 8:00 a.m. – 5:00 p.m. EST, with any questions.

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

Section 7. Filing a claim for covered services

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

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, M-F, 8am-5pm EST.

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

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

Submit your claims to: 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: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: UHC of Ohio, Marketing Dept., 9050 Center Pointe Dr., Suite 400, West Chester, OH 45069 (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) 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: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 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 more than one claim, you must clearly identify which documents apply to which claim.

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

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

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

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

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-231-2918 M-F, 8am–5pm. EST. and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health 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.

- **Should I enroll in Medicare?**

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

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost.** When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

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

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice 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.

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 M-F, 8am-5pm EST or through our website.

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

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

* Unless you have FEHB coverage through your spouse who is an active employee

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

- **Medicare + Choice**

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 + Choice plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare + Choice plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare + Choice plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare + Choice plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

This Plan and our Medicare + Choice plan: You may enroll in our Medicare + Choice 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 + Choice plan: You may enroll in another plan's Medicare + Choice plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare + Choice plan is primary, even out of the + Choice 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 + Choice plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare + Choice plan so we can correctly coordinate benefits with Medicare.

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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. Custodial care that lasts 90 days or more is sometimes known as long term care.

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

Coverage information

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.

Children's Equity Act

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

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

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

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

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2004 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2003 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

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

When you lose benefits

- **When FEHB coverage ends**

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

— Your enrollment ends, unless you cancel your enrollment, or

— You are a family member no longer eligible for coverage.

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

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. 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. You can also download the guide from OPM's website, www.opm.gov/insure.

- **Temporary continuation of coverage (TCC)**

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

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.

Two new Federal Programs complement FEHB benefits

Important information

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

The Federal Flexible Spending Account Programs — *FSAFEDS*

- **What is an FSA?**

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

There are two types of FSAs offered by the FSAFEDS Program:

Health Care Flexible Spending Account (HCFSA)

— Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.

— Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal income tax return, even if you don't have self and family health benefits coverage. ***Note:*** The IRS has a broader definition than that of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.

— The maximum amount that can be allotted for the HCFSA is $3,000 annually. The minimum amount is $250 annually.

Dependent Care Flexible Spending Account (DCFSA)

— Covers eligible dependent care expenses incurred so you can work, or if you are married, so you and your spouse can work, or your spouse can look for work or attend school full-time.

— Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified IRS dependent and/or with whom you jointly file your Federal income tax return.

— The maximum that can be allotted for the DCFSA is $5,000 annually. The minimum amount is $250 annually. ***Note:*** The IRS limits contributions to a Dependent Care FSA. For single taxpayers and taxpayers filing a joint return, the maximum is $5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is $2,500 per year. The limit includes any child care subsidy you may receive.

- **Enroll during Open Season**

You **must make an election** to enroll in an FSA during the FEHB Open Season. Even if you enrolled during the initial Open Season for 2003, you must make a new election to continue participating in 2004. Enrollment is easy!

— Enroll online anytime during Open Season (November 10 through December 8, 2003) at **www.fsafeds.com.**

— Call the toll-free number 1-877-FSAFEDS (372-3337) Monday through Friday, from 9 a.m. until 9 p.m. eastern time and a FSAFEDS Benefit Counselor will help you enroll.

What is SHPS?

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

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB — even if you're not enrolled in FEHB — you can choose to participate in either, or both, of the flexible spending accounts. If you are not eligible for FEHB, you are not eligible to enroll for a Health Care FSA. However, almost all Federal employees are eligible to enroll for the Dependent Care FSA. The only exception is intermittent (also called when actually employed [WAE]) employees expected to work less than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers signed on. Under IRS law, FSAs are not available to annuitants. In addition, the U.S. Postal Service and the Judicial Branch, among others, are Federal agencies that have their own plans with slightly different rules, but the advantages of having an FSA are the same no matter what agency you work for.

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

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits of an FSA, the IRS places strict guidelines on them. You need to estimate how much you want to allocate to an FSA because current IRS regulations require you forfeit any funds remaining in your account(s) at the end of the FSA plan year. This is referred to as the "use-it-or-lose-it" rule. You will have until April 29, 2004 to submit claims for your eligible expenses incurred during 2003 if you enrolled in FSAFEDS when it was initially offered. You will have until April 30, 2005 to submit claims for your eligible expenses incurred from January 1 through December 31, 2004 if you elect FSAFEDS during this Open Season.

The **FSAFEDS Calculator** at www.fsafeds.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

- ### What can my HCFSA pay for?

Every FEHB health plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 11 and detailed throughout this brochure. Your HCFSA will reimburse you for such costs when they are for tax deductible medical care for you and your dependents that is NOT covered by this FEHB Plan or any other coverage that you have.

Under the High Option of this Plan, typical out-of-pocket expenses include: inpatient hospital, durable medical equipment and dental (accidental). The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS Web site at http://www.irs.gov/pub/irs-pdf/p502.pdf.

If you do not see your service or expense listed in Publication 502, please call a FSAFEDS Benefit Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

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

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

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

- **Tax credits and deductions**

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

Health care expenses

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

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

Dependent care expenses

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account. Visit www.fsafeds.com and download the Dependent Care Tax Credit Worksheet from the Quick Links box to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

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

Probably not. While there is an administrative fee of $4.00 per month for an HCFSA and 1.5% of the annual election for a DCFSA, most agencies have elected to pay these fees out of their share of employment tax savings. To be sure, check the FSAFEDS.com website or call 1-877-FSAFEDS (372-3337). Also, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the plan year and wind up forfeiting your end of year account balance, per the IRS "use-it-or-lose-it" rule.

- **Contact us**

To find out more or to enroll, please visit the **FSAFEDS website at www.fsafeds.com**, or contact SHPS by email or by phone. SHPS Benefit Counselors are available from 9:00 a.m. until 9:00 p.m. eastern time, Monday through Friday.

- E-mail: fsafeds@shps.net
- Telephone: 1-877-FSAFEDS (372-3337)
- TTY: 1-800-952-0450 (for hearing impaired individuals that would like to utilize a text messaging service)

The Federal Long Term Care Insurance Program

It's important protection

Here's why you should consider enrolling in the Federal Long Term Care Insurance Program:

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive when you need assistance performing activities of daily living — such as bathing or dressing yourself. This need can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you control over the type of care you receive and where you receive it. It can also help you remain independent, so you won't have to worry about being a burden to your loved ones.
- **It's to your advantage to apply sooner rather than later.** Long term care insurance is something you must apply for, and pass a medical screening (called underwriting) in order to be enrolled. Certain medical conditions will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a change in health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting applications, which asks fewer questions. If you marry, your new spouse will also have a limited opportunity to apply using abbreviated underwriting. Qualified relatives are also eligible to apply with full underwriting.

To find out more and to request an application

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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. - 2004

- **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	15
Services provided by a hospital: • Inpatient ..... • Outpatient.....	 $250 per admission copay *Nothing*	24 25
Emergency benefits: • In-area ..... • Out-of-area.....	$75 per visit $75 per visit	28 28
Mental health and substance abuse treatment	Regular cost sharing	29-30
Prescription drugs	$10 (retail) $20 (mail order) copay per prescription unit or refill for generic drugs and a $15 (retail) $30 (mail order) copay per prescription unit or refill for name brand drugs on the Plan's Formulary Drug List. $30 (retail) $60 (mail order) copay per prescription unit or refill for drugs not on the Plan's Formulary Drug List.	32
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	39
Protection against catastrophic costs (your catastrophic protection 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

2004 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 a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Govt Share	Your Share	Govt Share	Your Share	USPS Share	Your Share
High Option Self Only	3U1	$121.40	$ 76.09	$263.03	$164.87	$143.32	$ 54.17
High Option Self & Family	3U2	$277.09	$177.14	$600.36	$383.81	$327.12	$127.11