Univera Healthcare-WNY

(formerly HealthCarePlan)

http://www.univerahealthcare.org

2001

A Health Maintenance Organization

Serving: Western New York State

Enrollment in this Plan is limited; see page 6 for requirements.

Enrollment codes for this Plan:

Q81 Self Only
Q82 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management
Retirement and Insurance Service
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Federal Employees
Health Benefits Program

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Introduction

Univera Healthcare - WNY, Inc.
205 Park Club Lane
Buffalo, New York 14221

This brochure describes the benefits of Univera Healthcare – WNY, Inc. under our contract (CS 1891) 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 7. 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 Univera Healthcare – WNY.

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 contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Who provides my health care?

Univera Healthcare provides comprehensive managed health care to its membership. The Univera network of doctors, hospitals and other health care providers throughout the community will provide medical care, diagnostic laboratory and x-ray services, pharmacy and optical services.

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.

- Accreditation status
- Compliance with State or Federal licensing, certification, or fiscal solvency requirements, if applicable
- Clinical protocols, practice guidelines and utilization review standards used by the Plan
- Number of primary care and specialty providers, including board certification status
- Years in existence
- Profit status

If you want more information about us, call (800) 427-8490, or write to Univera Healthcare Marketing Department, 205 Park Club Lane, Buffalo, New York 14221-5239. You may also contact us by fax at (716) 847-1257 or visit our website at www.univerahealthcare.org.

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: Western New York, including Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming 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. We will not pay for any other health care services unless pre-approved in writing by a Univera Healthcare Medical Director.

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 1-800-337-3338, **or** checking our website http://www.univerahealthcare.org. 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 9.1% for Self Only or 9.1% for Self and Family.
- You pay $10 per visit for cardiac rehabilitation. Previously, you paid 50% of the charges. See page 19.
- The quantity of prescription drugs dispensed at one time is limited to a 30-day supply. Previously, drugs were dispensed for up to a 31-day supply. See page 38.
- The Plan covers drugs prescribed for smoking cessation only as part of an approved disease management program.
- You pay a $10 copay for each home health care visit, beginning with the first visit in a calendar year. Previously, you did not pay a copay for the first 20 visits in a calendar year. See page 23.
- You pay the $10 office visit copayment for all x-rays (other than screening mammograms), radiological procedures and radiation therapy. Previously, you paid nothing for radiological procedures that do not require the attendance or assistance of a doctor. See page 14.
- The Plan eliminated coverage for weight loss medications. See page 38
- We now provide benefits for intra-vaginal insemination. See page 17.
- We decreased the copay for an urgent care center visit from $35 to $10. See page 33.
- We changed our prescription drug copays as follows. See page 37.
  $5 - generic
  $15 - preferred brand
  $35 - non-preferred brand

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (800) 337-3338.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and/or coinsurance, and you will not have to file claims.

- **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. Ordinarily, you must get your care from providers who contract with us.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website. The Provider Directory lists participating doctors by specialty, with their locations and phone numbers. Directories are provided to all interested enrollees at the time of enrollment, or you may request a directory by calling the Plan's Marketing Department at 847-0881. **Important note**: When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's network of providers; the continued availability and/or participation of any one doctor, hospital, or other provider cannot be guaranteed.

- **Plan facilities**

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

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. You may select a primary care physician on your enrollment application, or by calling the Plan's Marketing Department at 847-0881. Check the participation status of any provider by telephoning the provider directly, or by calling us. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. You may change your primary care physician at any time; just call the Plan's Customer Service Department at (800) 337-3338.

- **Primary care**

Your primary care physician can be a family practitioner, internist, general practitioner, 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, you may see Plan providers for certain services without a referral. You do not need a referral from your primary care physician to obtain behavioral health services or routine eye care from Plan providers. Female members do not need a referral from the primary care physician to obtain routine and acute obstetric (maternity) and gynecologic services from a Plan ob-gyn provider.

If you need to see a non-Plan specialist, your primary care doctor must request written prior approval from a Plan Medical Director.

When you receive a referral from your primary care doctor, you must return to the primary care doctor after the consultation unless your doctor authorizes additional visits. All follow-up care must be provided or authorized by the primary care doctor. Do not go to the specialist for a second visit unless your primary care doctor has arranged for, and the Plan has issued an authorization for, the referral in advance. If you are receiving services from a doctor who leaves the Plan, the Plan will pay for covered services until the Plan can arrange for you to be seen by another participating doctor.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will work with the specialist to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk 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.

- 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.

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (800) 337-3338. 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 most services. For certain 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.

We call this review and approval process pre-authorization. Your physician must obtain pre-authorization for the following services: all hospital admissions and some surgeries, additional medical services such as durable medical equipment, prosthetic devices, physical, occupational, speech therapies, certain prescription drugs, and some diagnostic testing. In addition, pre-authorization is required for services provided by non-plan providers.

To obtain pre-authorization, your physician will contact us in writing. Most of the time, if the requested service is covered under your contract, a Univera representative will issue a pre-authorization for the service. Otherwise, a Plan Medical Director will review any medical documentation submitted by your physician to make a determination. We will notify you of the decision in writing. If the request is denied, you have the right to appeal our decision.

Your physician must obtain pre-authorization from the Plan Medical Director for all referrals to non-Plan providers. The Plan will not cover any non-emergency medical services from non-Plan providers without the written pre-authorization of the Plan Medical Director. You will be responsible for all costs for these services.

Section 4. Your costs for covered services

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

• **Copayments**	A copayment is a fixed amount of money you pay when you receive services. Example: When you see your primary care physician you pay a copayment of $10 per office visit.
•**Deductible**	We do not have a deductible.
•**Coinsurance**	Coinsurance is the percentage of our negotiated fee that you must pay for your care. Only certain specified services require Coinsurance. Example: In our Plan, you pay 50% of our allowance for infertility services and fertility drugs.
Your out-of-pocket maximum	We do not have an out-of-pocket maximum.

Section 5. Benefits – OVERVIEW

(See page 7 for how our benefits changed this year and page 57 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 claims forms, claims filing advice, or more information about our benefits, contact us at (800) 337-3338 or at our website at www.univerahealthcare.org.

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

IMPORTANT

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

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	Nothing
Other diagnostic tests, such as: • X-rays • Non-routine Mammograms • Cat Scans/MRI • Non-obstetrical Ultrasound • Electrocardiogram and EEG	$10 per provider per day
Preventive care, adult	
Routine screenings, such as: • Annual physical exam • Blood lead level – One annually • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including ••Fecal occult blood test ••Sigmoidoscopy, screening – every five years starting at age 50	$10 for the associated office 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 for the associated office visit

Preventive care, adult *(continued)*	**You pay**
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
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
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics • Well-child care charges for routine examinations, immunizations and care (through age 19)	Nothing.
• Examinations, such as: ••Eye exams through age 19 to determine the need for vision correction. ••Ear exams through age 19 to determine the need for hearing correction	$10 per visit

Maternity care	You pay
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 Section 5c 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).	Nothing
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges.*
Family planning	
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	$10 per visit
Not covered: reversal of voluntary surgical sterilization	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: ••intravaginal insemination (IVI) ••intracervical insemination (ICI) ••intrauterine insemination (IUI)	50% of the charges
Note: We cover fertility drugs under the prescription drug benefit.	50% of the charges
Not covered: • *Assisted reproductive technology (ART) procedures, other than Artificial insemination, such as:* ••*in vitro fertilization* ••*embryo transfer and GIFT* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm and storage*	*All charges.*
Allergy care	
Testing and treatment Allergy injection	$10 per visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization, treatment of environmental allergies with therapies not generally recognized by licensed allergists as safe and effective.	*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 27 • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: – GHT is a self-injectable medication covered under your Prescription drug benefits, Section 5(f). We will only cover GHT when we pre-authorize the treatment. The prescribing physician must request pre-authorization from a Plan Medical Director and provide evidence that GHT is medically necessary. 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.	$10 per visit

Rehabilitative therapies	You pay
Physical therapy, occupational therapy and speech therapy -- • Up to two consecutive months per condition for the services of each of the following: ••qualified physical therapists; ••speech therapists; and ••occupational therapists. Note: We only cover 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. Cardiac rehabilitation (stages I and II) following a heart transplant, bypass surgery, PTCA, chronic heart failure, chronic stable angina pectoris, or a myocardial infarction – • Up to 36 visits over a twelve-week period, in an approved cardiac rehabilitation program.	$10 per visit
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Cardiac rehabilitation stage III*	*All charges.*
Hearing services (testing, treatment, and supplies)	
• Hearing testing	$10 per visit
• Standard hearing aids, when medically necessary	Nothing.
Not covered: • *Repair, maintenance, or replacement of a hearing aid or its parts.* • *An eyeglass type or other deluxe hearing aid, to the extent the charge exceeds the costs of a covered hearing aid.*	*All charges.*

Vision services (testing, treatment, and supplies)	You pay
▪ Diagnosis and treatment of diseases of the eye. ▪ Treatment of accidental injury to the eye. ▪ Annual eye refraction.	$10 per visit
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	$10 per visit
Not covered: • *Eyeglasses or contact lenses, except as described above.* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges.*
Foot care	
Routine foot care when you are under active treatment for complications of a metabolic or peripheral vascular disease of the lower extremities, such as diabetes. See orthopedic and prosthetic devices for information on orthopedic 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
A Prosthetic Appliance is an external device used to replace all or part of a body organ or the function of a permanently inoperative body organ. Plan Services include medically necessary standard prosthetic appliances when ordered by a Plan doctor and provided by a Plan supplier, including: • 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 are covered as hospital benefits; see Section 5 (c) for payment information. See 5(b) for coverage of the surgery to insert the device. An orthopedic device is a rigid or semi-rigid device used to support a weak or deformed body member, or to restrict or eliminate motion in a diseased or injured part of the body. Rigid or semi-rigid devices are those that include molded plastic or metal stays. Plan services include medically necessary standard orthopedic devices ordered by your Plan doctor and provided by a Plan supplier, including: • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome; and • Custom-made braces.	Nothing
Not covered: • *Dentures and other devices used with the teeth* • *Orthopedic and corrective shoes* • *Arch supports* • *Orthopedic devices used solely for sports* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All charges.*

Durable medical equipment (DME) and Disposable medical supplies	You pay
Durable medical equipment is equipment that (a) can withstand repeated use; (b) is not designed for a specific individual's use; (c) is primarily and customarily used for a medical purpose; (d) generally is not useful in the absence of illness or injury; and (e) is used in the home. Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Hospital beds; • Oxygen; • Dialysis equipment; • Wheelchairs; • Crutches; • Walkers. Disposable medical supplies are items used to treat conditions due to injury or illness, which do not withstand repeated use and are discarded when their usefulness is discarded. Plan Services do not include disposable medical supplies except as specifically described in this Brochure. Coverage is limited to the following supplies when ordered by your Plan doctor and provided by a Plan supplier: • Compression stockings and sleeves, up to two pairs per calendar year; • Suction catheters, for use with an authorized suction machine; • Tracheostomy care supplies; • Urinary supplies related to a non-permanent urinary dysfunction; and • Disposable medical supplies dispensed at the time of treatment in a hospital emergency room, outpatient surgery setting, physician's office or urgent care center.	Nothing
Not covered: • *Non-standard or deluxe equipment* • *Disposable medical supplies, except as specifically listed* • *Physician equipment*	*All charges.*

Diabetic care	You pay
• Diabetic Supplies, such as Insulin, oral agents for controlling blood sugar, tests strips for glucose monitors, urine testing strips, syringes, cartridges for the legally blind, and additional diabetes supplies specified by the Commissioner of Health. • Diabetic Equipment, such as blood glucose monitor, blood glucose monitor for the legally blind, injection aids, insulin pumps and appurtenances, insulin infusion devices, data management systems and additional diabetes equipment specified by the Commissioner of Health.	$10 per item
Home health services	
Home health services ordered by your primary care doctor and provided by home health agency personnel, including registered nurses (RNs), licensed practical nurses (LPNs), and/or home health aides. Covered services include: • part-time or intermittent skilled nursing care (as defined by the Medicare program), • physical, occupational and/or speech therapy, • oxygen therapy, intravenous fluids and medications, and associated supplies. **NOTE:** Home health care is an alternative to hospital or skilled nursing facility care. This means that home health care is covered only if your condition would otherwise require hospitalization or confinement in a skilled nursing facility if home care services were not provided. The only exception is for Medically Necessary infusion therapy, which may be provided in your home if no reasonable alternative outpatient setting is available.	$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.*
Educational classes and programs	
Coverage is limited to: • Diabetes self-management	$10 per visit

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

IMPORTANT

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

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

IMPORTANT

Benefit Description	You pay
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 • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information.	$10 per visit when the surgery is performed on an outpatient basis. Nothing when the surgery is performed while you are inpatient in a hospital.

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 Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$10 per visit when the surgery is performed on an outpatient basis. Nothing when the surgery is performed while you are inpatient in a hospital.
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 when the surgery is performed on an outpatient basis. Nothing when the surgery is performed while you are inpatient in a hospital.
• 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 this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	See above.
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 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.	$10 per visit when the surgery is performed on an outpatient basis. Nothing when the surgery is performed while you are inpatient in a hospital.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogeneic 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) – Eligibility for all transplant evaluations, and for all transplant procedures must be pre-authorized by the Plan Medical Director. All transplant procedures must be performed at a facility designated by the Plan. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	$10 per visit when the surgery is performed on an outpatient basis. Nothing when the surgery is performed while you are inpatient in a hospital.
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* • *Investigational procedures* • *Travel and accommodations* • *Dual listings for transplants*	*All charges.*

Anesthesia	You pay
Professional services provided in – • Hospital (inpatient) • Skilled nursing facility	Nothing
Professional services provided in – • Hospital outpatient department • Ambulatory surgical center • Office	$10 per visit

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

IMPORTANT

Here are some important things to remember about these benefits:

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

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 • 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
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, extended care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Acquisition of blood and blood products*	*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: acquisition of blood and blood derivatives not replaced by the member.	*All charges.*

Extended care benefits/skilled nursing care facility benefits	You pay
Skilled nursing facility (SNF): • 45 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by your Plan doctor and approved by the Plan. • All necessary services are covered, including: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by your Plan doctor.	Nothing
Not covered: custodial care	*All charges.*
Hospice care	
• Supportive and palliative care for a terminally ill member in the home or hospice facility, when authorized by a Plan doctor who certifies that the patient is in the terminal stage of illness with a life expectancy of approximately six months or less. Coverage includes: • Up to 210 days of hospice care • Up to 5 grief counseling visits for family members	Nothing
Not covered: Independent nursing, homemaker services	*All charges.*
Ambulance	
• Local professional ambulance service when medically appropriate	$35 per service.

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 with Medicare.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

If you are in an emergency situation, we encourage you to call your Plan doctor. Otherwise, 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 us. 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.

Follow-up care after an emergency:

If you need to be hospitalized due to the emergency, you must notify the Plan within 48 hours or on the first working day following your admission, unless it was not reasonably possible to do so. If you are hospitalized in non-Plan facilities and your Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically appropriate with any ambulance charges covered in full.

After an emergency, contact your Plan doctor. Your Plan doctor must authorize and arrange all necessary follow-up care. Any follow-up care recommended by non-Plan providers must be approved by the Plan and provided by Plan providers.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$10 per visit $10 per visit $35 per visit
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	$10 per visit $10 per service $35 per service
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 medically appropriate. See 5(c) for non-emergency service.	$35 per service
Not covered: air ambulance, unless medically necessary	*All charges.*

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 with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

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

Mental health and substance abuse benefits - Continued on next page

Mental health and substance abuse benefits *(continued)*	**You pay**
• Diagnostic tests	$10 per visit
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Benefit – *CONTINUED*

Pre-authorization

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

- You must call the Plan's Behavioral Health Department at (800) 330-9314, to obtain authorization for treatment. You do not need a referral from your primary care physician.
- Your Plan doctor must obtain pre-authorization for inpatient mental health and substance abuse services, in the same way that pre-authorization is required for other inpatient services.

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.

Limitation

We may limit your benefits if you do not 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. • Certain prescription drugs may require pre-authorization from the Plan, due to their cost or possible use for purposes that are not medically necessary or appropriate. We have the right to determine whether a drug needs pre-authorization; a pre-authorization list, as updated by us from time to time, is available upon request. • Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.	IMPORTANT

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

- **Who can write your prescription.** A licensed physician, or other licensed health care provider legally authorized to prescribe under Title 8 of the New York State Education Law, must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy.
  - Pharmacies that participate in this Plan are located throughout the United States.
  - Through mail order. Call the plan at (800) 337-3338 for information on how to utilize the mail order process.
- **We do not use a formulary.** We employ a tiered pharmacy benefit design based on evidence-based medicine, nationally recognized guidelines and the recommendations of external advisory committees. Your copay depends upon the classification of a given drug into the first, second or third tier. Members have access to virtually all FDA-approved drugs, subject to medical necessity.
- **These are the dispensing limitations.** Retail pharmacies will dispense supplies of up to 30 days. Certain medications are subject to quantity limitations based on their potential for inappropriate or unsafe use, or status as a "lifestyle" drug. For example, Viagra is limited to 6 pills per month, or 52 per year. Members may refill medications after 80% of the previous dispensing has been used, except for those medications subject to quantity limitations.
- **When you have to file a claim.** If you are required to pay for your prescription up front, you may submit your pharmacy label receipt to us for consideration of payment. Medications that require pre-authorization will still need to meet the medical guidelines established by Univera for coverage.

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. • Disposable needles and syringes for the administration of covered medications Note: disposable needles and syringes for the administration of Insulin are covered under Diabetic care, Section 5(a). • Drugs for sexual dysfunction (see prior authorization) • Contraceptive drugs and devices	$5 per 30-day supply of a first tier drug. $15 per 30-day supply of a second tier drug. $35 per 30-day supply of a third tier drug. .
Here are some things to keep in mind about our prescription drug program: • A generic equivalent may be dispensed if it is available, unless your physician specifically requires a name brand. • To order a prescription drug brochure, call (800) 337-3338. • Classification of a drug into a given tier is at the discretion of the Plan.	
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Drugs available without a prescription or for which there is a nonprescription equivalent* • *Drugs to enhance athletic performance* • *Medical supplies such as dressings and antiseptics* • *Drugs prescribed for weight loss*	*All charges.*

Section 5 (g). Special Features

Feature	Description
Services for deaf and hearing impaired	Call 800-662-1220. The Deaf Adult Services Phone Line will connect you to our Plan.
Centers of excellence for transplants/heart surgery/etc.	The Plan participates with LifeTrac Centers of Excellence for transplants. Contact the Plan at 800-337-3338 for further information.
Travel benefit services overseas	You are covered for emergency services anywhere in the world.

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 with 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.	You pay $10 per visit.
Dental benefits	
We have no other dental benefits.	

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

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

Health Education Programs

- Prepared Childbirth Classes are designed to help both parents prepare for birth through exercise, relaxation and communication.
- Adult Weight Control is a program to help modify habits, improve exercise practices and develop other life skills which can help manage weight.
- Smoking Cessation assistance options offered include coverage of American Lung Association and Roswell Park classes; American Cancer Society classes; Univera Healthcare nicotine dependency clinics; and Freedom From Smoking Workbooks.
- Arthritis Education is a designed to help increase a participant's flexibility, strength, and balance.
- Diabetes Education teaches nutrition, self-care and monitoring skills necessary to cope with diabetes.
- Nutritional Counseling relates to the management of disease or medical condition.
- Cardiopulmonary Resuscitation (CPR) Adult and Pediatric combined or pediatric alone programs follow the guidelines of the American Heart Association.

There is a registration fee for some of the programs, however, special arrangements are available for financial hardship. Some programs require a referral from your Plan doctor.

Dental Services

- Preventive dental services are available from a select list of Western New York dentists through Univera Healthcare's Dental Discount Program. A set of services includes an examination, bite-wing x-rays and a prophylaxis. Limited to one set of services every six months and subject to a $35 copayment for each set of services received.

Vision Services

- As part of your vision coverage, you can take advantage of discounts through Vision Service Plan (VSP), a nationally recognized vision services provider. You can receive a 20% discount on lenses and frames and a 15% discount on fitting fees for contact lenses from participating providers.

Acupuncture and Massage Therapy

- Professional acupuncture and massage therapy services are available at a 20% discount from participating providers. You must present your identification card to the participating providers. Fees for services will be posted at participating locations.

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, and we agree, as discussed under *What Services Require Our Prior Approval* on page 10.**

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 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 HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at (800) 337-3338.

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

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

Submit your claims to: Univera Healthcare-WNY, Customer Service Department, 205 Park Club Lane, Buffalo, NY 14221-5239. Please call the Plan's Customer Service Department at (800) 337-3338 regarding claims payments.

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 pre-authorization:

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: Univera Healthcare-WNY, Customer Service Department, 205 Park Club Lane, Buffalo, NY 14221-5239; 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 III, 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 pre-authorization/prior approval, then call us at (800) 337-3338 and we will expedite our review; or

(b) We denied your initial request for care or pre-authorization/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 III 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 health care expenses without regard to fault. This is called "double coverage."

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

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

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 provided, directed, authorized or arranged by your Plan PCP, or pre-certified by the Plan if applicable.

We will not waive any of our copayments or coinsurance.

(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 re-employed annuitant with the Federal government when… a) The position is excluded from FEHB, or	✓	
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	✓	
b) Are an active employee		✓

- **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. 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 or coinsurance.

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 managed care plan 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 members, eligible dependents of military persons, 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 11.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 11.

Covered services

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

Custodial care

Any service that can be provided by an average individual who does not have medical training. Examples of Custodial Care include:

a. Assistance in performing activities of daily living such as feeding, dressing, or preparation of special diets;
b. Administration of oral medications, routine changing of dressing or preparation of special diets;
c. Assistance in walking or getting out of bed;
d. Child care necessitated by the incapacity of a parent; or
e. Respite care.

Experimental or investigational services

Services that do not have Food and Drug Administration (FDA) or comparable approval to market for those specific indications and methods of use being considered. Approval to market means permission for commercial distribution.

Medical necessity

Medical necessity refers to our determination that a covered service is essential for the diagnosis and/or treatment of your condition, disease or injury.

Us/We

Us and we refer to Univera Healthcare.

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 (877) 800-0910 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.

NOTES:

Summary of benefits for Univera Healthcare WNY - 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	13
Services provided by a hospital: • Inpatient ..... • Outpatient.....	Nothing Nothing	29 30
Emergency benefits: • In-area ..... • Out-of-area.....	$35 per emergency room visit $10 per urgent care center visit	33 33
Mental health and substance abuse treatment	Regular cost sharing.	34
Prescription drugs.....	*$5 first tier* *$15 second tier* *$35 third tier*	37
Dental Care.....	No benefit.	40
Vision Care..... One annual eye refraction	$10 per visit	20
Special features: Services for deaf and hearing impaired, Centers of excellence for transplants, travel benefits		39
Protection against catastrophic costs (your out-of-pocket maximum).....	No benefit.	NA

2001 Rate Information for
Univera Healthcare – WNY
(formerly HealthCarePlan)

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
Western New York State							
Self Only	Q81	$61.22	$20.41	$132.65	$44.22	$72.45	$9.18
Self and Family	Q82	$173.48	$57.82	$375.86	$125.29	$205.28	$26.02