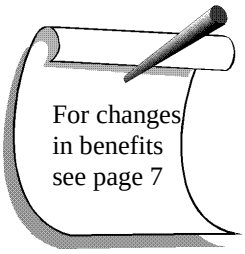
UNITY HEALTH PLANS INSURANCE CORPORATION

http://www.unityhealth.com

2001

A Health Maintenance Organization



Serving: *Southern and Central Wisconsin*

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

Enrollment codes for this Plan:

W41 Self Only
W42 Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
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Introduction

Unity Health Plans Insurance Corporation
840 Carolina Street
Sauk City, WI 53583

This brochure describes the benefits of Unity Health Plans under our contract (CS 2268) 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 51. 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 Unity Health Plans.

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.

We will provide coverage to you for the services of a provider, regardless of whether the provider is a participating provider at the time services are provided, if the provider was represented as a participating provider in the marketing materials that were provided or available to you for the current benefit year and if the following conditions apply:

1. If your chosen PCP leaves the Unity Health Plans Network, you will be able to continue seeing that provider through the end of the contract year for your plan. OR
2. If you are seeing a specialist who leaves the Unity Health Plans Network, you will be able to continue seeing the specialist:
   a. if you are pregnant and in your second or third trimester, through the end of your postpartum period. OR
   b. for 90 days past the provider's termination date with Unity Health Plans or through the end of the course of treatment, whichever is shorter.
3. This provision will not apply if the provider is termed from Unity Health Plans for misconduct or the provider is no longer practicing in our service area.

Unity Health Plans is a mixed model HMO contracting with the Community Physicians Network (CPN), local community hospitals, and the UW Health Medical Center. When you enroll, each member must select a primary care physician (PCP) from our list of over 647 participating PCPs. Approximately 2,409 doctors are available by referral for specialty care. Please choose your PCP carefully; your choice is very important. Your PCP provides or obtains authorizations for all treatments and services covered by Unity Health Plans. Your PCP will coordinate and manage your entire health program. You need the expert advice that your PCP can provide you. Together you can develop the health care program that is best suited to your lifestyle.

Your PCP can take care of most problems directly. If other services are necessary, he or she will direct you to the right sources for x-rays, lab tests, or whatever you may need. Your PCP will decide if you need to see another doctor. All referrals to other doctors must be made in writing by your PCP and approved by our Medical Management. It is your responsibility to make sure that the referral is approved before you see the doctor.

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.

- Unity Health Plans is licensed in the State of Wisconsin as an insurance corporation. The articles of incorporation for HMO of Wisconsin, Inc. were filed and approved by the state on April 1, 1987, and modified with the name change to Unity Health Plans Insurance Corporation on March 3, 1995. Prior to incorporation, HMO of Wisconsin was a not for profit chapter 613 service insurance corporation established in 1983.
- Unity is an Insurance Corporation, organized pursuant to Chapter 611 of the Wisconsin Revised Statutes and has been in existence for 13 years.
- We are a for profit company.

If you want more information about us, call 800/362-3310, or write to Unity Health Plans, 840 Carolina Street, Sauk City, WI 53583. You may also contact us by fax at 608/643-2564 or visit our website at www.unityhealth.com.

Service Area

To enroll with us, you must live or work in our service area. This is where our providers practice. Our service area is the Wisconsin counties of:

Adams	Dodge	Green Lake	Lafayette	Sauk
Columbia	Fond du Lac	Iowa	Marquette	Vernon
Crawford	Grant	Jefferson	Richland	Waushara
Dane	Green	Juneau	Rock	

You must get your care from providers who contract with us. If you receive care outside of our service area or from non-participating providers, we will only pay for emergency care. We will not pay for any other health care services.

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 Unity Customer Service at 800/362-3310, **or** checking our website www.unityhealth.com. 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 applied only to women.

Changes to this Plan

- Your share of the non-Postal premium will increase/decrease by 9.5% for Self Only or 19.2% for Self and Family.
- We now have no out of pocket-of-pocket maximum. Previously there was an out -of-pocket maximum of $4,200 per Self Only or $11,000 Self and Family enrollment per calendar year.
- We now pay 100% for medically appropriate ambulance transportation when medical attention is required in route. Previously we paid up to $300 per occurrence for ground transportation and $1000 per occurrence for air ambulance and 80% of charges thereafter.
- Skilled nursing facility benefits have changed from 120 days per calendar year to 90 days following a covered hospital confinement when admitted for continued treatment of the same condition to the skilled nursing facility within 24 hours of discharge from a hospital.
- The copay for emergency services provided at a hospital has increased from $25 to $50.
- You now pay a $10 office copay for your annual eye refraction.
- You will now pay a $6 copay for generic medications included on the formulary, $12 for a brand name medication on the formulary, and $24 for a non-formulary medication. Previously you paid $5 for a generic drug and $10 for a brand name drug. Drugs will now be dispensed in a 30 day supply rather than a 34 day supply.
- Treatment for accidental injury to teeth must now begin within three (3) months of the accident and will be

covered for a maximum of twelve (12) months after treatment begins. Previously treatment only had to begin within three (3) months of the accident.

- There is now a $500 penalty for not notifying us of an urgent or emergency inpatient admission to a non-participating provider within 72 hours or three (3) business days following your admission or as soon thereafter as reasonably practical. We previously had this same notice requirement, but not the penalty.

- The counties of Chippewa and Eau Claire have been eliminated from the Plan's Service Area.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card. 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 800/362-3310.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, 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 all medical doctors according to national standards. Your provider's clinic may assist you with specific questions regarding the board certification status, residency, and educational background of a particular provider.

We list Plan providers in the provider directory, which we update periodically. This directory is divided into three sections that each list PCPs, hospitals, and specialists. It's important to note that all of your care must be obtained from the Plan providers listed in the same section as your PCP. **If you seek care from a provider listed in a section other than the one your PCP is in, it will be considered the same as receiving care from a non-Plan provider.** The introduction of our Provider Directory also explains this in more detail. The list is also on our website.

- **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. To select your primary care physician, call Customer Service at 800/ 362-3310 and tell them whom you have chosen.

- **Primary care**

Your primary care physician can be a family or general practitioner, pediatrician, internal medicine doctor, or an OB-GYN physician. 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. If we receive your request to change your primary care physician on or before the 20th day of the month, the change will become effective the first day of the following month.

• Specialty care

Your primary care physician will make a written referral request and submit it to Unity's Medical Management for review. It is your responsibility to make sure the referral request is approved before you receive care. However, you may see Plan behavioral health providers, chiropractors, OB-GYN physicians and ophthalmologists/optometrists for your annual eye exam without a referral from your primary care physician.

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 Unity Health Plans' Medical Management 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 or, if we drop out of the Program, contact your new plan.

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

• Hospital care

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800/362-3310. 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 must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. 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 prior authorization or pre-authorization. Your physician must obtain prior authorization for services such as treatment from a specialist or durable medical equipment and supplies.

Your physician will handle any prior authorization request to Medical Management. The request will include:

1. The specific type and extent of care, durable medical equipment, or supply which is necessary;
2. The number of visits, or the period of time during which care will be provided;
3. The name of the Plan provider to whom you are being referred.

You are also required to notify us of all urgent or emergency inpatient admissions no later than 72 hours or three (3) business days following the day of admission, or as soon thereafter as reasonably possible. Please call us at 800/362-3310, between 7:00 AM and 5:00 PM (Central Time), Monday through Friday, to provide notice of all such admissions.

If you fail to provide the required notice of an emergency inpatient admission to a non-Plan provider, within the timeframe described above, your benefit will be reduced by $500.00. This section does not reduce state mandated Mental Health/AODA or kidney transplant benefits.

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**	We do not have a deductible
•**Coinsurance**	Coinsurance is the percentage of our negotiated fee that you must pay for your care. Example: In our Plan, you pay 20% of our allowance for durable medical equipment and supplies.
•**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 51 for a benefits summary.)

NOTE: This benefits section is broken into subsections. Please read the important things you should keep in mind at the beginning of each subsection. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 800/362-3310 or at our website at www.unityhealth.com.

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- 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	$10 per visit
Professional services of physicians · In an urgent care center · During a hospital stay · In a skilled nursing facility · Initial examination of a newborn child covered under a family enrollment · Office medical consultations · Second surgical opinion	$10 per visit
At home	Nothing
Not covered: · *Hearing aid exams* · *Homemaker services and private duty nursing*	*All charges*

Lab, X-ray and other diagnostic tests	
Tests, such as: · Blood tests · Urinalysis · Non-routine pap tests · Pathology · X-rays · Non-routine Mammograms · Cat Scans/MRI · Ultrasound · Electrocardiogram and EEG	Nothing if you receive these services during your office visit; otherwise, $10 per visit
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 ●● 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	$10 per visit
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Routine Immunizations, limited to: · Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) · Influenza vaccine, annually, age 65 and over · Pneumococcal vaccines, a one time vaccine, 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	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 page 10 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* *· Expenses related to surrogate mother services*	*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, genetic counseling* *· genetic counseling* *· contraceptive medications or devices that are available without a prescription*	*All charges.*
Infertility services	**You pay**
Diagnosis and treatment of infertility, such as: ·Artificial insemination: ••*intravaginal insemination (IVI)* ••*intracervical insemination (ICI)* ••*intrauterine insemination (IUI)*	$10 per visit
Not covered: *·Assisted reproductive technology (ART) procedures, such as:* ••*in vitro fertilization* ••*embryo transfer and GIFT* *· Services and supplies related to excluded ART procedures* *· Cost of donor sperm* *· Fertility drugs*	*All charges.*
Allergy care	
· Testing and treatment · Allergy injection	$10 per visit
· Allergy serum	Nothing
Not covered: provocative food testing and sublingual (under the tongue) allergy desensitization, testing, and/or treatment	*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 24. ·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 we preauthorize the treatment. Have your doctor submit a written referral to Medical Management for preauthorization. We will ask that information be submitted to establish that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. 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 three (3) months per condition if significant improvement can be expected in three (3) months: ••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 following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 36 visits in a 12 week period	Nothing
Not covered: *·long-term rehabilitative therapy* *·exercise programs* *·maintenance therapy for chronic conditions* *· physical, speech, and occupational therapy are not covered for the following conditions: learning disabilities; developmental delay; communication delay; perceptual disorder; mental retardation or related conditions; behavior disorders; multiple handicapped; sensory deficit; and motor dysfunctions*	*All charges.*

Hearing services (testing, treatment, and supplies)	
·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* *·cochlear implants*	*All charges.*
Vision services (testing, treatment, and supplies)	**You pay**
· Eye exam to determine the need for vision correction for children through age 17 (see preventive care) · Annual eye refraction without a referral. More than one (1) exam in a one year period requires a written referral request from your PCP.	$10 per visit
Not covered: *·Eyeglasses, contact lenses, and fittings for contact lenses* *· Dispensing fees* *·Eye exercises and orthoptics* *·Kerato-refractive eye surgery including, but not limited to, tangenital, radial keratotomy and other refractive surgery*	*All charges.*
Foot care	**You pay**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$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 except when performed by your PCP.* *·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**
·The initial acquisition of 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, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5 (c) for payment information. See 5(b) for coverage of the surgery to insert the device.	20% coinsurance

· Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. All nonsurgical treatment, intraoral splints, and therapy devices and appliances are subject to an annual treatment limitation of $1,250.00.	All charges after $1,250.00 annually
Not covered: · *orthopedic and corrective shoes* · *arch supports* · *foot orthotics* · *heel pads and heel cups* *foot pads and bunion covers* · *lumbosacral supports* · *corsets, trusses, elastic stockings, support hose, over-the-counter shoe inserts, supports and elastic bandages, and other supportive devices*	*All charges.*
Durable medical equipment (DME)	**You pay**
Rental or purchase, at our option, of DME prescribed by your plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: · hospital beds; · wheelchairs, we will only cover one (1) power/motorized/customized wheelchair per lifetime; · splints, crutches, trusses, orthopedic braces and appliances; · walkers; · blood glucose monitors; and · insulin infusion pumps, limited to one per calendar year. Note: Call us at 800/362-3310 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% coinsurance

Not covered: *· Customization of vehicles and/or lifts for the wheelchairs and/or scooters Motorized wheel chairs* *· Supplies and equipment which are not primarily intended for medical use, such as air conditioners, exercise bicycles, filter vacuum cleaners, etc.* *· Disposable supplies and equipment, such as batteries, antiseptics, and tape* *· Any and all types of modifications to your home and the items associated with the modifications, including but not limited to ramps, grab bars, stair lifts, and chair lifts* *· Repair of DME* *· Replacement of DME unless the item is no longer useful; the original equipment is no longer appropriate for the member's condition; the replacement must not be a deluxe or more advanced technology model t than required; and the replacement request has been prior authorized by us.*	*All charges.*
Home health services	
·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.	nothing
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	
Chiropractic services	$10 per visit
Not covered: *· acupuncture* *· naturopathic services* *· hypnotherapy* *· biofeedback* *· massage therapy*	. 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 have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- 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. · Voluntary sterilization · Norplant (a surgically implanted contraceptive) · 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

Surgical procedures *(Continued)*	**You pay**
Not covered: *·Reversal of voluntary sterilization and related procedures* *·Routine treatment of conditions of the foot; see Foot care.* *· Plastic surgery primarily for cosmetic purposes.* *· Transplants not listed as covered and anti-rejection and immuno-suppressive drugs, and follow-up care which is received as a result of treatment for non-covered transplant procedures.* *· Breast augmentation and any treatment for complications resulting from these procedures. This exclusion does not apply to the reconstruction of affected tissues incident to a mastectomy.*	*All charges.*
Reconstructive surgery	
·Surgery to correct a functional defect ·Surgery to correct a condition caused by injury or illness if: ••the condition produced a major effect on the member's appearance and ••the condition can reasonably be expected to be corrected by such surgery ·Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. ·All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance 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
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	

Oral surgical procedures, limited to: · Reduction of fractures of the jaws or facial bones due to an accident; · Surgical correction of cleft lip, cleft palate or severe functional malocclusion; · Cutting of accessory sinuses, salivary glands or ducts; · Excision of leukoplakia or malignancies; · Excision of cysts and incision of abscesses when done as independent procedures; · Surgical removal of bony or tissue impacted teeth; · Removal of apex of tooth root (apicoectomy); · Removal of exostosis of the jaw and hard palate; · External and internal incision and drainage of cellulitis; · Frenectomy; · Vestibuloplasty -- surgical modification of the gingival-mucous membrane relationship in the vestibule of the mouth; and · Residual root removal or root amputation	$10 per visit
Not covered: *·Oral implants and transplants* *·Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* *· Oral surgical procedures which are related to the correction of functional deformities of the mandible or maxillae* *· Procedures that reposition the mandible or maxillae* *· Procedures to correct malocclusion* *· Non-surgical procedures such as the extraction of teeth by pulling, root canal procedures, and filling, capping, recapping or dental implants.*	*All charges.*
Organ/tissue transplants	**You pay**

Limited to: ·Cornea ·Heart ·Heart/lung ·Kidney ·Kidney/Pancreas ·Liver ·Lung: Single –Double ·Pancreas ·Allogeneic (donor) bone marrow transplants; Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
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) Professional services provided in – · Hospital outpatient department · Skilled nursing facility · Ambulatory surgical center · Office Dental anesthesia services for dental care are covered under certain circumstances and subject to referral and prior authorization. These services are available if any of the following applies: · The member is a child under 5 years of age. · You have a chronic disability that meets all of the conditions under s.230.04(9r)(a)2 of Wisconsin state law. · You have a medical condition that requires hospitalization or general anesthesia for dental care.	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 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. 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 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**
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* *·Take-home drugs and supplies dispensed at the time of hospital discharge that can be purchased on an outpatient basis whether billed directly or separately by the hospital*	*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 · Blood and blood plasma, if not donated or replaced · Pre-surgical testing · Dressings, casts, and sterile tray services · Medical supplies, including oxygen · Anesthetics and anesthesia service NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Not covered: blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/skilled nursing care facility benefits	**You pay**
Limited to 90 days per covered confinement when you are admitted within 24 hours of discharge from a hospital for continued treatment of the same condition.	Nothing
Not covered: custodial care	*All charges*
Hospice care	
Limited to six months per member per year. Services must be authorized by us in advance and provided under the direction of a plan doctor.	Nothing
Not covered: *· Independent nursing* *· homemaker services*	*All charges*

Ambulance	
· Local professional ambulance service when medically appropriate and medical attention is required in route. · Air ambulance services require prior authorization by us.	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 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:

- Call your PCP if time permits.
- Go to the nearest hospital or call 911.
- Whenever possible, use a participating hospital.
- Have someone show your Unity Member ID card to the emergency room hospital staff.
- Notify us within three business days following any emergency treatment, unless it is not reasonably possible to notify us.
- Notify your PCP of your emergency care. Your PCP can coordinate any necessary follow-up services.
- If an ER physician refers you to a specialist for a follow-up visit, call your PCP before seeing the specialist. All referrals to specialists must come from your PCP. Out of area referrals require prior authorization from Unity Medical Management.

Benefit Description	You pay
Emergency within our service area	
· Emergency care at a doctor's office	$10 per visit
· Emergency care at an urgent care center	$10 per visit
· Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: If you use a non-participating provider for emergency care services and do not notify us within three (3) business days of receiving the care, your benefit will be reduced by $500. If you are admitted as an inpatient directly from the emergency room, your copay will be waived.	$50 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 Note: If you use a non-participating provider for emergency care services and do not notify us within three (3) business days of receiving the care, your benefit will be reduced by $500. If you are admitted as an inpatient directly from the emergency room, your copay will be waived.	$10 per visit $10 per visit $50 per visit
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. Air ambulance services require prior authorization by us.	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 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	
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 · Diagnostic tests	$10 per visit
· Services provided by a hospital or other facility · Services in approved alternative care settings such as partial hospitalization, 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.*

Preauthorization

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

If your PCP is located in a county other than Dane County or the communities of Black Earth or Cambridge, you must call Innovative Resource Group at 800/989-2792 for prior authorization of your behavioral care. They can assist you in selecting an appropriate provider and then work with your provider to ensure that your treatment plan meets your specific needs.

If your PCP is in Dane County (except for the communities of Black Earth or Cambridge) you do not need a referral for seeing a UW Health provider. All inpatient care requires pre-authorization and you must call Medical Management at 888/829-5687.

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.
- 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 must write the prescription.

·**Where you can obtain them.** You must fill the prescription at a plan pharmacy

· **We use a formulary.** Our prescription drug formulary is a pharmacy tool used by our participating clinic providers and pharmacists. The formulary is a list of prescription drugs covered under most Unity policies. The formulary assists in the management of drug selections and promotes proper use of prescription drugs. Unity Health Plans does not cover all prescriptions. Some prescriptions may require prior authorization. If you would like to check the status of a request, contact our Pharmacy Services Department at 1-800-603-7078.

· **These are the dispensing limitations.** Members shall be limited to the amount of prescription drugs prescribed by the physician, but not exceeding a 30-day supply; or one commercially prepared unit, whichever is less. Examples of a commercially prepared unit include, but are not limited to: (1) one inhaler; (2) one vial ophthalmic medication; (3) one Imitrex packet (9 tablets), (4) one vial of Insulin. Also, the quantity of glucose sticks/strips a member may purchase at one time is limited to 100. If the prescription drug is one that is determined by us to be a maintenance drug, you may receive up to a 102 day supply.

·**When you have to file a claim.** Mail to: 903 Oregon Street, Oshkosh, WI 54901

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 : · Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. · Oral contraceptive drugs –up to a three cycle supply may be obtained for a single copay. · Insulin, with one copay charge per vial · Insulin syringes, and glucose test strips · Disposable needles and syringes for the administration of covered medications · Drugs for sexual dysfunction (see Prior Authorization below) · Contraceptive drugs and devices, including Norplant (which is covered under surgical services)	$ 6 per generic drug $ 12 per brand name drug $24 per non-formulary drug Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
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. ·We administer an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 800/362-3310.	
Covered medications and supplies (cont)	**You Pay**

Not covered: *·Drugs and supplies for cosmetic purposes* *·Vitamins, nutrients and food supplements even if a physician prescribes or administers them* *·Nonprescription medicines* *· Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies.* *· Appetite suppressants including anti-obesity and anorexients.* *· Fertility drugs* *· Medical supplies such as dressings and antiseptics* *· Smoking cessation drugs and medication, including nicotine patches* *· Drugs for cosmetic purposes* *· Drugs to enhance athletic performance, including anabolic steroids* *· Medications used to prevent or treat hair loss* *· Any irrigation solutions or supplies*	*All Charges*

Section 5 (g). Special Features

Feature	Description
Services for deaf and hearing impaired	TDD is available by contacting us at 608/643-1421.

Section 5 (h). Dental benefits

IMPORTANT

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

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

IMPORTANT

Accidental injury benefit

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. Coverage for injuries resulting from eating accidents is excluded. Treatment must begin within 90 days after the accident and will be covered for a maximum of twelve months after treatment begins. You pay nothing up to $1000 per accident and all charges thereafter.

Dental benefits

We have no other dental benefits.

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.**

- 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 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 800/362-3310.

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 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: Unity Health Plans, 840 Carolina Street, Sauk City, WI 53583

Prescription drugs

Submit your claims to: 903 Oregon Street, Oshkosh, WI 54901

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: Unity Health Plans, 840 Carolina Street, Sauk City, WI 53583 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 (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your medical 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, Branch II, P.O. Box 436, Washington, D.C. 20044-0436. 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 800/362-3310 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 III, Branch 2 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

•What is Medicare?

Medicare is a Health Insurance Program for:

•• People 65 years of age and older.

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

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

Medicare has two parts:

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

•• 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 PCP must continue to submit necessary written referrals for authorization by Medical Management.

We will not waive any of our copayments and 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 reemployed 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, or	✓	
b) Are an active employee		✓

Most Unity Health Plans providers accept Medicare assignment. When using these providers, you do not need to submit anything to us. In those few cases when a provider does not accept assignment, we will notify you if a copy of your Explanation of Medicare Benefits (EOMB) is needed.

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in a Medicare+Choice plan. To learn more about enrolling in a Medicare+Choice plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare+Choice plan, the following options are available to you:

This Plan and another Plan's Medicare+Choice plan: You may enroll in another plan's Medicare+Choice plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare+Choice plan is primary, but we will not waive any of our copayments, coinsurance, or deductibles

Suspended FEHB coverage and a Medicare+Choice plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan. 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 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

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. We reserve the right to be provided notice of any claim against a third party and you agree to cooperate in protecting our interest and providing necessary information to us upon request. 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.

Coinsurance

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

Covered services

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

Custodial care

Custodial care includes room and board, nursing care, personal care or other care which is designed to assist an individual in the activities of daily living, e.g., eating, dressing, help in walking, supervision of meals. It is care and treatment that generally is received by an individual who has reached the maximum level of recovery in the opinion of his/her physician. In the case of an institutionalized person, custodial care also includes room and board, nursing care, or other such care which is provided to an individual for whom it cannot reasonably be expected, in the opinion of the attending physician, that medical or surgical treatment will enable that person to live outside of the institution. Custodial care also includes rest care, respite care and home care provided by family members. Care may still be considered custodial as determined by us if: a) the member is under the care of a physician; b) the physician prescribes services to support and maintain the member's condition; or c) services and supplies are being provided by a registered nurse or licensed practical nurse.

Experimental or investigational

Experimental or investigational treatment or services are those drugs, procedures, surgeries, equipment and devices that do not meet each of the criteria below, as determined by Unity Health Plans: 1) the services must have FDA approval; 2) scientific evidence must permit conclusions concerning the effect on health outcome; and 3) the research and experimental stage of the development of the treatment or service must be completed. These types of treatment or services are subject to review by Unity Health Plans in accordance with the policies and procedures of the Unity Health Plans Technology Assessment Sub-Committee. Copies of these policies and procedures may be obtained by calling Unity Health Plans Customer Service at 800/362-3310.

Medical necessity

Services, treatments, or supplies that are provided by a hospital, physician, or licensed health care provider. These services or treatments must be necessary in order to identify or treat sickness or injury. Your attending physician in conjunction with our Medical Director must determine them to be: 1) consistent with the symptoms or diagnosis and treatment of your sickness or injury; and 2) appropriate with regard to standards of acceptable medical practice; and 3) not solely for the convenience of you, a physician, hospital or other health care provider; and 4) the most appropriate supply or level of service that can safely be provided to you; and 5) not primarily for cosmetic improvement of your appearance regardless of psychological benefit.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. It is the usual, customary, and reasonable amount we allow for a covered service rendered by a provider. We determine the usual, customary, and reasonable charge for an item or service. A usual, customary, and reasonable amount is not more than the following:

1) The usual charge, which is the fee charged by the provider for service or item to majority of his/her patients.
2) The customary charge, which is the fee that falls within a range of the usual charges of most providers in a geographic area that will generate a statistically credible claims distribution for the same or similar service.
3) The reasonable charge, which is the usual and customary charge taking into consideration the complexity of treatment for a particular case.
4) A charge is negotiated by us with a participating provider. If a provider is not a participating provider, we shall pay based on the usual, customary, and reasonable amount of the covered service.

Us/We

Us and we refer to Unity Health Plans

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 (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 800/362-3310 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.

Summary of benefits for Unity Health Plans - 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	14
Services provided by a hospital: • Inpatient • Outpatient	Nothing *Day surgery, Nothing* *Walk-In, $10 copay*	26 27
Emergency benefits: • In-area • Out-of-area	$50 per emergency room visit $50 per emergency room visit	28 29
Mental health and substance abuse treatment	Regular cost sharing	30
Prescription drugs	*$6 Generic* *$12 Name Brand Formulary* *$24 Name Brand Non-Formulary* *Cost sharing applies when generic is available*	32
Dental Care	No benefit.	35
Vision Care	$10 Annual Routine Exam	19

2001 Rate Information for
Unity Health Plans Insurance Corporation

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	W41	$81.76	$27.25	$177.14	$59.05	$96.75	$12.26
Self and Family	W42	$195.82	$93.06	$424.28	$201.63	$231.17	$57.71