CDPHP Universal Benefits®, Inc.

www.cdphp.com

(877) 269-2134 or (518) 641-3140

2016

A Prepaid Comprehensive Medical Plan (High and Standard Option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details.

Serving: Upstate, Hudson Valley, and Central New York

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page **12** for requirements.

IMPORTANT
- Rates: Back Cover
- Changes for 2016: Page 13
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Enrollment codes for this Plan

SG1 High Option - Self Only
SG3 High Option- Self Plus One
SG2 High Option - Self and Family
SG4 Standard Option – Self Only
SG6 Standard Option- Self Plus One
SG5 Standard Option – Self and Family

Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from CDPHP UBI About

Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the CDPHP UBI prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (800) 633-4227, TTY: (877) 486-2048.

Table of Contents

Introduction

This brochure describes the benefits of CDPHP Universal Benefits, Inc. (CDPHP UBI) under Capital District Physicians' Health Plan's contracts (CS 2901) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at (518) 641-3140 or (877) 269-2134 or through our website: www.cdphp.com. The address for CDPHP UBI administrative offices is:

CDPHP UBI
500 Patroon Creek Blvd.
Albany, NY 12206

This brochure is the official statement of benefits. No verbal 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. If you enroll in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2016, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each Plan annually. Benefit changes are effective January 1, 2016, and changes are summarized on page 13. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

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

Stop Health Care Fraud!

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

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

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

- Do not give 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.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.

- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at (518) 641-3228 and explain the situation.

  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

(877) 499-7295

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise).
  - Your child 26 or over (unless he/she was disabled and incapable of self -support prior to age 26).
- 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.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly by your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

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.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don’t assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- http://www.talkaboutrx.org. 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 health care professionals working to improve patient safety.

Never Events

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. These conditions and errors are called "Never Events". When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct Never Events, if you use CDPHP participating providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

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

  See www.opm.gov/insure/health for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, and give you 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
  - 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. For information on your premium deductions, you must also contact your employing or retirement office.

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

  Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 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 or Self Plus One enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or 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 Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including your marriage, divorce, annulment, or when your child reaches age 26.

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.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage and same sex domestic partners) and children as described in the chart below. A Self Plus One enrollment covers you and one eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/insure .

- **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 Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self Plus One or 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 Plus One or Self and Family coverage, as appropriate, 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 Plus One or Self and Family, as appropriate, 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 Plus One or Self and Family, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the2016 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 2015 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.

If your enrollment continues after you are no longer eligible for coverage, (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance 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.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC).

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either 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 information about your coverage choices. You can also visit OPM's website at http://www.opm.gov/healthcare-insurance /healthcare/plan-information/.

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

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, or if you are a covered dependent child and you turn 26, regardless of marital status, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB coverage.

- **Finding replacement coverage**

This Plan no longer offers its own non-FEHB plan for conversion purposes. If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

In lieu of offering a non-FEHB plan for conversion purposes, we will assist you, as we would assist you in obtaining a plan conversion policy, in obtaining health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace. For assistance in finding coverage, please contact us at 1(855) 236-7113 or visit our website at www.cdphp.com.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit **www.HealthCare.gov**. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

We offer one plan with two different options from which to select. You may enroll in one of our prepaid comprehensive medical plans, either High Option or Standard Option.

General Features of our High and Standard Options

We have Open Access benefits

The High and Standard Options offer Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

The High and Standard Options cover the same services (with the exception of habilitative therapy), participating providers and out-of-pocket costs, but differ in premium rates.

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

Preventive care services

Preventive care services are generally covered with no cost-sharing and are not subject to copayments or annual limits when received from a network provider.

How we pay providers

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

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

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including copayments and/or coinsurance, cannot exceed $5,000 for Self Only enrollment, or $6,500 for Self Plus One or Self and Family coverage. Effective January 2016, Department of Health & Human Services (HHS) guidelines state that no individual shall be responsible for more than $6,850 in covered out-of-pocket expenses per plan year.

Your Rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (www.opm.gov/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- CDPHP Universal Benefits, Inc. (CDPHP UBI) is licensed under Article 43 in New York State.
- CDPHP UBI is an affiliate of Capital District Physicians' Health Plan, Inc. (CDPHP), a health plan that has been in existence for 28 years.
- CDPHP UBI is a not for profit health services corporation.

If you want more information about us, call (518) 641-3140 or (877) 269-2134, or write to CDPHP UBI, 500 Patroon Creek Blvd., Albany, NY 12206. You may also visit our website at www.cdphp.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

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

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

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

Section 2. Changes for 2016

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

Program-wide changes

- **Self Plus One enrollment type has been added effective January 1, 2016.**
- **We have removed the exclusion for services, drugs, or supplies related to sex transformation. See page 6.**

Changes to High Option only

Changes to Standard Option only

Changes to both High Option and Standard Option

- Protection against catastrophic costs (out-of-pocket maximum): You pay nothing after $5,000/Self Only or $6,500/Self and Family enrollment per year for medical and pharmacy combined qualified services. See page 20 for details.
- Acupuncture (10 visits per plan year). See page 36 for details.
- Medication Administered in office (administration and rx)- member pays 20%. See page 36 for details.
- Autism Spectrum Disorder treatment which includes coverage for: Screening and Diagnosis, Applied Behavioral Analysis, PT/ST/OT, Behavioral Health, Assistive Communication Devices, and Prescription coverage associated with a diagnosis of Autism Spectrum Disorder. See page 36 for details.
- CPAP disposable supplies must be preauthorized if cost is over $500 or item is rented. See page 35 for details.
- Gender reassignment surgery and related services, determined to be medically necessary, are covered under the enrollee's medical benefit unless such services are specifically identified as a contract exclusion. Previously these services were not covered. See pages 17, 38, 39, 54 for details.
- Falls Prevention: Exercise and physical therapy counseling in Older Adults in community-dwelling adults age 65 and older who are increased risk for falls. See page 28 for details.
- Falls Prevention: Vitamin D counseling in Older Adults in community-dwelling adults age 65 and older who are increased risk for falls. See page 28 for details.
- Skin cancer behavioral counseling for children, adolescents, and young adults ages 10 to 24 year who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer. See page 27 for details.
- One time screening for abdominal aortic aneurysm by ultrasonography in men ages 65-75 who have ever smoked. See page 27 for details.
- Healthy diet and exercise counseling to prevent cardiovascular disease for adults with cardiovascular risk factors. See page 27 for details.
- Low dose aspirin (81 mg) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia. See page 28 for details.
- Counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections. See page 27 for details.
- Screening for gonorrhea in sexually active women ages 24 years or younger and in older women who are at increased risk for infection. See page 27 for details.
- Screening for chlamydia in sexually active women ages 24 years or younger and in older women who are at increased risk for infection. See page 27 for details.
- Screening for hepatitis B virus infection in non-pregnant adolescents and adults at high risk for infection. See page 27 for details.
- Rates have increased for 2015. See back cover.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (518) 641-3140 or (877) 269-2134 or write to us at 500 Patroon Creek Blvd., Albany, NY 12206. You may also request replacement cards through our website at www.cdphp.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and/or coinsurance, if you use our point-of-service program, you can also get care from non-Plan providers but it will cost you more. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

- **Plan providers**

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

We list Plan providers in the CDPHP UBI provider directory, which we update periodically. The list is also available at Find-A-Doc on our website at www.cdphp.com.

- **Plan facilities**

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

What you must do to get covered care

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

- **Primary care**

You are encouraged to select a personal doctor within the network to coordinate your care, but you are not required to notify us of your selection. Your primary care provider can be an internist, family practitioner, general practitioner, or pediatrician (for children).

- **Specialty care**

  - Participating specialists are listed in our CDPHP UBI directory and in Find-A-Doc at our website at www.cdphp.com.
  - No referral is necessary to visit a participating specialist.
  - If you have a chronic and disabling condition and lose access to your specialist because we:

    - Terminate our contract with your specialist for other than cause;
    - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
    - Reduce our service area and you enroll in another FEHB Plan,

  you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

  If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

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

- **If you are hospitalized when your enrollment begins**

  We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (518) 641-3140 or (877) 269-2134. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

  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;
  - the day your benefits from your former plan run out;
  - 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 cases, the hospitalized family member's benefits under the new Plan begin on the effective date of enrollment.

How to get approval for...

You need prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services*.

- **Inpatient hospital admission**

  Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

  Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for:

  - Transplants
  - Skilled Nursing Facility
  - Inpatient rehabilitation or facility services

How to request precertification for an admission or get prior authorization for Other Services

First, your physician, your hospital, you, or your representative, must call us at (800) 274-2332 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay

- **Non-urgent care claims**

  For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

  If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

  If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

  If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

  We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

  You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at (518) 641-3140 or (877) 269-2134. You may also call OPM's Health Insurance Group II at (202) 606-3818between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at (518) 641-3140 or (877) 269-2134. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

  A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

  If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

  If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital

- **Treament for Gender Reassignment**

  Gender reassignment surgery and related services, determined to be medically necessary, will be covered under the enrollee's medical benefit unless such services are specifically identified as a contract exclusion. Preauthorization and medical review must be obtained in advance in order for gender reassignment services to be covered. A specific list of genital reconstruction procedures the plan will cover include but are not limited to: mastectomy, hysterectomy, salpingo-oophorectomy, colpectomy (removal of the vagina) and metoidioplasty (construction of a penis) include vaginoplasty, penile inversion to create a vagina and clitoris, penectomy, colovaginoplasty (creation of vagina from sigmoid colon), orchiectomy, clitoroplasty, and labiaplasty.

  After a diagnosis of gender dysphoria is made, the therapeutic approach may include one or more of the following: psychotherapy, hormones of the desired gender, real life experience in the desired role, and surgery to change the genitalia and other sex characteristics. Gender reassignment surgery is not a single procedure, but part of a complex process involving multiple medical, psychiatric, and surgical modalities performed in conjunction with each other. The Plan administers benefits for medically necessary gender reassignment surgery when all of the following clinical criteria, adapted from the World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, and supporting provider documentation outlined below are met.

  Medical Necessity Guidelines are as follows:

  Enrollee is diagnosed as having gender dysphoria disorder in accordance with the Diagnostic and Statistical Manual of Mental Disorders, including a diagnosis of true transsexualism as defined by the German Standards for the Treatment and Diagnostic Assessment of Transsexuals and WPATH (formerly known as the Harry Benjamin International Gender Dysphoria Association) as follows: The enrollee has demonstrated the desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone replacement. The transsexual identity has been present consistently for at least two years. The disorder is not due to another psychiatric disorder or a chromosomal abnormality.

  Eligibility criteria for gender reassignment:

  - Enrollee must be 18 years of age or older.
  - Enrollee has the capacity to make a fully informed decision and to consent to treatment.
  - Enrollee has successfully lived full-time in the preferred gender for at least 12 months prior to genital reassignment surgery without periods of returning to their original gender (real-life experience).
  - For genital reassignment surgery, the enrollee has undergone at least 12 months of continuous hormonal therapy recommended by a qualified mental health professional and provided under the supervision of a physician with endocrinological experience (which can be simultaneous with the real-life experience), unless medically contraindicated.
  - Hormone therapy is not required when performing a mastectomy in female to male members or for breast augmentation in male to female members. However, it is recommended that male to female members undergo feminizing hormone therapy (minimum of 12 months) prior to breast augmentation surgery in order to maximize breast growth to obtain better surgical outcomes.

- A mental health screening and/or assessment by a qualified mental health provider is required for referral to hormonal and surgical treatments for gender dysphoria (refer to documentation requirements below). Although highly recommended, psychotherapy is not an absolute requirement unless a mental health professional's initial assessment leads to a recommendation for psychotherapy that specifies the goals of the treatment, estimates its frequency and duration (usually a minimum of three months).
- If significant medical or mental health concerns are present, there must be documentation prior to surgery that such conditions are reasonably well controlled.
- Once medically necessary criteria have been met, and gender reassignment surgery is approved, the enrollee must undergo a complete physical examination by the physician performing the surgery.

Documentation must be submitted by a qualified mental health provider, whose minimal credentials is that of a master's degree in a clinical behavioral science field, to include all of the following:

- The member's general identifying characteristics.
- The initial and evolving gender, sexual, and other psychiatric diagnoses.
- The duration of their professional relationship including the type of psychotherapy or evaluation that the member has undergone.
- The eligibility and readiness criteria for hormone therapy/sex reassignment surgery have been met and the clinician's rationale for supporting the member's request for these services.
- A statement about the fact that informed consent has been obtained from the member.
- A statement that the referring health professional is available for coordination of care for the member.
- Prior to initiation of hormone therapy or breast surgery (e.g., mastectomy, chest reconstruction, augmentation mammoplasty), one letter of recommendation, in the form of a written comprehensive evaluation, is required by a qualified mental health professional acquainted with the member.

Prior to genital reassignment surgery (e.g., hysterectomy, ovariectomy, orchiectomy, metoidioplasty, phalloplasty, vaginoplasty), the following is required:

- Two letters of recommendation, in the form of a written comprehensive evaluation, are required from qualified mental health professionals who have independently assessed the member.
- Documentation of a urological examination for the purpose of identifying and perhaps treating abnormalities of the genitourinary tract, since genital surgical sex reassignment includes the invasion of, and the alteration of, the genitourinary tract.
- The physician completing the physical exam must indicate in writing there are no medical contraindications to surgical gender reassignment.

Note: Refer to Section 5(b) for a list of gender reassignment surgical exclusions.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

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

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

Within the exception of emergency care, you obtain prior authorization for providers and facilities that do not participate with us if you enroll in the High or Standard Option. The number to call is (800) 274-2332.

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

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.

3. Write to you and maintain our denial

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care:

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g. coinsurance and copayments) for the covered care you receive.
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: For the High Option when you see your primary care physician, you pay a copayment of $20 per office visit, and when you go in the hospital, you pay $100 per day, up to a maximum of $500 per confinement.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Example: In our High Option Plan, you pay 20 percent of our allowance for durable medical equipment.
Deductible	This plan does not have a deductible.
Differences between our Plan allowance and the bill	Network Providers agree to accept our Plan allowance so if you use a network provider, you never have to worry about paying the difference between our Plan allowance and the billed amount for covered services. Non-Network Providers: If you use a non-network provider, you will have to pay the difference between our Plan allowance and the billed amount.
Out of Pocket Maximum	The total amount of applicable copayments and/or coinsurance that you must satifsy, before which the Plan will pay one hundred percent (100%) of the Allowed amount for covered benefits. All amounts you pay for copayments and/or coinsurances are applicable toward the out of pocket maximum. The member is also responsible for all differences, if any, between the allowed amount and the non-participating provider's charge, regardless of whether the out of pocket maximum has been met.
Your catastrophic protection out-of-pocket maximum	After your (copayments and coinsurance) total $5,000 for Self Only or $5,000 per person for Self Pluis One, or $6,500 per Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out of pocket maximum, and you must continue to pay copayments for these services: • Non-covered services • Amounts that exceed our allowable charge for a covered service • Precertification penalties
Carryover	If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1. Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

High and Standard Option Benefits

See page 13 for how our benefits changed this year. Pages 82 through 85 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. High and Standard Option Benefits Overview

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

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High and Standard Option benefits, contact us at (877) 269-2134 or on our website at www.cdphp.com.

Each option offers unique features.

High Option

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

- **Standard Option**
- Same providers as High Option, but higher out-of-pocket costs.
- No referrals for in-network specialty care.
- Primary care physician recommended but not required.
- Many preventive services at no charge.
- Same benefits as High Option, except for Habilitative physical and occupational therapy is not covered.
- Moderate premium costs.

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay	
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians • In a physician's office	$20 per visit for primary care $30 per visit for specialist	$25 per visit for primary care $40 per visit for specialist
Professional services of physicians • In an urgent care center	$40 per visit	$50 per visit
• During a hospital stay • In a skilled nursing facility	Nothing	10% of the Plan allowance
• Office medical consultations • Second surgical opinion/inpatient consultation	$20 per office visit $30 per visit for specialist	$25 per visit for primary care $40 per visit for specialist 10% of the Plan allowance for inpatient services
At home	$20 per visit	$25 per visit for primary care
Not covered: • *Surgery primarily for cosmetic purposes* • *Homemaker services*	*All charges*	*All charges*
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasounds	Nothing if you receive these services at a preferred facility; otherwise, $30 per office visit	Nothing if you receive these services at a preferred facility; otherwise, $40 per office visit 10% of the Plan allowance for inpatient services
Electrocardiogram and EEG	$30 per provider visit	$40 per provider visit

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay	
Lab, X-ray and other diagnostic tests (cont.)	**High Option**	**Standard Option**
		10% of the Plan allowance for inpatient services
Lung Cancer Screening – Note: Annual low dose computed tomography in adults ages 55 to 80 years who have a 30 pack per year smoking history and currently smoke or have quit within the past 15 years	Nothing	Nothing
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24 – 28 weeks gestation or first prenatal visit for women at a high risk • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery. • 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 in 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 for non-maternity care the same as for illness and injury.	$20 office visit for the initial diagnosis. You pay nothing thereafter for prenatal care or the first postpartum care visit; $20 per office visit for all postpartum care visits thereafter.	$25 office visit for the initial diagnosis. You pay nothing thereafter for prenatal care or the first postpartum care visit; $25 per office visit for all postpartum care visits thereafter. 10% of the Plan allowance for inpatient services.
• Breastfeeding support, supplies and counseling for each birth	Nothing	Nothing
Preventive care, adult	**High Option**	**Standard Option**
Routine screenings, such as but not limited to: • Total Blood Cholesterol—Once every five years • Colorectal Cancer Screening, including - Fecal occult blood test – every five years starting at age 50 - Sigmoidoscopy, screening – every five years starting at age 50 - Colonoscopy—once every ten years starting at age 50.	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
One routine annual physical exam (non-gynecological) per calendar year Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ And at HHS at https://healthcare.gov/preventive-care-benefits/	Nothing	Nothing
• Routine Prostate Specific Antigen (PSA) test - one annually for men age 40 and older • Hepatitis C virus infection screening in adults at high risk for infection and a one-time screening for adults born between 1945 and 1965. • HIV screening for adults to 65 years and older adults who are at increased risk.	Nothing	Nothing
• BRCA Risk Assessment - Screening of women with a family history of breast, ovarian, tubal, or peritoneal cancer with an increased risk of harmful mutations in breast susceptibility genes. Women with positive screening, results receive genetic counseling and if indicated, BRCA testing. • Screening for hepatitis B virus infection in non-pregnant adolescents and adults at high risk for infection. • Healthy diet and exercise counseling to prevent cardiovascular disease for adults with cardiovascular risk factors. • Skin cancer behavioral counseling for children, adolescents, and young adults ages 10 to 24 year who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer. • One time screening for abdominal aortic aneurysm by ultrasonography in men ages 65-75 who have ever smoked. • Counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections • Screening for gonorrhea in sexually active women ages 24 years or younger and in older women who are at increased risk for infection. • Screening for chlamydia in sexually active women ages 24 years or younger and in older women who are at increased risk for infection.	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
• Falls Prevention: Exercise and physical therapy counseling in Older Adults in community-dwelling adults age 65 and older who are increased risk for falls. • Falls Prevention- Vitamin D counseling in Older Adults in community-dwelling adults age 65 and older who are increased risk for falls. • Low dose aspirin (81 mg) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.		
Well woman care - ; including, but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	Nothing	Nothing
Routine mammogram - covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 49, one every one to two calendar years • From age 50 to 70, annually • Over age 71, as indicated	Nothing	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): • 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 older	Nothing	Nothing
Not covered: • Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	All charges	All charges

Benefit Description	You pay	
Preventive care, children	**High Option**	**Standard Option**
• Well-child care charges for routine examinations, immunizations and care (up to age 22). Visits covered at 2 weeks, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, and 30 months, then annually to age 22. • Childhood immunizations recommended by the American Academy of Pediatrics. • HIV screening for adolescents 15 years and older, and younger than 15 years when at an increased risk.	Nothing	Nothing
Examinations (other than well-child care), such as: • Eye exams through age 17 to determine the need for vision correction. Limited to one every 24 months. • Ear exams through age 17 to determine the need for hearing correction. • Examinations done on the day of immunizations (up to age 22). Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ And at HHS at https://healthcare.gov/preventive-care-benefits/	Nothing	Nothing
Family planning	**High Option**	**Standard Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Visits to insert or implant covered contraceptive devices • Genetic counseling when approved Contraceptive counseling on an annual basis	Nothing for females Nothing for females $20 per office visit $30 per visit for specialist Nothing	Nothing for females Nothing for females 10% of the Plan allowance for inpatient services Nothing
Note: We cover oral contraceptives under the prescription drug benefit. Please refer to Section 5(f).		
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*	*All charges*

Benefit Description	You pay	
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Fertility drugs Note: We cover fertility drugs under the prescription drug benefit for up to six cycles per pregnancy. See Section 5(f). Members must be at least 21 years of age but no more than 44 years old to be covered for infertility services.	$30 per office visit Nothing for inpatient services	$40 per visit for specialist 10% of the Plan allowance for inpatient services
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Leuprolide Acetate when used for cessation of ovulation* • *Items such as ovulation predictor kits and home pregnancy kits* • *IVIG when utilized for infertility or pregnancy loss*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment	$20 per office visit $30 per visit for specialist	$25 per visit for primary care $40 per visit for specialist 10% of the Plan allowance for inpatient services
• Allergy injections • Allergy serum	20% of the Plan allowance	20% of the Plan allowance
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*

Benefit Description	You pay	
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 40. • Respiratory and inhalation therapy	$20 per office visit for chemotherapy and radiation therapy	$25 per office visit for chemotherapy and radiation therapy 10% of the Plan allowance for inpatient services
Dialysis – hemodialysis and peritoneal dialysis	$20 per office visit if received as an outpatient. Covered in full if part of home care.	$25 per office visit if received as an outpatient. Covered in full if part of home care.
Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	$30 per office visit if received as an outpatient. Covered in full if part of home care.	$40 per office visit if received as an outpatient. Covered in full if part of home care.
Home dialysis – equipment and supplies	$30 per month	$40 per month
• Growth hormone therapy (GHT) Note: Growth hormone is covered under the Prescription Drug Benefit. Note: - We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services which are determined to be medically necessary based off of the criteria established in our Growth Hormone policy from the date you submit the information. 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. *Please refer to Section 5(f) for coverage for prescription drugs. See Services requiring prior approval in Section 3.*	$30 per office visit	$40 per office visit
Physical and occupational therapies	**High Option**	**Standard Option**
Physical and occupational therapy are limited to up to 2 months for each specific diagnosis and related conditions per calendar year: • Qualified Physical Therapists • Occupational Therapists Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. • Medically necessary cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction. • Habilitative physical and occupational therapy are limited up to 2 months for each specific diagnosis and related condition per calendar year (High Option Plan only).	$30 per office visit $30 per outpatient visit Nothing per visit during covered inpatient admission	$40 per office visit $40 per outpatient visit 10% of the Plan allowance for inpatient services Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.

Physical and occupational therapies - continued on next page

Benefit Description	You pay	
Physical and occupational therapies (cont.)	**High Option**	**Standard Option**
Note: These services require prior approval. See Section 3.		
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Continuous ECG monitoring and Thallium stress tests* • *Services for chronic or maintenance phase of cardiac rehabilitation*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
Speech therapy is limited to up to 2 months for each specific diagnosis and related conditions per calendar year. Note: Please refer to Section 3 for services requiring prior approval.	$30 per office visit $30 per outpatient visit Nothing per visit during covered inpatient admission	$40 per office visit $40 per outpatient visit 10% of the Plan allowance for inpatient services
Not covered: • *Care beyond treatment period.*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Hearing examinations and testing for treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D. O., or audiologist. Note; For routine hearing screening performed during a child's preventative care visit, see Section 5 (a) *Preventive care, children.* • External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section5(a) *Orthopedic and prosthetic devices.* *Not covered:* • *Hearing services that are not shown as covered*	$30 per office visit Up to a $600 limit for routine hearing aids or repair to an existing one every three years	$40 per office visit Up to a $600 limit for routine hearing aids or repair to an existing one every three years
Not covered: • *Hearing services that are not shown as covered*	*All charges*	*All charges*

Benefit Description	You pay	
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Eye glasses or contact lenses necessitated by certain medical conditions such as aphakia, keratoconus, or endocrine exophthalmos or following intraocular surgery. Replacement reviewed based on medical necessity.	20% of the Plan allowance	50% of the Plan allowance
• Routine eye exam and eye refractions once every 24 months • Eye exercises and orthoptics when approved	$30 per office visit	$40 per office visit
Not covered:•Eye glasses or contact lenses•Radial keratotomy and other refractive surgery	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	$20 for primary care office visit $30 per visit for specialist	$25 for primary care office visit $40 per visit for specialist
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• Artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy	20% of the Plan allowance. Must be preauthorized if cost is over $500	50% of the Plan allowance. Must be preauthorized if cost is over $500
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants	$30 per office visit Up to a $600 limit for routine hearing aids or repair to an existing one every three years.	$40 per office visit Up to a $600 limit for routine hearing aids or repair to an existing one every three years.
• Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical and anesthesia services. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) services provided by a hospital or other facility, and ambulance services.	Nothing	Nothing

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Approved lumbosacral supports	20% of the Plan allowance. Must be preauthorized if cost is over $500	50% of the Plan allowance. Must be preauthorized if cost is over $500
Hair prosthesis. CDPHP provides benefits for the purchase of one medically necessary cranial prosthesis, wig, or toupee per lifetime per member for replacement of hair loss as a result of injury, disease, or treatment of a disease. Coverage is limited to a maximum amount of $400 per prosthesis, wig or toupee. This limitation is applied to the balance remaining after the member's payment of the coinsurance.	20% of the Plan allowance	50% of the Plan allowance
Not covered: • *Stump Hose* • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* *Prosthetic replacements provided less than 3 years after the last one we covered unless medically indicated*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers	20% of the Plan allowance. Must be preauthorized if cost is over $500 or item is rented	50% of the Plan allowance. Must be preauthorized if cost is over $500 or item is rented
• Blood glucose monitors and test strips (see Note below) • Insulin pumps	$20 per item	$25 per item

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
Note: Blood glucose monitors and test strips are covered only when obtained from CDPHP's **designated manufacturer of diabetic equipment or supplies**. If you require a different glucose monitor or test strip that is not available from CDPHP's designated diabetic equipment or supply manufacturer, you or your physician must submit a request for a medical exception by calling our Member Services department at (518) 641-3140 or (877) 269-2134. CDPHP's Medical Director will review the need for an exception and make the determination.	$20 per item	$25 per item
Your Plan physician will call us for authorization of this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment. Note: See "Services requiring our prior approval" in Section 3.		
CPAP disposable supplies will be covered at the DME coverage level.	20% of plan allowance	50% of plan allowance
Not covered: Motorized wheelchairs or motorized scooters	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
• Home health care ordered by a Plan physician, approved by the Plan's medical director, and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. Some services include: home infusion therapy, medical supplies, drugs and medications. Please refer to Section 3, "Services requiring our prior approval."	Nothing	Nothing
• Oxygen therapy	20% of the Plan allowance	50% of the Plan allowance
Not covered • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.* • *rest cures*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**
• Medically necessary care for spinal manipulation	$30 per office visit	$40 per office visit

Benefit Description	You pay	
Alternative treatments	**High Option**	**Standard Option**
Acupuncture (10 visits per plan year)	$30 per office visit	$40 per office visit
Educational classes and programs	**High Option**	**Standard Option**
CDPHP offers a variety of innovative wellness classes and disease management programs. Programs and classes are also available to address childhood obesity. Please refer to Section 5, Non-FEHB Benefits Available to Members, page 62.	Nothing	Nothing
• Tobacco cessation programs, including individual/group/telephone counseling, and for physician prescribed over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for counseling for up to two quit attempts per year. Nothing for physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for counseling for up to two quit attempts per year. Nothing for physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence.
• Tobacco use interventions for children and adolescents, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.	Nothing	Nothing
• Childhood obesity education	Nothing	Nothing
Medications Administered in the Office	**High Option**	**Standard Option**
Medications administered in the office (Administration and Rx); this includes allergy injections	20% of Plan allowance	20% of Plan allowance
Treatment and Services Associated with Autism Spectrum Disorder	**High Option**	**Standard Option**
• Screening and Diagnosis of Austism Spectrum Disorder	$30 per office visit	$40 per office visit
• Applied Behavioral Analysis associated with Autism Spectrum Disorder	$30 per office visit	$40 per office visit
• Speech Therapy, Physical Therapy, and Occupational Therapy associated with Autism Spectrum Disorder	$30 per office visit	$40 per office visit
• Assistive Communication Devices associated with Autism Spectrum Disorder	$20 copay per device	$25 copay per device
Note: Please see page 54 for Behavioral Health Services associated with Autism Spectrum Disorder and page 56 for Prescription Drug Coverage associated with Autism Spectrum Disorder. A calendar year limit of 680 hours per person applies.		

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care. You pay all charges for non-participating providers.
- 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 Medicare and other coverage.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOU MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay	
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery)* • Surgical treatment (bariatric surgery) of morbid obesity, a condition in which you weigh 100 pounds or 100% over your normal weight according to current underwriting standards; there is documented failure of a non-surgical attempt; and your body mass index is 40 or higher (or 35 or higher and you have severe co-morbidities). Note: This procedure requires preauthorization. Please call the Plan at (877) 269-2134 for further information. • Insertion of internal prosthetic devices. See 5(a), *Orthopedic and prosthetic devices* for device coverage information. Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy)	$20 per primary care office visit $30 per visit for specialist care Nothing at outpatient or inpatient facility	$25 per primary care office visit $40 per visit for specialist care Nothing at outpatient facility 10% of the Plan allowance for inpatient services

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• Surgically implanted contraceptive and intrauterine devices (IUDs). Note: Devices are covered under 5 (f) Prescription drug coverage. • Treatment of burns • Gender reassignment surgery and related services, determined to be medically necessary, are covered under the enrollee's medical benefit unless such services are specifically identified as a contract exclusion. Once medically necessary criteria have been met, and gender reassignment surgery is approved, the enrollee must undergo a complete physical examination by the physician performing the surgery. Note: Transgender reassignment surgery and related services require precertification. Please call the Plan at (877) 269-2134 for further information. (see Section 3. How you get care)	$20 per primary care office visit $30 per visit for specialist care Nothing at outpatient or inpatient facility	$25 per primary care office visit $40 per visit for specialist care Nothing at outpatient facility 10% of the Plan allowance for inpatient services
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care* • *The following services related to gender reassignment surgery are considered comestic in nature and are not covered: Breast augmentation other than when performed as part of the initial gender reassignment surgery; Blepharoplasty; Collagen injections; Rhinoplasty; Lip reduction/ enhancement; Face or forhead lift; Chin implant; Nose implant; Trachea shave/reduction thyroid chondroplasty; Laryngoplasty or shortening of the vocal cords; Liposuction; Electrolysis; Jaw shortening; Facial bone reduction; Hair removal or transplantation.*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
Not covered • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*All charges*	*All charges*
• Surgery to correct a functional defect • Surgery to correct a condition caused by illness or injury if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
• 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; and webbed fingers and toes. • Gender reassignment surgery (see Section 3. How you get care) • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Dental work related to TMJ*	*All charges*	*All charges*

Benefit Description	You pay	
Organ/tissue transplants	**High Option**	**Standard Option**
Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to *Other services* in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description • Cornea • Heart • Lung: single/bilateral/lobar • Kidney • Liver • Pancreas • Intestinal transplants • Isolated small intestine • Small intestine with the liver • Small intestine with multiple organs, such as the liver, stomach and pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Allogeneic transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Advanced neuroblastoma • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Severe combined immunodeficiency	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Severe or very severe aplastic anemia • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies • Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) • Sickle cell anemia • X-linked lymphoproliferative syndrome Autologous transplant for • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Advanced neuroblastoma • Ependymoblastoma • Ewing's sarcoma • Medulloblastoma • Pineoblastoma Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) Allogeneic blood or marrow stem cell transplants for • Advanced forms of myelodysplastic syndromes • Advanced neuroblastoma • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies • Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) • Myeloproliferative disorders • Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome • Sickle cell anemia	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Thalassemia major (homozygous beta-thalassemia) • X-linked lymphoproliferative syndrome	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services
Autologous blood or marrow stem cell transplants for • Multiple myeloma • Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors • Breast cancer • Epithelial ovarian cancer • Amyloidosis • Ewing's sarcoma • Medulloblastoma Allogeneic transplants for • Chronic lymphocytic leukemia • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma Nonmyeloablative allogeneic transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced forms of myelodysplastic syndromes • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Colon cancer • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Chronic lymphocytic leukema/small lymphocytic lymphoma • Multiple myeloma • Multiple sclerosis • Myeloproliferative disorders • Non-small cell lung cancer • Ovarian cancer • Prostate cancer • Renal cell carcinoma • Sarcomas • Sickle Cell Disease	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Autologous transplants for • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Early state (indolent or non-advanced) small cell lymphocytic lymphoma	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) • Myeloproliferative disorder (MDDs) • Paroxysmal Nocturnal Hemoglobinuria • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Autologous transplants for • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Neuroblastoma	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services
Allogeneic transplants for • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Beta Thalassemia Major • Chronic inflammatory demyelination polyneuropathy (CIDP) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma • Multiple sclerosis • Sickle Cell anemia Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Breast cancer • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Colon cancer • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma • Multiple sclerosis • Myeloproliferative disorders (MDDs) • Myelodysplasia/Myelodysplastic Syndrome	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Non-small cell lung cancer • Ovarian cancer • Prostate cancer • Renal cell carcinoma • Sarcomas • Sickle cell anemia	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services
Autologous Transplants for • Advanced Childhood kidney cancers • Advanced Ewing sarcoma • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Aggressive non-Hodgkin's lymphoma • Breast Cancer • Childhood rhabdomyosarcoma • Chronic myelogenous leukemia • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Epithelial Ovarian Cancer • Mantle Cell (Non-Hodgkin lymphoma) • Multiple sclerosis • Small cell lung cancer • Systemic lupus erythematosus • Systemic sclerosis	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
National Transplant Program (NTP) – CDPHP UBI facilitates organ transplants at a CDPHP UBI approved transplant center. Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor screening tests and donor search expense for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members. **Note: Please see Section 3 for "Services requiring our prior approval."**	$30 per office visit; nothing at outpatient or inpatient facility	$40 per office visit; 10% of the Plan allowance for inpatient services
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*

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

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

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

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

SOME SERVICES REQUIRE PRECERTIFICATION. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay	
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as • ward, semiprivate, or intensive care accommodations • general nursing care • 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.	$100 copay per day up to a maximum of $500 per admission. For individual coverage, inpatient copays are limited to two per calendar year. For family coverage, inpatient copays are limited to three per calendar year. The copayment does not apply to hospital inpatient charges for newborn nursery care.	$500 per admission plus 10% of the Plan allowance. For individual coverage, inpatient copays are limited to two per calendar year. For family coverage, inpatient copays are limited to three per calendar year. The copayment does not apply to hospital inpatient charges for newborn nursery care.
Other hospital services and supplies, such as: • operating, recovery, maternity, and other treatment rooms • prescribed drugs and medicines • diagnostic laboratory tests and X-rays • administration of blood and blood products • blood or blood plasma, if not donated or replaced • dressings, splints, casts, and sterile tray services • medical supplies and equipment, including oxygen • anesthetics, including nurse anesthetist services • take-home items • medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing	10% of the Plan allowance
Not covered: • *Custodial care*	*All charges*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care except when medically necessary in the hospital when ordered and approved by a CDPHP UBI participating physician*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• 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 biologics • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$75 per visit	$100 per visit
Services not associated with a medical procedure being done on the same day: Outpatient hospital diagnostic x-ray and laboratory tests.	Nothing if you receive these services at a preferred facility; otherwise, $30 per visit	Nothing if you receive these services at a preferred facility; otherwise, $40 per visit
Not covered: Blood and blood derivatives not replaced by the member. Storage of blood and blood derivatives, except in the case of autologous blood donations required for a scheduled surgical procedure.	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
Skilled nursing facility (SNF): up to 90 days in lieu of hospitalization.	Nothing	10% of the Plan allowance
Not covered: Custodial care	*All charges*	*All charges*

Benefit Description	You pay	
Hospice care	**High Option**	**Standard Option**
Up to 210 days combined inpatient and outpatient	Nothing	Nothing
Not covered: Independent nursing, homemaker services	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Local professional ambulance service when medically appropriate. Air ambulance if medically appropriate and approved.	$50 per trip	$100 per trip
Not covered: Transportation for convenience.	*All charges*	*All charges*

Section 5(d). Emergency services/accidents

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

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

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

Emergencies outside our service area: If you have an emergency outside of CDPHP UBI's service area, simply go to the nearest hospital emergency room. If you are required to pay for services at the time of treatment, please request an itemized bill. Send the bill along with your name and member ID number to CDPHP's Member Services Department, 500 Patroon Creek Blvd., Albany, NY 12206.

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

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

Benefit Description	You pay	
Emergency within our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office	$20 per primary care visit $30 per visit for specialist	$25 per visit primary care $40 per visit for specialist
• Emergency care at an urgent care center	$40 per visit	$50 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: If the emergency results in admission to a hospital, the emergency room copay is waived. Please refer to Section 5c for inpatient hospital coverage.	$50 per visit	$100 per visit
Not covered: Elective care or non-emergency care	*All charges*	*All charges*

Benefit Description	You pay	
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office	$20 per visit primary care $30 per visit for specialist	$25 per visit primary care $40 per visit for specialist
• Emergency care at an urgent care center	$40 per visit	$50 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: If the emergency results in admission to a hospital, the emergency room copay is waived. Please refer to Section 5c for inpatient hospital coverage.	$50 per visit	$100 per visit
Ambulance	**High Option**	**Standard Option**
• Local professional ambulance service when medically appropriate • Air ambulance if medically appropriate and approved. Note: See 5(c) for non-emergency service.	$50 per trip	$100 per trip
Not covered: Transportation for convenience.	*All charges*	*All charges*

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

Important things to keep in mind about these benefits:

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

Benefit Description	You pay	
Professional services	**High Option**	**Standard Option**
All diagnostic and treatment serivces recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers. • Medication management	$20 per visit	$25 per visit
Diagnostic tests	**High Option**	**Standard Option**
Diagnostic tests	$20 per visit or test	$25 per visit or test
Services provided by a hospital or other facility	**High Option**	**Standard Option**
-Mental health -Chemical abuse Services in approved alternative care settings such as partial hospitalization, halfway house and residential treatment, full-day hospitalization, facility based intensive outpatient treatment.	$20 per outpatient visit $20 per outpatient visit $100 copay per day up to a maximum of $500 per admission. For individual coverage inpatient copays are limited to two per calendar year. For family coverage, inpatient copays are limited to three per calendar year.	$25 per outpatient visit $25 per outpatient visit $500 per admission plus 10% of the Plan allowance. For individual coverage inpatient copays are limited to two per calendar year. For family coverage, inpatient copays are limited to three per calendar year.

Benefit Description	You pay	
Screening and Counseling	**High Option**	**Standard Option**
Alcohol misuse screening and counseling in adults age 18 years or older.	Nothing	Nothing
Behavioral health services associated with autism spectrum disorder (Note: A calendar year limit of 680 hours per person applies). Mental health services associated with gender reassignment surgery. Note: Mental health services related to gender reassignment surgery would be the same as for any mental health condition. (see Section 3. How you get care)	$20 per office visit	$25 per office visit
Not covered	**High Option**	**Standard Option**
• Services we have not approved for ongoing treatment. Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.	*All charges*	*All charges*

Preauthorization	To be eligible for ongoing services, you will need to obtain a treatment plan. Mental Health Care--You have direct access to in-network mental health care. A direct access toll-free telephone number to the CDPHP Behavioral Health Unit at (888) 320-9584 TDD (877) 261-1164, will connect you to a qualified mental health clinician who will assist and arrange for treatment. For your convenience, the telephone number for mental health services is imprinted on your CDPHP UBI ID card. Alcohol/Substance Abuse Benefits--You have direct access to in-network alcohol and substance abuse care. A direct access toll-free telephone number to the CDPHP Behavioral Health Unit at (888) 320-9584 TDD (877) 261-1164, will connect you to a qualified mental health clinician who will assist and arrange for treatment. For your convenience, the telephone number for mental health services is imprinted on your CDPHP UBI ID card. These benefits are coordinated the CDPHP Behavioral Health Unit. CDPHP UBI members can contact CDPHP directly at (888) 320-9584 TDD (877) 261-1164.
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f). Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/autorizations must be renewed periodically.
- Certain drugs require our prior approval. Please refer to the prescription drug formulary available on our website at www.cdphp.com.
- Federal Law prevents the pharmacy from accepting unused medications.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription?** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication. Prescription drugs listed on CDPHP's specialty pharmacy list must be obtained at CDPHP UBI's participating specialty pharmacy vendor(s) for up to a 30-day supply, upon approval from CDPHP UBI. Please refer to Section 3, Services requiring our approval. Approved maintenance prescriptions can be refilled through the mail for a 90-day supply.
- **We use a formulary.** A formulary is a list of prescription drugs covered by CDPHP UBI based on their efficacy and cost in providing effective patient care. We have an open formulary and cover non-formulary drugs. Prior authorization or a medical exception request may be required.
- **We use step therapy for certain prescription medications.** The Step Therapy program is a form of prior authorization whereby certain drugs are not covered unless you have tried one or more "prerequisite therapy" medication(s) first. If we determine that it is medically necessary for you to use a step-therapy medication as initial therapy, your Plan physician can request a medical exception or you can initiate the process online at cdphp.com. The step therapy process must be followed and the request approved before filling the prescription. Once all necessary information is obtained from your physician, a determination will be made within 3 business days. Once a decision has been made, you will be contacted by your physician and you will receive a determination letter from CDPHP.
- **These are the dispensing limitations.** Prescriptions filled at a participating pharmacy are limited to a 30-day supply. Maintenance prescriptions are filled up to a 90-day supply by mail order. Only certain maintenance prescriptions are available via mail order to insure quality, proper dosage, and medical appropriateness. Prescription refills received prior to the next scheduled refill date will not be filled. Plan members called to active duty (or members in time of national emergency) who need to obtain prescribed medications should call our Member Services Department at (877) 269-2134.
- **Why use generic drugs?** Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your plan less money than brand name drugs.
- **When you do have to file a claim.** You do not have to submit claims.

Benefit Description	You pay	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Self-administered injectable drugs • Drugs for sexual dysfunction within applicable limits. Please call the Plan for information. • Nutritional supplements for the therapeutic treatment of phenylketonuria (PKU). • Infertility prescriptions available for members between 21 and 44 years of age, up to six cycles per pregnancy attempt. • Prescription drugs for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low protein or which contain modified protein which are medically necessary for up to 12 months. Benefit limit of $2,500. • Prescription Drugs for the treatment of Autism Spectrum Disorder. • Hormone Therapy (see Section 3. How you get care) Please note: Some hormone therapies require prior authorization. Prior authorization must be obtained from the CDPHP pharmacy department. The prior authorization request must include a treatment plan for the use of the requested hormonal medication.	25% of the Plan allowance with a $400 per prescription maximum, up to a 30-day supply. Member pharmacy cost share will apply toward the annual out-of-pocket maximum.	30% of the Plan allowance with a $400 per prescription maximum, up to a 30-day supply. Member pharmacy cost share will apply toward the annual out-of-pocket maximum.
• Women's contraceptive drugs and devices • Breast Cancer Preventive Medication- Note: For women who are at an increased risk for breast cancer and at a low risk for adverse medication effects. Note: Over-the-counter contraceptives drugs and devices approved by the FDA require a written prescription by an approved provider.	Nothing	Nothing
Tobacco cessation prescriptions Note: Physician prescribed over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the smoking cessation benefit. (See page 34.)	Nothing	Nothing
Insulin, oral agents to control blood sugar, needles, test strips (see Note below), lancets, and visual reading and urine test strips	$20 per item	$25 per item

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
Note: Blood glucose monitors and test strips are covered only when obtained from CDPHP's **designated manufacturer of diabetic equipment or supplies**. If you require a different glucose monitor or test strip that is not available from CDPHP's designated diabetic equipment or supply manufacturer, you or your physician must submit a request for a medical exception by calling our Member Services department at (518) 641-3140 or (877) 269-2134. CDPHP's Medical Director will review the need for an exception and make the determination.	$20 per item	$25 per item
Durable medical equipment for insulin dependent persons	$20 per item	$25 per item
Non-insulin disposable needles and syringes for the administration of covered medication	20% of the Plan allowance	50% of the Plan allowance
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients, and food supplements that can be purchased without a prescription* • *Nonprescription medicines except for any over-the-counter products listed on our formulary and as stated above* • *Weight loss prescriptions* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies*	*All charges*	*All charges*

Section 5(g). Dental benefits

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.

Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
Accidental injury benefit	**High Option**	**Standard Option**
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.	$30 per visit	$40 per visit
Dental benefits Prevention of dental caries in children from birth through age 5 years: Primary Care clinicians can apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. Prevention of dental caries in children from birth through age 5 years: Primary Care clinicians can prescribe oral fluoride supplementation starting at 6 months for children whose water supply is deficient in fluoride.	*Nothing*	*Nothing*

Section 5(h). Special features

Feature	Description
On-line tools	Easy-to-use Internet-based tools to help you manage your own health and make smarter decisions that may reduce health care costs. These programs are available to members through www.cdphp.com. **Secure Member Site** Access the secure portal through www.cdphp.com to view your claim history, specific plan benefits, copayments, coinsurance, and more**.** **My HealthSource** The CDPHP secure portal now includes a useful online module that provides you a central location to record your personal health information. For members with complex conditions requiring case management, it provides a means of interacting securely with CDPHP care managers. **Visit Us On Social Media** • **Keep up with CDPHP via** Facebook**,** Twitter**, or** LinkedIn**!** • **CDPHP® InMotion℠** is your personal training log and friend. It's a mobile app that helps you track runs, log gym workouts, and set nutrition goals. It also enables you to analyze your results and share them via social media. • **CaféWell** is a social media site that offers fitness challenges, fun, and interactive support. This free virtual community connects you with others to compare notes on staying healthy. It also offers a health encyclopedia and other wellness tools. **Finding A Doctor Has Never Been Easier** • **Find-A-Doc -** Online search tool that offers details on CDPHP's network physicians including name, specialty, location, and doctors that are certified by the Bridges to Excellence Program. The enhanced site provides Google maps and ZIP code radius searches to help you locate CDPHP participating physicians in your area. • **My CDPHP Mobile App -** Be sure to download My CDPHP Mobile to your smartphone. It's convenient, free, and easy to use! Now, in addition to showing provider network listings, it allows you to log in securely to access personal benefit details and view, email, or fax your member ID card. **Rx Corner -** A secure tool that provides Rx history specific to the member along with pricing, generic substitution and formulary information **Healthy Babies -** CDPHP partners with the National Healthy Babies Coalition to offer **text4baby**. This is a free text messaging service. Text4baby sends timely tips on topics such as nutrition and immunizations to women from the first trimester of pregnancy through the newborn's first year. Members may sign up for the service by texting BABY to 511411 (or BEBE for Spanish).
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits are subject to our ongoing review.

- By approving an alternative benefit, we do not guarantee you will continue to receive it.
- The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits.
- If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request.
- Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).

Non-emergency care for full-time students out of the area

If you are away at school and need medical care (non-preventive) for an illness or injury, coverage is available. When a medical situation develops, call (800) 274-2332 prior to seeking care and request that CDPHP UBI authorize coverage of necessary treatment by a practitioner in the area.

Services for deaf and hearing impaired

The telephone system also includes a TDD system. Members may call (877) 261-1164 for services.

Childbirth Education Reimbursement Program

CDPHP UBI will reimburse expectant mothers 50 percent of the cost, up to $30 per year, for participating in and completing childbirth education classes. Once you complete the class, send the receipt and certificate of completion along with your name and member ID to CDPHP UBI, 500 Patroon Creek Blvd, Albany, NY 12206, for reimbursement.

Centers of Excellence

CDPHP facilitates care at approved transplant centers for medically necessary, non-experimental treatment.

Section 5(i). Health education resources and account management tools

Special features	Description
Health Education Resources	**Personalized Online Help** Send a secure message to a health professional; receive an answer confidentially within 24 hours. For members that would like to make lifestyle changes to improve their health, CDPHP can help with personalized, web-based support. Through our innovative Health Coach Connection Dialog Center, we can bring you these free online wellness programs: • Healthy Conversation on Quitting Smoking for Good • Healthy Conversation on Healthy Eating • Healthy Conversation on Healthy Weight • Healthy Conversation on Healthy Thinking • Healthy Conversation on Sleeping Well • Healthy Conversation on Dealing with Low Back Pain • Healthy Conversation on Getting Active Each program begins with a 15-20 minute survey. Based on your answers, a personalized wellness plan will be created just for you. You will receive follow-up information and support to help you stay on track as you work to reach your wellness goals.
Quality Data	CDPHP has a robust quality management program devoted to improving the care and service our members receive. Click on "Commitment to Quality" in the lower right-hand corner of any page at www.cdphp.com for details. You can review survey results regarding members' satisfaction with their primary care providers, and data on the quality and safety of the hospitals in our network.
Care support	**Health Coach Connection SM** - Personal Health Coaches are available by phone or online, 24 hours a day, 7 days a week to answer your health questions and support you in the management of chronic illnesses. A Health Coach is a trained health care professional who can provide you with information on a variety of health issues, help you monitor your health needs, and work more closely with your doctor. **Single-Source Referral Line** - Looking for wellness support and advice? CDPHP has a variety of programs that might help. Call our new single-source referral line—**1 (888) 94-CDPHP (23747)**—and leave a confidential message about your health concern. An expert professional will call you back with suggestions for CDPHP programs that can help fulfill your unique needs. **CDPHP Behavioral Health Access Center -** Call 1 (888) 320-9584 if you have questions about your behavioral health benefits or need help finding a provider of care. If calling after hours you may press "1" to be connected with the CONTACT Lifeline where you can speak with a licensed mental health professional.
Reward program	**Life Points** The Life Points program rewards members for healthy behaviors. Members aged 19 and older can earn points for a variety of healthy activities such as: gym memberships, participating in a CDPHP wellness class, receiving a flu vaccine, and more. Members can earn points worth up to $365 per year, per contract. The first required step to begin earning points is to complete your online Personal Health Assessment (PHA). Go to www.cdphp.com/lifepoints to get started today!

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 a FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information, contact the Plan at (518) 641-3140 or visit their website at www.cdphp.com.

Rx for Less

Many common generic drugs for blood pressure, heart disease, and diabetes are now available for as low as a penny a pill for CDPHP members filling prescriptions at CVS, Walmart, Price Chopper, Hannaford, and ShopRite. Details are available in Rx Corner at www.cdphp.com**.**

CVS ExtraCare® Health Card

CDPHP partners with CVS Caremark to offer members special savings on commonly used health products. You'll receive a CVS ExtraCare® Health card in the mail. Present the card at a CVS retail store and get a 20 percent discount on CVS brand health-related items.

Wellness Programs

CDPHP UBI offers a variety of innovative wellness classes to help you manage your health. The programs are free, exclusively for CDPHP members, and provided by trained educators.

A schedule of up-to-date wellness programs appears on www.cdphp.com and in *SmartMoves*, CDPHP UBI's quarterly member newsletter. Topics include: Zumba, stress management, healthy cooking, and many more.

Smoking Cessation Programs

- **The Butt Stops Here** is a seven-week smoking cessation program that covers behavior modification with the use of nicotine replacement therapy.

Award Winning Weight Management Programs:

- The **Weigh 2 Be** program addresses nutrition, exercise, and stress management. Enrolled members will be incentivized for healthy behaviors. Please contact the Plan for exciting new incentives at (518) 641-3140 or visit the website at www.cdphp.com.
- **Alliance for a Healthier Generation** provides comprehensive health benefits for the prevention, assessment, and treatment of childhood obesity. Members aged 3 to 18 diagnosed as overweight or obese are eligible for four office visits with their primary care provider for weight counseling and four visits with a registered dietitian for nutrition counseling per year. These services are subject to applicable copayments, coinsurances, and/or group-specific contract limitations, if any.

Hearing Aid Discounts

As a member of CDPHP, you are eligible for a valuable hearing care program available through Hearing Care Solutions (HCS), which offers hearing aid discounts between 50 and 63 percent off retail prices. HCS can be reached at (866) 344-7756 between 8 a.m. and 8 p.m., Monday through Friday.

Section 6. General exclusions – services, drugs and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under *Services Requiring Our Prior Approval* on page 15. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services).***

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs, or devices (see page 37 for specifics concerning transplants);
- 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 you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies required for obtaining or continuing employment or insurance, attending schools or camp, or travel; or
- Services, drugs, or supplies you receive without charge while in active military service.
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.
- Research costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval) including urgent care claims procedures. 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 and/or coinsurance.

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

Medical, hospital, and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at (518) 641-3140 or (877) 269-2134 or at our website at www.cdphp.com.

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

- Covered member's name, date of birth, address, phone number 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 payor – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services

Note: Cancelled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

CDPHP Universal Benefits, Inc.
500 Patroon Creek Blvd.
Albany, NY 12206

(518) 641-3140 or (877) 269-2134

www.cdphp.com

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.

Urgent care claims procedures

If you have an Urgent care claim, please contact our Customer Service Department at (518) 641-3140 or (877) 269-2134.

Urgent care claims must meet the definition found in Section 10 of this brochure, and most urgent care claims will be claims for access to care rather than claims for care already received.

We will notify you of our decision not later than 24 hours after we receive the claim as long as you provide us with sufficient information to decide the claim. If you or your authorized representative fails to provide sufficient information we will inform you or your authorized representative of the specific information necessary to complete the claim not later than 24 hours after we receive the claim and a time frame for our receipt of this information. We will decide the claim within 48 hours of (i) receiving the information or (ii) the end of the time frame, whichever is earlier.

Concurrent care claims procedures

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment as an appealable decision. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

Pre-service claims procedures

As indicated in Section 3, certain care requires Plan approval in advance. We will notify you of our decision within 15 days after the receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you fail to follow these pre-service claim procedures, then we will notify you of your failure to follow these procedures as long as (1) your request is made to our customer service department and (2) your request names you, your medical condition or symptom, and the specific treatment, service, procedure, or product requested. We will provide this notice within five days following the failure or 24 hours if your pre-service claim is for urgent care. Notification may be oral, unless you request written correspondence.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive the claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review as long as we notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.opm.gov.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3. You may be able to appeal to the U.S. Office of Personnel Management (OPM) immediately if we do not follow the particular requirements of this disputed claims process. For more information about situations in which you are entitled to immediately appeal and how to do so, please visit www.cdphp.com.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing us at 500 Patroon Creek Blvd., Albany, NY 12206 or calling (518) 641-3140 or (877) 269-2134. Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who make the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

1 Ask us in writing to reconsider our initial decision. You must:

a) Write to us within 6 months from the date of our decision; and

b) Send your request to us at: CDPHP UBI, 500 Patroon Creek Blvd., Albany, NY 12206; and

c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

e.) Include your email address (optional), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision quicker.

2 In the case of a post-service, we have 30 days from the date we receive your request to:

a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or precertify your hospital stay or grant your request for prior approval for a service, drug, or supply); or

b) Write to you and maintain our denial - go to step 4; or

c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

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.

In the case of an appeal of an urgent care claim, we will notify you of our decision not later than 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

3 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 Operations, Health Insurance 2, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

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. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

4 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 file a lawsuit. 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 file a lawsuit 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 you did not indicate that your claim was a claim for urgent care, then call us at (518) 641-3140 or (877) 269-2134. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 2 at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers Compensation Programs if you are receiving Worker's Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has 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 payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC website at http://www.NAIC.org.

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

When we are the secondary payor, 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.

When you have Medicare

- **What is Medicare?**

Medicare is a Health Insurance Program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact (800) MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at (800) 772-1213, TTY: (800) 325-0778.

- **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 (800) 772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

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

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private 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.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

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

The Original Medicare Plan (Orginal 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 hosiptal that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicans and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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

Claims process when you have the Original Medicare Plan - You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payor, we process the claim first.
- When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at (518) 641-3140 or (8770) 269-2134 or see our website at www.cdphp.com.

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

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at (800) MEDICARE (800) 633-4227, TTY: (877) 486-2048 or at www.medicare.gov.

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

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

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

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

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

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) 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	✓	
6) 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) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
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 payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan covers some of these costs, as long as the test is a covered benefit. We encourage you to contact the plan to discuss specific services if you participate in a clinical trial.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs. (See Page 41)

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assigness receive payment form any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgement, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the jusgement, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP Coverage)

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone 1-877-888-3337 (TTY 1-877-889-5680), you will be asked to provide information on your FEHB plan so that your plan can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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.
Clinical Trials Cost Categories	An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application. • Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. • Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. • Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes are generally covered by the clinical trials. This plan does not cover these costs.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 20.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 20.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g. coinsurance and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Care that does not have a direct medical benefit such as house cleaning, preparing meals, personal hygiene. Custodial care that lasts 90 days or longer is sometimes known as long-term care.
Experimental or investigational service	A procedure that is not approved by the Federal Food and Drug Administration and/or the National Institute of Health Technology Assessment.
Group health coverage	Medical benefits such as hospital, surgical, and preventive care that are purchased on an employer-sponsored basis.
Health care professional	A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.
Medical necessity	A service or treatment which is appropriate and consistent with the diagnosis and accepted standards in the medical community.
Out of Pocket Maximum	The total amount of applicable Copayments and/or Coinsurance that you must satisfy, before which CDPHP UBI will pay one hundred percent (100%) of the Allowed Amount for Covered benefits. All amounts you pay for Copayments and/or Coinsurances are applicable toward the Out of Pocket Maximum. The Member is also responsible for all differences, if any, between the Allowed Amount and the non-participating provider's charge regardless of whether the Out of Pocket Maximum has been met.

Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance by the average community charges. Our providers accept the allowances as payment in full.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Subrogation	A cariier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Us/We	Us and We refer to CDPHP Universal Benefits, Inc., an affiliate of Capital District Physicians' Health Plan, Inc. (CDPHP).
You	You refers to the enrollee and each covered family member.
Urgent care claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health • Waiting could seriously jeopardize your ability to regain maximum function • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at (518) 641-3140 or (877) 269-2134. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and/or dependent care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program(FEDVIP**), provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary BEFORE taxes are wthheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** –Reimburses you for eligible out-of-pocket health care expenses (such as copayments, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at (877) FSAFEDS (877)372-3337, Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: (800) 952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is, separate and different from the FEHB Program. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. M**ost FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**

Vision Insurance

All vision plans will provide comprehensive eye examinations and coverage your choice of either lenses and frames or for contact lenses. Other benefits such as discounts on lasik surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call (877) 888-3337, TTY: (877) 889-5680. If you do not have access to a computer of phone, contact your employing office or retirement system for guidance on how to enroll.

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call (800) LTC-FEDS (800) 582-3337, TTY: (800) 843-3557 or visit www.ltcfeds.com .

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Summary of benefits for the High Option of CDPHP UBI - 2016

- **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.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $30 specialist	25
Services provided by a hospital:		
• **Inpatient**	$100 copay per day up to a maximum of $500 per admission. For individual coverage, inpatient copays are limited to two per calendar year. For family coverage, inpatient copays are limited to three per calendar year.	48
• **Outpatient**	$30 per visit $75 for outpatient surgery	49
Emergency benefits:		
• **In-area**	$50 per visit to hospital emergency room; $40 per visit to urgent care center	51
• **Out-of-area**	$50 per visit to hospital emergency room	51
Mental health and substance abuse treatment	Regular cost sharing	53
Prescription drugs:		
• Retail pharmacy/Mail order	25% of the Plan allowance with a $400 per prescription maximum, up to a 30-day supply. Member pharmacy cost share will apply toward the annual out-of-pocket maximum.	55
Dental care	$30 per visit for accidental injury benefit	58
Vision care	$30 per visit for one refraction every 24 months	33
Special features:	On-line tools Flexible benefits option Non-emergency medical care for full-time students attending school out of the area Services for the deaf and hearing impaired Childbirth Education Reimbursement Program	59

	Centers of Excellence for transplants/heart surgery	
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,000/Self Only or $6,500/Self Plus One or Self and Family enrollment per year for medical and pharmacy combined qualified services.	20

Summary of benefits for the Standard Option of CDPHP UBI - 2016

- 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.

Standard Option Benefits	You Pay	You Pay
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $25 primary care; $40 specialist	25
Services provided by a hospital:		
• Inpatient	$500 copay per admission plus 10% of the Plan allowance. For individual coverage, inpatient copays are limited to two per calendar year. For family coverage, inpatient copays are limited to three per calendar year.	48
• Outpatient	$40 per visit $100 for outpatient surgery	49
Emergency benefits:		
• In-area	$100 per visit to hospital emergency room; $50 per visit to urgent care center	51
• Out-of-area	$100 per visit to hospital emergency room	51
Mental health and substance abuse treatment	Regular cost sharing	53
Prescription drugs:		
• Retail pharmacy/Mail order	30% of the Plan allowance with a $400 per prescription maximum, up to a 30-day supply. Member pharmacy cost share will apply toward the annual out-of-pocket maximum.	55
Dental care	$40 per visit for accidental injury benefit	58
Vision care	$40 per visit for one refraction every 24 months	33
Special Features:	On-line tools Flexible benefits option Non-emergency medical care for full-time students attending school out of the area Services for the deaf and hearing impaired Childbirth Education Reimbursement Program	59

	Centers of Excellence for transplants/heart surgery	
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,000/Self Only or $6,500/Self Plus One or Self and Family enrollment per year for medical and pharmacy combined qualified services.	20

2016 Rate Information for CDPHP UBI

For 2016 health premium information, please see: http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.