



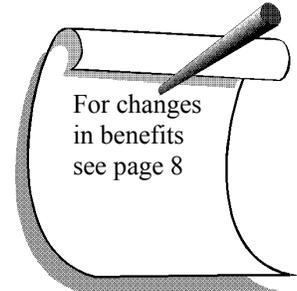
Union Health Service 2004

<http://www.unionhealth.org>

A Health Maintenance Organization

Serving: Chicago Area

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.



Enrollment codes for this Plan:

**761 Self Only
762 Self and Family**

Authorized for distribution by the:



**United States
Office of Personnel Management**

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



RI 73-026



OFFICE OF THE DIRECTOR

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

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,

A handwritten signature in black ink, appearing to read "Kay Coles James".

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 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 healthcare 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
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 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.

Table of Contents

Introduction	4
Plain Language	4
Stop Health Care Fraud!	4
Preventing medical mistakes	5
Section 1. Facts about this HMO plan	7
How we pay providers	7
Your Rights.....	7
Service Area	7
Section 2. How we change for 2004.....	8
Program-wide changes.....	8
Changes to this Plan.....	8
Section 3. How you get care.....	9
Identification cards	9
Where you get covered care.....	9
• Plan providers.....	9
• Plan facilities.....	9
What you must do to get covered care.....	9
• Primary care	9
• Specialty care	9
• Hospital care.....	10
Circumstances beyond our control.....	11
Services requiring our prior approval	11
Section 4. Your costs for covered services.....	12
• Copayments.....	12
• Deductible	12
• Coinsurance.....	12
Your catastrophic protection out-of-pocket maximum	12
Section 5. Benefits.....	13
Overview	13
(a) Medical services and supplies provided by physicians and other health care professionals.....	14
(b) Surgical and anesthesia services provided by physicians and other health care professionals	22
(c) Services provided by a hospital or other facility, and ambulance services	26
(d) Emergency services/accidents.....	29
(e) Mental health and substance abuse benefits.....	31
(f) Prescription drug benefits	34
(g) Special features	36
(h) Dental benefits	37
(i) Non-FEHB benefits available to Plan members.....	38

Section 6. General exclusions -- things we don't cover	39
Section 7. Filing a claim for covered services	40
Section 8. The disputed claims process	42
Section 9. Coordinating benefits with other coverage	44
When you have other health coverage	44
• What is Medicare	44
• Should I enroll in Medicare?	44
• Medicare + Choice	47
• TRICARE and CHAMPVA	47
• Workers' Compensation	47
• Medicaid	48
• Other Government agencies	48
• When others are responsible for injuries	48
Section 10. Definitions of terms we use in this brochure	49
Section 11. FEHB facts	50
Coverage information	50
• No pre-existing condition limitation	50
• Where you get information about enrolling in the FEHB Program	50
• Types of coverage available for you and your family	50
• Children's Equity Act	50
• When benefits and premiums start	51
• When you retire	51
When you lose benefits	51
• When FEHB coverage ends	51
• Spouse equity coverage	52
• Temporary Continuation of Coverage (TCC)	52
• Converting to individual coverage	52
• Getting a Certificate of Group Health Plan Coverage	53
Two New Federal Programs complement FEHB benefits	54
The Federal Flexible Spending Account Programs - FSAFE	54
The Federal Long Term Insurance Program	57
Index	59
Summary of benefits	60
Rates	Back Cover

Introduction

This brochure describes the benefits of Union Health Service under our contract (CS 1571) with the United States Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for Union Health Service administrative office is:

Union Health Service
1634 West Polk Street
Chicago, Illinois 60612

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 8. 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 Union Health Service
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

If you have a comment or suggestion 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 email us at fehwebcomments@opm.gov. You may also write to OPM at the United States 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 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:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 312/829-4224 ext. 3359 and explain the situation.
- 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 your 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 employ individual physicians, own and operate our medical centers, and contract with hospitals to provide the benefits in this brochure. Most physicians are salaried employees. Other Plan providers accept a negotiated payment from us. You will only be responsible for your copayments or coinsurance.

UHS is a Staff Model Group Practice Plan that employs most of our doctors. All doctors are either Board Certified or Eligible in their specialties and are affiliated with some of the area's finest hospitals.

Your Rights

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

Union Health Service is a staff model not-for-profit Health Maintenance Organization. Union Health Service is a state certified HMO. We were established in 1955.

If you want more information about us, call our Member Service Department at 312 829-4224 ext. 3379, or write to Union Health Service, 1634 West Polk Street, Chicago, IL 60612. You may also contact us by fax at 312/423-4380 or visit our website at: www.unionhealth.org.

Service Area

To enroll with us, you must live in or work in our service area. This is where our providers practice. Our service area is: The Chicago Area located in Cook and DuPage, Kane, Will and Kendall counties, Illinois

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 approval.

If you or a covered family member moves outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member moves outside of the service area, 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 your 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 page 54.
- We added information regarding Preventing medical mistakes. See page 5.
- We added information regarding enrolling in Medicare. See page 44.
- We revised the Medicare Primary Payer Chart. See page 46.

Changes to this Plan

- Your share of the non-Postal premium will increase 15.3 % for Self Only or 15.3 % for Self and Family.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card after 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 our Member Service Department at 312 829-4224 ext. 3379 or write to us at 1634 West Polk Street; Chicago, Illinois 60612.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments and deductibles. You will not have to file claims.

- **Plan providers**

Plan providers are physicians and other health care professionals in our group that we employ to provide covered services to our members. We credential Plan providers in accordance with state and national standards.

We list Plan providers in the provider directory, which we update periodically.

- **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 on our web site, www.unionhealth.org and in our provider directory, which we update periodically.

What you must do to get covered care

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

- **Primary care**

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

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

- **Specialty care**

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

Here are other things you should know about specialty care:

- If you need to see a participating specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan.
- If you are seeing a specialist when you enroll in our Plan, talk to 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. Contact us.
- 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 Medical Management Department immediately at 312 829-4224 ext.3210. 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 has authority to refer you for internal services. For external services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

Our Medical Director must approve your referral to an outside specialist before you receive treatment. When you receive a referral from your primary care physician to an outside specialist, you must return to the primary care physician after the consultation. Your primary care physician must provide or authorize all follow-up care. On outside referrals, your primary care physician will give specific instructions to the specialist as to what services are authorized. If the specialist suggests additional services or visits, you must check with your primary care physician for approval and authorization. Do not go to the outside specialist unless your primary care physician has arranged for and the Plan has issued an authorization for the referral in advance.

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 \$10 per office visit.

- **Deductible**

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. UHS has a deductible for orthopedic and prosthetic devices and durable medical equipment, see page 20, otherwise we do not have a deductible.

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

- **Coinsurance**

Coinsurance is the percentage of our negotiated fee that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

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

Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance and Copayments

Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated copayments and deductibles required for a few benefits.

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

Section 5. Benefits – OVERVIEW

(See page 8 for how our benefits changed this year and page 60 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 advice, or more information about our benefits, contact our Member Service Department at 312 829-4224 ext.3379, or at our Web site at www.unionhealth.org

(a) Medical services and supplies provided by physicians and other health care professionals.....	14-21
•Diagnostic and treatment services	
•Lab, X-ray, and other diagnostic tests	
•Preventive care, adult	
•Preventive care, children	
•Maternity care	
•Family planning	
•Infertility services	
•Allergy care	
•Treatment Therapies	
•Physical and Occupational therapies	
•Speech Therapy	
•Hearing services (testing, treatment, and supplies)	
•Vision services (testing, treatment, and supplies)	
•Foot care	
•Orthopedic and prosthetic devices	
•Durable medical equipment (DME)	
•Home health services	
•Chiropractic	
•Alternative Treatments	
•Educational classes and programs	
(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	22-25
•Surgical procedures	
•Reconstructive surgery	
•Oral and maxillofacial surgery	
•Organ/tissue transplants	
•Anesthesia	
(c) Services provided by a hospital or other facility, and ambulance services.....	26-28
•Inpatient hospital	
•Outpatient hospital or ambulatory surgical center	
•Extended care benefits/skilled nursing care facility benefits	
•Hospice care	
•Ambulance	
(d) Emergency services/accidents	29-30
•Medical emergency	
•Ambulance	
(e) Mental health and substance abuse benefits	31-33
(f) Prescription drug benefits.....	34-35
(g) Special features.....	36
•Not for Profit Organization	
•24 hour emergency line	
•High risk pregnancies	
•Centers of excellence for transplants/heart surgery/etc	
•Translation Services	
•Extended Hours	
•Continuity of Care	
•Staff Model	
(h) Dental benefits.....	37
(i) Non-FEHB benefits available to Plan members	38
Summary of benefits.....	60

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

**I
M
P
O
R
T
A
N
T**

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 deductibles for prosthetic and orthopedic devices and durable medical equipment
- Be sure to read Section 4, *Your costs for covered service*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including Medicare.

**I
M
P
O
R
T
A
N
T**

Benefit Description	You pay After the calendar year deductible...
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician's office • In an urgent care center • Office medical consultations • Second surgical opinion 	\$10 per visit
Professional services of physicians <ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	Nothing
At home	\$10 per visit

Diagnostic and treatment services -- Continued on next page

Lab, X-ray and other diagnostic tests	You Pay
<p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing
Preventive care, adult	
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 <p>Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older</p>	<p>Nothing</p> <p>\$10 per visit</p>
<p>Routine pap test</p> <p>Note: The office visit is covered if pap test is received on the same day; see <i>Diagnosis and Treatment</i>, above.</p>	\$10 per visit
<p>Routine mammogram –covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> • 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 	Nothing.
<p><i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i></p>	<i>All Charges</i>
<p>Routine immunizations, limited to:</p> <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and over 	\$10 per visit

Preventive care, children	You pay
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	\$10 per visit
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: <ul style="list-style-type: none"> - Eye exams through age 17 to determine the need for vision correction. - Ear exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22) 	\$10 per visit
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need prior approval for your normal delivery; see page 28 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	\$10 per visit
<i>Not covered: Routine sonograms to determine fetal age, size or sex</i>	<i>All charges</i>

Family planning	You pay
<p>A range of voluntary family planning services, such as;</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs(such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>NOTE: We cover oral contraceptives under the prescription drug benefit</p>	\$10 per visit
<p><i>Not covered: reversal of voluntary surgical sterilization, genetic counseling,</i></p>	<i>All charges.</i>
Infertility services	
<p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) • Fertility drugs are covered as mandated by the State of Illinois. • Other assisted reproductive technology (ART) procedures that enable a woman with otherwise untreatable infertility to become pregnant through artificial conception procedures such as in vitro fertilization and embryo transfers including medical examinations in accordance with the limitations specified in the State of Illinois mandated benefits. <p>Note: The State of Illinois has limitations on the number of ART procedures.</p>	\$10 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>in vitro fertilization</i> - <i>embryo transfer and GIFT and zygote ZIFT</i> - <i>Zygote transfer</i> • <i>Services and supplies related to excluded ART procedures</i> 	<i>All charges.</i>
Allergy care	
<p>Testing and treatment</p>	\$10 per visit

Allergy serum	Nothing
Allergy injection	
<i>Not covered: provocative food testing and sublingual allergy desensitization</i>	<i>All charges.</i>
Treatment therapies	You pay
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplant is limited to those transplants listed under Organ/Tissue Transplants on page 24.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: – We will only cover GHT when the treatment is authorized by the Medical Director. We will ask your primary care physician to submit information that establishes that the GHT is medically necessary. Authorization must be given before you begin GHT treatment; otherwise, we will only cover GHT services from the date of approval. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See Services requiring our prior approval in Section 3.</p> <p>Growth Hormone therapy is covered under the plan's medical benefits.</p>	\$10 per visit
Physical and Occupational therapies	
<ul style="list-style-type: none"> • 60 treatments per condition for the services of each of the following: <ul style="list-style-type: none"> - licensed physical therapists; - occupational therapists. <p>Note: We only cover short-term therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.</p> <ul style="list-style-type: none"> • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 30 sessions. 	\$10 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>long-term rehabilitative therapy</i> • <i>exercise programs</i> 	<i>All charges.</i>

Speech therapy	You Pay
<ul style="list-style-type: none"> • 60 treatments per condition upon approval of the Plan's Medical Director. 	\$10 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>therapy that will not result in improvement to your condition within 60 visits</i> 	<i>All charges</i>
Hearing services (testing, treatment, and supplies)	You Pay
<ul style="list-style-type: none"> • Hearing testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	\$10 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>all other hearing testing</i> • <i>hearing aids, testing and examinations for them</i> 	<i>All charges.</i>
Vision services (testing, treatment, and supplies)	You Pay
In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, you may obtain an annual eye refraction (which includes the written lens prescription).	\$10 per visit
<ul style="list-style-type: none"> • Eye exam to determine the need for vision correction for children through age 17 (see preventive care) • Annual eye refractions 	\$10 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses.</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<i>All charges.</i>
Foot care	You Pay
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>See orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	\$10 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained, flat feet, bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<i>All charges.</i>

Orthopedic and prosthetic devices	You pay
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	<p>20% of charges after you pay the calendar year deductible.</p> <p>\$100 deductible per member per calendar year (maximum \$300 family deductible).</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • Corsets, trusses, elastic stockings, support hose, and other supportive devices • Replacement of an otherwise covered prostheses before (1) any evidence of a manufacturing defect is known or (2) normal wear and tear with proper use for which either condition causes the prior prostheses to become unusable for its intended purpose. 	<p><i>All charges.</i></p>
Durable medical equipment (DME)	
<p>Purchase or rental (up to the purchase price), at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician as medically necessary, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Hospital beds; • Wheelchairs • Crutches • Walkers; • Blood glucose monitors; and • Insulin pumps. <p>Note: Call our Medical Management Department at 312 829-4224 ext. 3210 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>20% of charges after you pay the calendar year deductible.</p> <p>\$100 deductible per member per calendar year (maximum \$300 family deductible).</p>

<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Motorized wheel chairs</i> • <i>Equipment that is not medically necessary</i> 	<p><i>All charges.</i></p>
<p>Home health services</p>	<p>You Pay</p>
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. • Home health care is provided for homebound members at their home when prescribed by a Plan physician. <p>Note: Our Medical Management Department will monitor all home health care.</p>	<p>\$10 per visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<p><i>All charges.</i></p>
<p>Alternative treatments</p>	
<p><i>No benefit for services such as:</i></p> <ul style="list-style-type: none"> • <i>Acupuncture</i> • <i>Naturopathic services</i> • <i>Hypnotherapy</i> • <i>Biofeedback</i> 	<p><i>All charges.</i></p>
<p>Chiropractic</p>	
<p>Your UHS Orthopedic physician may refer you for a chiropractic consultation or chiropractic care.</p> <p>Note: You must receive prior approval from the Plan's Medical Director to receive chiropractic services. The Plan's medical director will review your chiropractor's treatment plan after you receive your consultation. (See section 3 for services requiring prior approval)</p>	<p>\$10 per visit</p>

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

I
M
P
O
R
T
A
N
T

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 only have deductibles for prosthetic and orthopedic devices and durable medical equipment
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including 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
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information and services requiring our prior approval shown in Section 3 to be sure which services require precertification or prior approval.

I
M
P
O
R
T
A
N
T

Benefit Description	You pay After the calendar year deductible...
<p>Surgical procedures</p> <p>A comprehensive range of services and operative procedures, such as:</p> <ul style="list-style-type: none"> • 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. Surgery for morbid obesity should be performed only as a last resort, when the member's health is endangered and more conservative medical measures, including prescription drugs such as appetite suppressants, have not been successful. • Insertion of internal prosthetic devices such as pacemakers and artificial joints. See 5(a) – Orthopedic and prosthetic devices for device coverage information. 	<p>\$10 per visit; nothing for hospital visits</p>

Surgical procedures continued on next page.

Surgical procedures (Continued)	You pay
<ul style="list-style-type: none"> • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns 	\$10 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care.</i> 	<i>All charges.</i>
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; or webbed toes. 	\$10 per visit; nothing for hospital visits
<ul style="list-style-type: none"> • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance on the other breast; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	\$10 per visit; nothing for hospital visits
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<i>All charges</i>

Oral and maxillofacial surgery	You Pay
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>\$10 per visit; nothing for hospital visits</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> • <i>Shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, and any other dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.</i> 	<p><i>All charges.</i></p>
Organ/tissue transplants	
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Kidney • Liver • 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 (<i>autologous bone marrow transplants limited to non-random clinical trials</i>) • Intestinal transplants (small intestine) and small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas <p>Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's Medical Director in accordance with the Plan's protocols.</p> <p>Note: Transplants must be approved by the Medical Director. We will refer you to a specific treatment location. We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>\$10 per visit; nothing for hospital visits.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<p><i>All charges</i></p>

Anesthesia	You pay
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	Nothing

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

**I
M
P
O
R
T
A
N
T**

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 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 Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 (services requiring our approval) to be sure which services require precertification.

**I
M
P
O
R
T
A
N
T**

Benefit Description	You pay
Inpatient hospital	
Room and board, such as <ul style="list-style-type: none"> • 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.	Nothing

Inpatient hospital continued on next page.

Inpatient hospital (<i>Continued</i>)	You pay
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • 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 (Note: calendar year deductible applies to durable medical equipment and prosthetic and orthopedic devices.) 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care, rest cures, domiciliary or convalescent care</i> • <i>Non-covered facilities</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> 	<i>All charges.</i>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	Nothing
<i>Not covered: blood and blood derivatives not replaced by the member</i>	<i>All charges</i>

Extended care benefits/skilled nursing care facility benefits	You pay
<p>We provide a comprehensive range of benefits for up to 60 days per calendar year when full time nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan.</p> <ul style="list-style-type: none"> • Bed, board and general nursing • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility (SNF) when prescribed by a Plan doctor and managed by our Medical Management Department. 	Nothing
<i>Not covered: custodial care</i>	All charges
Hospice care	
<p>We cover supportive and palliative care for a terminally ill member in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less</p>	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	All charges
Ambulance	
<ul style="list-style-type: none"> • Local professional ambulance service when approved by the Plan and medically appropriate 	Nothing

Section 5 (d). Emergency services/accidents

I
M
P
O
R
T
A
N
T

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

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

I
M
P
O
R
T
A
N
T

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please call the Plan 24-hour emergency number at once at 312/829-4224. The Plan has doctors on call around the clock, seven days a week. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 48 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been 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-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

Emergencies outside our service area: Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness

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

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at a Plan extended care center 	\$10 per visit
<ul style="list-style-type: none"> • Emergency care at a non-Plan urgent care center • Emergency care as an outpatient at a hospital, including doctors' services 	\$25 per visit
We waive the copay if you are admitted to the hospital.	
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>
Emergency outside our service area	
<ul style="list-style-type: none"> • 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 	\$25 per visit
We waive the copay if you are admitted to the hospital.	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges.</i>
Ambulance	
Professional ambulance service when medically appropriate. Air ambulance when approved by the Plan and medically appropriate See 5(c) for non-emergency service.	Nothing

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

I
M
P
O
R
T
A
N
T

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

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

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

I
M
P
O
R
T
A
N
T

Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. When treatment exceeds twelve month period Primary Care Physician and/or the patient can request patient have a second opinion if it appears patient is not doing as well as expected.</p>	<p>Your cost sharing responsibilities are no greater than for other illness or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$10 per visit</p>

Mental health and substance abuse benefits - Continued on next page

Mental health and substance abuse benefits <i>(Continued)</i>	You pay
<ul style="list-style-type: none"> • Diagnostic tests when ordered by a Plan doctor 	Nothing
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	Nothing.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services we have not approved.</i> • <i>Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate</i> • <i>Services rendered or billed by a school or a member of its staff</i> • <i>Psychotherapy or psychoanalysis credited toward furthering education, training, or earning a degree</i> • <i>Intelligence, IQ, aptitude, ability, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition.</i> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	All charges.

Preauthorization

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

YOU MUST GET PRECERTIFICATION OF SOME PROCEDURES. Please refer to Section 3 for information on which services require precertification or prior approval.

The Plan emergency number, (312) 829-4224, can be accessed 24-hours a day 7 days a week.

- Referrals will be written by the Plan Primary Care Physicians to network mental health and substance abuse providers
- Upon initial consultation an authorized treatment plan will be determined and structured.
- Inpatient services will be precertified through the Plan’s case managers
- Review and discharge planning are all through the Plan case managers

Limitation

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

Reporting

You should be aware that exchanges between patients and their therapist are confidential and are not shared with UHS staff. However, UHS does require that your Primary Care Physician of record at UHS be notified by you and/or your therapist of medication your therapist has ordered. This is important since most medications can have various effects with various patients including internal organ changes which your Primary Care Physician may need to periodically monitor. The therapist then will need to communicate such medication regimen and a generic statement as to progress.

Section 5 (f). Prescription drug benefits

I M P O R T A N T	<p>Here are some important things to keep in mind about these benefits:</p> <ul style="list-style-type: none"> • We cover prescribed drugs and medications, as described in the chart beginning on the next page. • All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary. • Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including Medicare. 	I M P O R T A N T
	<p>There are important features you should be aware of. These include:</p> <ul style="list-style-type: none"> • Who can write your prescription? A Plan physician or Plan licensed dentist must write the prescription. • Where you can obtain them? You must fill the prescription at a Plan pharmacy. The Plan pharmacy can fill some maintenance medications by mail. • These are the dispensing limitations. Prescription drugs will be dispensed for up to a 30-day supply or 100 unit supply, whichever is less; 240 milliliters of liquid (8oz.); 60 grams of ointment, creams or topical preparation; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin). If you are called to active duty or require medication during a national or other emergency call us at 312 829-4224 extension 3379. <p>Certain maintenance prescriptions can be mail ordered according to Food and Drug Administration Guidelines and you can obtain these by mail from the Plan pharmacy. Contact the Plan pharmacy at 312 829-4224 ext. 3260 to make arrangements.</p> <p>A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.</p> <p>Sexual dysfunction drugs have dispensing limitations. Contact the Plan pharmacy for details.</p> <ul style="list-style-type: none"> • Why use generic drugs. Generic drugs are lower-priced drugs in which the therapeutic ingredient is chemically equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs. • When you have to file a claim. You will not have to file a claim unless you receive covered prescription drugs during an out of area emergency. See Section 7 for information on how to file your claim 	

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as Not covered. • Insulin • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction when medically necessary (contact the Plan Pharmacy for limits) • Contraceptive drugs and devices • Intravenous fluids and medication for home use, implantable drugs, and some injectable drugs are covered under Medical and Surgical benefits • Fertility drugs are covered under infertility benefits, see page 17 	\$15 per prescription unit or refill
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Vitamins and nutritional substances that can be purchased without a prescription</i> • <i>Drugs available without a prescription or for which there is a nonprescription equivalent available</i> • <i>Drugs obtained at a non-Plan pharmacy except for out of area emergencies</i> • <i>Drugs to enhance athletic performance</i> • <i>Medical supplies such as dressings and antiseptics</i> 	<i>All Charges</i>

Section 5 (g). Special Features

Feature	Description
Not for Profit Organization	UHS is a not-for-profit organization managed by a Board composed of members representing Unions, physicians, and community leaders.
24 hour emergency line	Emergencies - 24 hours a day, 7 days a week, you may call 1-312-829-4224.
High risk pregnancies	Affiliated with Major Medical Centers
Centers of excellence for transplants/heart surgery/etc	Affiliated with Major Medical Centers and guided by National Transplant Program
Translation Services	Extensive translation skills among staff and physicians
Extended Hours	UHS offers extended clinic hours at our main facility on weekends, for patients in need of unscheduled visits.
Continuity of Care	Union Health Service has low physician and employee turnover
Staff Model	Because of our staff model status, most physicians are employees who work for UHS at our locations. For example: podiatry, ophthalmology, optometry, cardiology, allergy, gastroenterology, and dentists are all some of the many specialties that work at our main medical facility.

Section 5 (h). Dental benefits

**I
M
P
O
R
T
A
N
T**

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 non-dental physical impairment makes hospitalization necessary to safeguard the health of the patient: See Section 5 (c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including Medicare.

**I
M
P
O
R
T
A
N
T**

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.	\$10 per visit

Dental benefits

We have no other FEHB dental benefits. (Please refer to Non-FEHB benefits available to Plan members)

Section 5 (i). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

- Vision care**
- One annual refraction (which includes the written lens prescription) may be obtained from a UHS optometrist. The services are available by appointment at the UHS Eye Care Center 312 829-4224 ext. 3320 located at the UHS Main Facility, 1634 West Polk Street, Chicago, IL 60612
 - UHS Plan members receive special package prices and discounts on eyeglasses, frames, lenses, contact lenses and optical accessories at all For Eyes Optical store locations.
 - For further information about our Vision Benefits please contact our Member Service Department at 312 829-4224 ext.3379

- Dental Care**
- Dental Services are available to UHS Plan members. The services are available by appointment through a dentists contracting with UHS. The appointments can be made by directly contacting the private office of the participating dentists.
 - Annual Office.....No Charge
 - Annual Oral Examination and diagnosis..... No Charge
 - Annual Fluoride Treatment.....No Charge
(dependent under age 19)
 - Other dental services are available at reduced cost with an additional 20% discount. Payment is required at the time of service.

The contracting dentists may change from time to time and updated information may be obtained from our web site (www.unionhealth.org) or by contacting the UHS Marketing Department at 312 829-4224 ext. 3222.

Benefits on this page are not part of the FEHB contract

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, 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, or deductible.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 312 829-4224 ext. 3304.

When you must file a claim -- such as for services you receive outside of the Plan's service area-- submit the hospital bill or the claim on the HCFA-1500 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: Union Health Service Insurance Department
1634 West Polk Street
Chicago, Illinois 60612

Prescription drugs

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

Submit your claims to: Union Health Service Pharmacy
1634 West Polk Street
Chicago, IL 60612

Other supplies or services

- All other claims for supplies or services should be sent to the following department for review and processing

Submit your claims to: Union Health Service Insurance Department
1634 West Polk Street
Chicago, Illinois 60612

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: <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: UHS Medical Director, 1634 West Polk Street, Chicago, IL 60612; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude 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: <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial -- go to step 4; orAsk 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.

The Disputed Claims process (Continued)

Send OPM the following information:

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

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

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

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

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

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

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

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

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

- (a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 312 829-4224 ext. 3359 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 202/606-0755 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 or a covered family member has coverage under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

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

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

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

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-Stage 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 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 (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. 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. Your care must continue to be authorized by your Plan PCP, or precertified as required

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 312 829-4224 ext.3304.

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

- Deductible for inpatient hospitalization
- The balance of what Medicare does not pay for physician services

In the following cases, we do not waive any out-of-pocket costs:

- Medical services and supplies provided by physicians and other health care professionals who do not follow all of our rules, and guidelines;
- Care received from out-of-plan providers.

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

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	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 or 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 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 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	✓	

• Medicare + Choice

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from 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 the 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. We do not have a Medicare + Choice Plan; however, we do have a Medicare Health Care Prepayment Plan (HCPP). For more information on our Medicare HCPP, call us at 312/829/4224 ext. 3379.

If you enroll in a Medicare + Choice plan, the following options are available to you: **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 managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare + 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 eligible 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.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See page 12.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 12.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Treatment or services that are designed mainly to help the patient with daily living activities. Custodial care that lasts 90 days or more is sometimes known as Long term care
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12.
Experimental or investigational services	If a medical treatment, procedure, drug, device, or biological product is FDA approved, the Plan will use this as a basis for providing coverage. If it lacks FDA's approval, the Plan will make a policy decision based on specific statements from specialty societies or medical organizations such as the American Cancer Society, the American College of Surgeons, and the American Medical Society
Group health coverage	Health care coverage that a member is eligible for because of employment by, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies.
Medically necessary	<p>A Medically Necessary service is a service that is (1) consistent with the Enrollee's condition, disease, ailment or injury, (2) appropriate with regard to standards of good medical practice, (3) not solely for the convenience of the Enrollee or provider, and (4) the most appropriate supply or level of service which can be safely rendered to the Enrollee. When specifically applied to an inpatient, it further means that the Enrollee's medical symptoms or condition require that the diagnosis or treatment cannot be effectively, safely and economically provided to the Enrollee in an outpatient setting.</p> <p>Your Primary Care Physician, in accordance with the above standards adopted by Union Health Service, will determine when a service is medically necessary.</p>
Us/We	Us and we refer to Union Health Service
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 your FEHB coverage. These materials tell you:

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

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

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren you're 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 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 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, you must continue your FEHB coverage into retirement (if eligible) and cannot make any changes after retirement. 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. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's 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, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

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

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

• **Converting to individual coverage**

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

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

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

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

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans. For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have 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 Program - *FSAFEDS*

- **What is an FSA?**

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

There are two types of FSAs offered by 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. 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**

Every FEHB health plan includes cost sharing features, such as deductibles you must **pay for?** 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 XX 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 this Plan, typical out-of-pocket expenses include a \$100 deductible per member per calendar year (maximum \$300 family deductible) 20% of charges after you pay the calendar year deductible for orthopedic and prosthetic devices and durable medical equipment.

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**
deducts taxes

An FSA lets you allot money for eligible expenses *before* your agency 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 web site 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 Web site** 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 application, 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 does not explain your benefit coverage.

- Accidental injury 19, 23, 37
Allergy care 13, 17, 18
Alternative treatment 13, 21
Ambulance 13, 26, 28, 29, 30
Anesthesia 13, 22, 25, 27
Autologous bone marrow transplant 18, 24
Biopsies 22
Blood and blood plasma 27
Breast cancer screening 24
Casts 27
Catastrophic protection 12
Changes for 2004 8
Chemotherapy 18
Childbirth 16
Cholesterol tests 15
Claims 5, 7, 34, 38, 40, 41, 42, 43, 44, 45, 47, 54, 57
Coinsurance 7, 12, 49, 55
Colorectal cancer screening 15
Congenital anomalies 22, 23
Contraceptive devices and drugs 17, 35
Coordinating of benefits 14, 22, 26, 29, 31, 34, 37, 44
Covered services 9, 12, 40, 49
Covered Plan Providers 7, 9, 10, 47
Crutches 20
Deductible 12, 20, 27, 40, 45, 49, 55
Definitions 49
Dental care 20, 24, 27, 37, 38, 39, 54
Diagnostic services 13, 14, 15, 21, 27, 31, 32
Disputed claims review 42, 43
Donor expenses (transplants) 24
Dressings 27, 35
Durable medical equipment (DME) 12, 13, 14, 19, 20, 22, 27, 55
Effective date of enrollment 9, 11, 12, 49, 51
Emergency 13, 29, 30, 32, 34, 36, 39, 40
Experimental or investigational 39, 49
Eyeglasses 19, 38
Family planning 13, 17
Fecal occult blood test 15
General Exclusions 13
Hearing services 13, 19
Home health services 13, 21
Hospice care 13, 28
Home nursing care 21
Hospital 5, 6, 10, 13, 14, 16, 25, 26, 27, 29, 30, 32, 44, 45, 48
Immunizations 7, 15, 16
Infertility 13, 17, 35
Inhospital physician care 22
Inpatient Hospital Benefits 13, 26, 27, 28, 32, 45
Insulin 20, 34, 35
Laboratory and pathological services 27
Magnetic Resonance Imagings (MRIs) 15
Mail Order Prescription Drugs 34, 35
Mammograms 15
Maternity Benefits 13, 16, 27
Medicaid 48
Medically necessary 11, 39, 44
Medicare 8, 44, 45, 46, 47
Mental Conditions/Substance Abuse Benefits 13, 31, 32
Newborn care 16
Non-FEHB Benefits 13, 38
Nursery charges 16
Obstetrical care 16
Occupational therapy 13, 18
Office visits 7, 12, 15
Oral and maxillofacial surgery 13, 24
Orthopedic devices 14, 22, 27
Out-of-pocket expenses 12, 44, 45
Outpatient facility care 28
Oxygen 20, 21, 27
Pap test 15
Physical examination 7, 15
Physical therapy 13, 18
Physician 7, 9, 10, 11, 12, 14, 18, 20, 21, 22, 26, 31, 32, 33, 34, 35, 36, 40, 45, 49
Precertification/Prior-approval 22, 26, 32, 43
Preventive care, adult 13, 15
Preventive care, children 13, 16
Prescription drugs 22, 34, 40, 45, 47
Preventive services 7, 13, 15, 16, 19
Prior approval 7, 11, 16, 18, 21, 22, 43
Prostate cancer screening 15
Prosthetic devices 12, 13, 19, 20, 22, 23, 55
Psychologist 31
Psychotherapy 32
Radiation therapy 18
Rehabilitation therapies 18
Renal dialysis 44, 46
Room and board 26
Second surgical opinion 14
Skilled nursing facility care 10, 13, 14, 25, 28
Speech therapy 13, 19
Splints 27
Sterilization procedures 17, 23
Subrogation 48
Substance abuse 13, 31, 32
Surgery 6, 13, 16, 18, 19, 20, 22, 23, 24, 26, 36
 - Anesthesia 6, 13, 22, 25, 27
 - Oral 13, 24
 - Outpatient 27
 - Reconstructive 13, 22, 23Syringes 35
Temporary continuation of coverage 5, 51, 52, 53
Transplants 13, 18, 24, 35
Treatment therapies 13, 18
Vision services 13, 16, 19, 38, 54
Well child care 16
Wheelchairs 20
Workers' compensation 47
X-rays 15, 27

Summary of benefits for the *Union Health Service* – 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: \$10 primary care; \$10 specialist	14
Services provided by a hospital: • Inpatient	"Nothing"	26
• Outpatient.....		27
Emergency benefits: • In-area	\$25 per....	30
• Out-of-area	\$25 per...	30
Mental health and substance abuse treatment	Regular cost sharing	31
Prescription drugs	\$15 per prescription unit or refill	34
Dental Care.....	Accidental injury benefit	37
Vision Care.....	Medical, surgical for diagnosis and treatment of diseases, one annual eye refraction	19
Special features..... hour emergency line, High risk pregnancies, Centers for excellence for transplants/heart surgery/etc., Translation services, Urgent care, Continuity of Care, Staff Model	Not for Profit Organization, 24	36

2004 Rate Information for Union Health Service

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	<i>Non-Postal Premium</i>				<i>Postal Premium</i>	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

Location: Chicago Area

Self Only	761	\$92.78	\$30.92	\$201.02	\$67.00	\$109.78	\$13.92
Self and Family	762	\$230.06	\$76.68	\$498.45	\$166.15	\$272.23	\$34.51