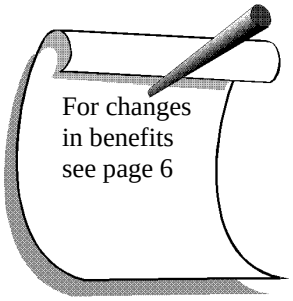
Union Health Service 2001

A Health Maintenance Organization



Serving: Chicago Area

Enrollment in this Plan is limited; see page 5 for requirements.

Enrollment codes for this Plan:

761 Self Only
762 Self and Family

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Table of Contents

Introduction 4

Plain Language 4

Section 1. Facts about this HMO plan 5

How we pay providers 5

Patients' Bill of Rights 5

Service Area 5

Section 2. How we change for 2001 6

Program-wide changes 6

Changes to this Plan 6

Section 3. How you get care 7

Identification cards 7

Where you get covered care 7

- Plan providers 7
- Plan facilities 7

What you must do to get covered care 7

- Primary care 7
- Specialty care 7
- Hospital care 8

Circumstances beyond our control 9

Services requiring our prior approval 9

Section 4. Your costs for covered services 10

- Copayments 10
- Deductible 10
- Coinsurance 10

Your out-of-pocket maximum 10

Section 5. Benefits 11

Overview 11

(a) Medical services and supplies provided by physicians and other health care professionals 12

(b) Surgical and anesthesia services provided by physicians and other health care professionals 20

(c) Services provided by a hospital or other facility, and ambulance services 24

(d) Emergency services/accidents 27

(e) Mental health and substance abuse benefits 29

(f) Prescription drug benefits 32

(g) Special features 34

(h) Dental benefits 35

(i) Non-FEHB benefits available to Plan members 36

Section 6. General exclusions -- things we don't cover 37
Section 7. Filing a claim for covered services 38
Section 8. The disputed claims process 40
Section 9. Coordinating benefits with other coverage 42
When you have…
•Other health coverage 42
•Original Medicare 42
•Medicare managed care plan 44
TRICARE/Workers' Compensation/Medicaid 45
Other Government agencies 45
When others are responsible for injuries 45
Section 10. Definitions of terms we use in this brochure 46
Section 11. FEHB facts 47
Coverage information 47
• No pre-existing condition limitation 47
• Where you get information about enrolling in the FEHB Program 47
• Types of coverage available for you and your family 47
• When benefits and premiums start 48
• Your medical and claims records are confidential 48
• When you retire 48
When you lose benefits 48
• When FEHB coverage ends 48
• Spouse equity coverage 48
• Temporary Continuation of Coverage (TCC) 48
• Converting to individual coverage 49
• Getting a Certificate of Group Health Plan Coverage 49
Inspector General Advisory 49
Index 50
Summary of benefits 51
Rates ..... Back Cover

Introduction

Union Health Service, 1634 West Polk Street, Chicago, Illinois 60612

This brochure describes the benefits of Union Health Service under our contract (CS 1571) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 6. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means Union Health Service.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this HMO plan

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

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

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

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

How we pay providers

We employ individual physicians, own and operate our medical centers, and contract with hospitals to provide the benefits in this brochure. These individual physicians are salaried employees. Other Plan providers accept a negotiated payment from us. You will only be responsible for your copayments or coinsurance.

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

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

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

If you want more information about us, call our Member Service Department at 312 829-4224 ext. 3377, or write to Union Health Service, 1634 West Polk Street, Chicago, IL 60612. You may also contact us by fax at 312/423-4380.

Service Area

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

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care.

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

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling the UHS Member Advocate Department at 312 829-4224 ext.3377. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:
  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- Your share of the non-Postal premium will increase by 8% for Self Only or 7.6% for Self and Family.
- There are no changes other than those listed above.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call our Member Service Department at 312 829-4224 ext. 3377

Where you get covered care

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

- **Plan providers**

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

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

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically.

What you must do

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

- **Primary care**

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

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

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, a woman may see her Plan obstetrician/gynecologist without a referral.

Here are other things you should know about specialty care:

- If you need to see a participating specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan.

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

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

- If you have a chronic or disabling condition and lose access to your specialist because we:

  - terminate our contract with your specialist for other than cause; or

  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or

  - reduce our service area and you enroll in another FEHB Plan,

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

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our Medical Management department immediately at 312 829-4224 ext.3210. If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or

- The day your benefits from your former plan run out; or

- The 92nd day after you become a member of this Plan, whichever happens first.

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

Circumstances beyond our control

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

Services requiring our prior approval

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

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

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

• **Copayments**	A copayment is a fixed amount of money you pay to the provider when you receive services. Example: When you see your primary care physician you pay a copayment of $10 per office visit.
•**Deductible**	A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. UHS has a deductible for orthopedic and prosthetic devices and durable medical equipment, see page 18, otherwise we do not have a deductible. NOTE: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.
•**Coinsurance**	We do not have coinsurance.
Your out-of-pocket maximum for deductibles and copayments	Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated copayments and deductibles required for a few benefits

Section 5. Benefits -- OVERVIEW

(See page 6 for how our benefits changed this year and page 51 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. .Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain advice, or more information about our benefits, contact our Member Service Department at 312 829-4224 ext.3377.

(a) Medical services and supplies provided by physicians and other health care professionals……..12-19

- Diagnostic and treatment services
- Lab, X-ray, and other diagnostic tests
- Preventive care, adult
- Preventive care, children
- Maternity care
- Family planning
- Infertility services
- Allergy care
- Treatment therapies
- Rehabilitative therapies
- Hearing services (testing, treatment, and supplies)
- Vision services (testing, treatment, and supplies)
- Foot care
- Orthopedic and prosthetic devices
- Durable medical equipment (DME)
- Home health services
- Educational classes and programs

(b) Surgical and anesthesia services provided by physicians and other health care professionals 20-23

- Surgical procedures
- Reconstructive surgery
- Oral and maxillofacial surgery
- Organ/tissue transplants
- Anesthesia

(c) Services provided by a hospital or other facility, and ambulance services 24-26

- Inpatient hospital
- Outpatient hospital or ambulatory surgical center
- Extended care benefits/skilled nursing care facility benefits
- Hospice care
- Ambulance

(d) Emergency services/accidents 27-28

- Medical emergency
- Ambulance

(e) Mental health and substance abuse benefits..... 28-29

(f) Prescription drug benefits 32-33

(g) Special features 34

- Not for Profit Organization
- 24 hour emergency line
- High risk pregnancies
- Centers of excellence for transplants/heart surgery/etc
- Translation Services
- Urgent Care
- Continuity of Care
- Staff Model

(h) Dental benefits 35

(i) Non-FEHB benefits available to Plan members 36

Summary of benefits 51

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have deductibles for prosthetic and orthopedic devices and durable medical equipment
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including Medicare.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
Diagnostic and treatment services	
Professional services of physicians • In physician's office • In an urgent care center • Office medical consultations • Second surgical opinion	$10 per visit
Professional services of physicians • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment	Nothing
At home	$10 per visit

Diagnostic and treatment services -- Continued on next page

Lab, X-ray and other diagnostic tests	You Pay
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing
Preventive care, adult	
Routine screenings, such as: • Blood lead level – One annually • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including ••Fecal occult blood test	Nothing
••Sigmoidoscopy, screening – every five years starting at age 50	$10 per visit
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	$10 per visit
Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnosis and Treatment*, above.	$10 per visit
Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing.
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All Charges*
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	$10 per visit

Preventive care, children	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per visit
• Examinations, such as: ••Eye exams through age 17 to determine the need for vision correction. ••Ear exams through age 17 to determine the need for hearing correction ••Examinations done on the day of immunizations (through age 22) • Well-child care charges for routine examinations, immunizations and care (through age 22)	$10 per visit
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 26 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$10 per visit
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*

Family planning	You pay
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	$10 per visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling,	*All charges.*
Infertility services	
Diagnosis and treatment of infertility, such as: • Artificial insemination: ••intravaginal insemination (IVI) ••intracervical insemination (ICI) ••intrauterine insemination (IUI) • Fertility drugs are covered as mandated by the State of Illinois. • Other assisted reproductive technology (ART) procedures that enable a woman with otherwise untreatable infertility to become pregnant through artificial conception procedures such as in vitro fertilization and embryo transfers including medical examinations in accordance with the limitations specified in the State of Illinois mandated benefits. Note: The State of Illinois has limitations on the number of ART procedures.	$10 per visit
Not covered: • *Cost of donor sperm* • *Assisted reproductive technology (ART) procedures, such as:* •• *in vitro fertilization* •• *embryo transfer and GIFT* *Services and supplies related to excluded ART procedures*	*All charges.*
Allergy care	
Testing and treatment	$10 per visit
Allergy serum Allergy injection	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 22. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: – We will only cover GHT when the treatment is authorized by the Medical Director. We will ask your primary care physician to submit information that establishes that the GHT is medically necessary. Authorization must be given before you begin GHT treatment; otherwise, we will only cover GHT services from the date of approval. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See Services requiring our prior approval in Section 3. Growth Hormone therapy is covered under the plan's medical benefits.	$10 per visit
Rehabilitative therapies	
Physical therapy, occupational therapy and speech therapy -- • 60 treatments per condition for the services of each of the following: ••qualified physical therapists; ••speech therapists; and ••occupational therapists. Note: We only cover short-term therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 30 sessions.	$10 per visit
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges.*

Hearing services (testing, treatment, and supplies)	You Pay
• Hearing testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges.*
Vision services (testing, treatment, and supplies)	
In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, one annual eye refraction (which includes the written lens prescription) may be obtained.	$10 per visit
• Eye exam to determine the need for vision correction for children through age 17 (see preventive care) • Annual eye refractions	$10 per visit
Not covered: • *Eyeglasses or contact lenses.* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges.*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*

Orthopedic and prosthetic devices	You pay
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	20% of charges after you pay the calander year deductible. $100 deductible per member per calendar year (maximum $300 family deductible).
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges.*
Durable medical equipment (DME)	
Purchase or rental (up to the purchase price), at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician as medically necessary, such as oxygen and dialysis equipment. Under this benefit, we also cover: • hospital beds; • wheelchairs • crutches • walkers; • blood glucose monitors; and • insulin pumps. Note: Call our Medical Management Department at 312 829-4224 ext. 3210 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	20% of charges after you pay the calander year deductible. $100 deductible per member per calendar year (maximum $300 family deductible.
Not covered: • *Motorized wheel chairs* • *Equipment that is not medically necessary*	*All charges.*

Home health services	You Pay
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. • Home health care is provided for homebound members at their home when prescribed by a Plan physician. Note: Our Medical Management Department will monitor all home health care.	$10 per visit
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All charges.*
Alternative treatments	
Not covered: • *acupuncture* • *chiropractic services* • *naturopathic services* • *hypnotherapy* • *biofeedback*	*All charges.*

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We only have deductibles for prosthetic and orthopedic devices and durable medical equipment
- Be sure to read Section 4, Your costs for covered services for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility
- YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information and services requiring our prior approval shown in Section 3 to be sure which services require precertification or prior approval.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
Surgical procedures	
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. Surgery for morbid obesity should be performed only as a last resort, when the member's health is endangered and more conservative medical measures, including prescription drugs such as appetite suppressants, have not been successful. • Insertion of internal prosthetic devices such as pacemakers and artificial joints. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information.	$10 per visit; nothing for hospital visits

Surgical procedures continued on next page.

Surgical procedures *(Continued)*	**You pay**
• Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a). • Treatment of burns	$10 per visit
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: •• the condition produced a major effect on the member's appearance and •• the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.	$10 per visit; nothing for hospital visits
• All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; •• breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$10 per visit; nothing for hospital visits
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*

Oral and maxillofacial surgery	You Pay
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abcesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$10 per visit; nothing for hospital visits
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, and any other dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.*	*All charges.*
Organ/tissue transplants	
Limited to: • Cornea • Heart • Kidney • Liver • Allogeneic (donor) bone marrow transplants; • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • National Transplant Program (NTP) – We follow National Transplant Program guidelines for covered transplants. Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: Transplants must be approved by the Medical Director. We cover related medical and hospital expenses of the donor when we cover the recipient.	$10 per visit; nothing for hospital visits.
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*

Anesthesia	You pay
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, Your costs for covered services for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 (services requiring our approval) to be sure which services require precertification.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing

Inpatient hospital continued on next page.

Inpatient hospital *(Continued)*	**You pay**
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 • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies to durable medical equipment and prosthetic and orthopedic devices.)	Nothing
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Non-covered facilities* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Not covered: blood and blood derivatives not replaced by the member	*All charges*

Extended care benefits/skilled nursing care facility benefits	You pay
Extended care benefit: We provide a comprehensive range of benefits for up to 60 days per calendar year when full time nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. • Bed, board and general nursing • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility (SNF) when prescribed by a Plan doctor and managed by our Medical Management Department.	Nothing
Not covered: custodial care	All charges
Hospice care	
We cover supportive and palliative care for a terminally ill member in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less	Nothing
Not covered: Independent nursing, homemaker services	All charges
Ambulance	
• Local professional ambulance service when medically appropriate	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

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

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

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

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

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

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

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

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

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at a Plan urgent care center	$10 per visit
• Emergency care at a non-Plan urgent care center • Emergency care as an outpatient at a hospital, including doctors' services	$25 per visit
We waive the copay if you are admitted to the hospital.	
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$25 per visit
We waive the copay if you are admitted to the hospital.	
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges.*
Ambulance	
Professional ambulance service when approved by the Plan and medically appropriate. Air ambulance when approved by the Plan and medically appropriate See 5(c) for non-emergency service.	Nothing

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

IMPORTANT

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

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

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, Your costs for covered services for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits section below.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per visit

Mental health and substance abuse benefits - Continued on next page

Mental health and substance abuse benefits *(Continued)*	**You pay**
• Diagnostic tests when ordered by a Plan doctor	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing.
Not covered: • *Services we have not approved.* • *Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate* • *Services rendered or billed by a school or a member of its staff* • *Psychotherapy or psychoanalysis credited toward furthering education, training, or earning a degree* • *Intelligence, IQ, aptitude, ability, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition.* • *Continuing services if you do not substantially follow your treatment plan* *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	All charges.

Preauthorization

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

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

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

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

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following condition:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause.

If this condition applies to you, we will allow you reasonable time to transfer your care to a Plan mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.

Note: Members utilizing transitional care must call our Medical Management Department (312) 829-4224 ext. 3210

Limitation

We will limit your benefits if you do not substantially follow your treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, Your costs for covered services for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including Medicare.

IMPORTANT

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

- **Who can write your prescription.** A licensed physician must write the prescription – or – A plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, and some maintenance medication can be filled by mail by the Plan pharmacy.
- **These are the dispensing limitations.** Prescription drugs will be dispensed for up to a 30-day supply or 100 unit supply, whichever is less; 240 milliliters of liquid (8oz.); 60 grams of ointment, creams or topical preparation; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin).

  Certain maintenance prescriptions can be mail ordered according to Food and Drug Administration Guidelines and you can obtain these by mail from the plan pharmacy. Contact the plan pharmacy at 312 829-4224 ext. 3260 to make arrangements.

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies	
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. • Insulin • Disposable needles and syringes for the administration of covered medications • Intravenous fluids and medication for home use, implantable drugs, and some injectable drugs are covered under Medical and Surgical benefits • Drugs for sexual dysfunction when medically necessary • Fertility drugs are covered under infertility benefits, see page 15 • Contraceptive drugs and devices	$5 per prescription unit or refill

Covered medications and supplies *(continued)*	**You pay**
Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic. • Sexual dysfunction drugs have dispensing limitations. Contact the Plan pharmacy for details.	
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins and nutritional substances that can be purchased without a prescription* • *Drugs available without a prescription or for which there is a nonprescription equivalent available* • *Drugs obtained at a non-Plan pharmacy except for out of area emergencies* • *Drugs to enhance athletic performance* • *Smoking cessation drugs and medications, including the nicotine patch* • *Medical supplies such as dressings and antiseptics*	*All Charges*

Section 5 (g). Special Features

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

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, Your costs for covered services for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including Medicare.

IMPORTANT

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	$10 per visit

Dental benefits

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

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

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

Vision care

- One annual refraction (which includes the written lens prescription) may be obtained from a UHS optometrist. The services are available by appointment at the UHS Eye Care Center 312 829-4224 ext. 3320 located at the UHS Main Facility, 1634 West Polk Street, Chicago, IL 60612
- UHS Plan members receive special package prices and discounts on eyeglasses, frames, lenses and optical accessories at all For Eyes Optical store locations.
- For further information about our Vision Benefits please contact our Member Service Department at 312 829-4224 ext.3377

Dental Care

- Dental Services are available to UHS Plan members. The services are available by appointment at UHS Dental Office 312 829-4224 ext.3308 located at the UHS Main Facility, 1634 West Polk Street, Chicago, IL 60612
- Annual Office……No Charge
- Annual Oral Examination and diagnosis…….. No Charge
- Annual Fluoride Treatment……...No Charge (dependent under age 19)
- Other dental services are available at reduced cost with an additional 20% discount. Payment is required at the time of service.

The benefits are available only at the UHS Dental Office
For further information about our Dental Benefits, please contact our Marketing Department at 312 829-4224 ext.3222

Benefits on this page are not part of the FEHB contract

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

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

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

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

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

Medical and hospital benefits

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

When you must file a claim -- such as for out-of-area care – submit the hospital bill or the claim on the HCFA-1500 that includes the information shown below. Bills and receipts should be itemized and show:

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

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

Prescription drugs

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

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

Other supplies or services

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

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

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: UHS Medical Director,1634 West Polk Street, Chicago, IL 60612; 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.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, P.O. Box 436, Washington, D.C. 20044-0436.

The Disputed Claims process (Continued)

Send OPM the following information:

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

Note: If you want OPM to review different claims, 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 provide a copy of your specific written consent with the review request.

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

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

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

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 312 829-4224 ext. 3359 and we will expedite our review; or

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group health plan or have automobile insurance that pays heatlh care expenses without regard to fault. This is called "double coverage."

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

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

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

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

•What is Medicare?

Medicare is a Health Insurance Program for:

•• People 65 years of age and older.

•• Some people with disabilities, under 65 years of age.

•• People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

•• Part A (Hospital Insurance). Most people do not have to pay for Part A.

•• Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

•The Original Medicare Plan

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan PCP, or precertified as required

We will not waive any of our copayments, coinsurance, and deductibles.

(Primary payer chart begins on next page.)

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

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when… a) The position is excluded from FEHB…..……..…..…..….	……..✓	
b) The position is not excluded from FEHB …….	……..	……..✓
Ask your employing office which of these applies to you.		
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and a) Are an annuitant, or……	……✓	
b) Are an active employee……	……..	……✓

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

- When we are the primary payer, we process the claim first.

- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 312 829-4224 ext.3304.

We waive some costs when you have Medicare -- When Medicare is the primary payer, we will waive some out-of-pocket costs, as follows:

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

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

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

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. We do not have a Medicare Managed Care Plan; however, we do have a Medicare Health Care Prepayment Plan (HCPP). For more information on our Medicare HCPP, call us at 312/829/4224 ext. 3377. If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles.

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

- **Enrollment in Medicare Part B**

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

TRICARE

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 10.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 10

Covered services

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

Custodial care

Treatment or services that are designed mainly to help the patient with daily living activities

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 10.

Experimental or investigational services

If a medical treatment, procedure, drug, device, or biological product is FDA approved, the Plan will use this as a basis for providing coverage. If it lacks FDA's approval, the Plan will make a policy decision based on specific statements from specialty societies or medical organizations such as the American Cancer Society, the American College of Surgeons, and the American Medical Society

Group health coverage

Health care coverage that a member is eligible for because of employment by, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies.

Medically necessary

A Medically Necessary service is a service that is (1) consistent with the Enrollee's condition, disease, ailment or injury, (2) appropriate with regard to standards of good medical practice, (3) not solely for the convenience of the Enrollee or provider, and (4) the most appropriate supply or level of service which can be safely rendered to the Enrollee. When specifically applied to an inpatient, it further means that the Enrollee's medical symptoms or condition require that the diagnosis or treatment cannot be effectively, safely and economically provided to the Enrollee in an outpatient setting.

Your Primary Care Physician, in accordance with the above standards adopted by Union Health Service, will determine when a service is medically necessary.

Us/We

Us and we refer to Union Health Service

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about:

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

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

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

When benefits and premiums start

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

Your medical and claims records are confidential

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

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

When you retire

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

When you lose benefits

- **When FEHB coverage ends**

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

  - Your enrollment ends, unless you cancel your enrollment, or
  - You are a family member no longer eligible for coverage.

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

- **Spouse equity coverage**

  If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

- **TCC**

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

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

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

•Converting to individual coverage

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

•• Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay your premium, you cannot convert;

•• You decided not to receive coverage under TCC or the spouse equity law; or

•• You are not eligible for coverage under TCC or the spouse equity law.

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Inspector General Advisory

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 312/829-4224 ext. 3359 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE--202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

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

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

Accidental injury 35
Allergy tests 15
Alternative trement 19
Ambulance 26, 28
Anesthesia 23,25
Autologous bone marrow transplant 22
Biopsies 20
Blood and blood plasma 25
Breast cancer screening 13
Casts 25
Catastrophic protection 10
Changes for 2001 6
Chemotherapy 16
Childbirth 14
Cholesterol tests 13
Claims 38, 39
Coinsurance 10, 46
Colorectal cancer screening 13
Congenital anomalies 20
Contraceptive devices and drugs 32
Coordination of benefits 42
Covered services 46
Covered providers 7
Crutches 18
Deductible 10
Definitions 46
Dental care 35, 36
Diagnostic services 12
Disputed claims review 40, 41
Donor expenses (transplants) 22
Dressings 25, 33
Durable medical equipment (DME) 18
Effective date of enrollment 47
Emergency 27, 28
Experimental or investigational 46
Eyeglasses 17, 36
Family planning 15
Fecal occult blood test 13
General Exclusions 37
Hearing services 17
Home health services 19
Hospice care 26
Home nursing care 19
Hospital 9, 24
Immunizations 13, 14
Infertility 15
Inhospital physician care 24
Inpatient Hospital Benefits 24
Insulin 32
Laboratory and pathological services 13
Magnetic Resonance Imagings (MRIs) 13
Mail Order Prescription Drugs 32
Mammograms 13
Maternity Benefits 14
Medicaid 45
Medically necessary 46
Medicare 42, 43
Mental Conditions/Substance Abuse Benefits 29 ,30
Newborn care 14
Non-FEHB Benefits 36
Nursery charges 14
Obstetrical care 14
Occupational therapy 16
Office visits 12
Oral and maxillofacial surgery 22
Orthopedic devices 18
Out-of-pocket expenses 10
Outpatient facility care 25
Oxygen 25
Pap test 13
Physical examination 13
Physical therapy 16
Physician 7
Precertification/Prior-approval 9
Preventive care, adult 13
Preventive care, children 14
Prescription drugs 32, 33, 38
Preventive services 13,14
Prior approval 9
Prostate cancer screening 13
Prosthetic devices 18, 20
Psychologist 30
Psychotherapy 30
Radiation therapy 16
Rehabilitation therapies 16
Renal dialysis 16
Room and board 24
Second surgical opinion 12
Skilled nursing facility care 26
Smoking cessation 33
Speech therapy 16
Splints 25
Sterilization procedures 15, 21
Subrogation 45
Substance abuse 29, 30
Surgery 20, 21, 22, 23
- Anesthesia 23
- Oral 23
- Outpatient 25
- Reconstructive 21

Syringes 32
Temporary continuation of coverage 48
Transplants 22
Treatment therapies 15
Vision services 17, 36
Well child care 14
Wheelchairs 18
Workers' compensation 45
X-rays 13

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Summary of benefits for the *Union Health Service* - 2001

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $10 specialist	12
Services provided by a hospital: • Inpatient ..... • Outpatient	"Nothing"	24 25
Emergency benefits: • In-area ..... • Out-of-area	$25 per…. $25 per…	28 28
Mental health and substance abuse treatment	Regular benefits	29
Prescription drugs	$ 5 per prescription unit or refill	32
Dental Care	Accidental injury benefit	35
Vision Care	Medical, surgical for diagonosis and treatment of diseases, one annual eye refraction	17
Special features…… Not for Profit Organization, 24 hour emergency line, High risk pregnancies, Centers for excellence for transplants/heart surgery/etc., Translation services, Urgent care, Continuity of Care, Staff Model		34

2001 Rate Information for
Union Health Service

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	761	$67.31	$22.43	$145.83	$48.61	$79.64	$10.10
Self and Family	762	$166.92	$55.64	$361.66	$120.55	$197.52	$25.04