VALLEY HEALTH PLAN

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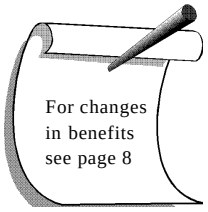
2001

A Health Maintenance Organization



Serving: West Central Wisconsin

Enrollment in this Plan is limited; see page 7 for requirements.

Enrollment codes for this Plan:

VH1 Self Only
VH2 Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
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FEHB
Federal Employees
Health Benefits Program

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Table of Contents

Introduction

Valley Health Plan, Inc.
2270 EastRidge Center
Eau Claire, WI 54701

This brochure describes the benefits of Valley Health Plan, Inc. under our contract (CS 2669) 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 8. 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 Valley Health Plan, Inc.

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?

Valley Health Plan is a group model HMO providing pre-paid health care. Services are providedby over 300 physicians in 35 different specialties and subspecialties including physicians at Midelfort Clinic - Mayo Health System,
Eau Claire's largest multi-specialty group medical practice. Our clinics are located throughout a 15 county service area.
Families must choose to receive their care from one of four options - Midelfort Option, Red Cedar Option, Cumberland
Option, or Indianhead Option. All family members must belong to the same option and are encouraged to choose a primary care physician from within their chosen option. Each family member may have a different primary care physician within their chosen option. Primary care physicians are those with a specialty in Internal Medicine, Pediatrics, and Family Practice.

Patients' Bill of Rights

Valley Health Plan has made a commitment to you by teaming up with our health care providers and support staff to Provide you with care for your health services. As part of the team, you work with the other players to get the care you need. Each team member has rights and responsibilities to make sure the best care is available. Take time to learn the roles of everyone on your health care team.

<u>Your role as a Valley Health Plan Member:</u>

- Use your Member Benefit Handbook as a guide to understanding what is and is not covered by Valley Health Plan.
- Call our Member Service Department to assist you in determining coverage or voicing concerns about the Plan or VHP providers (1-800-472-5411).
- Be active in all areas of your health and that of your family.
- Select and establish a relationship with one of the health plan's network of physicians.
- Make choices that help to maintain your health and prevent illness.
- Ask questions of your provider so you understand your health or illness.
- Follow the treatment plan agreed upon by your provider.

- Keep your appointment or give reasonable notice to the provider if you must cancel.
- Provide, to the extent necessary, information that Valley Health Plan and your provider need in order to care for you.

Patients' Bill of Rights (continued)

Your Doctor's Role:

- Get to know you and your health care needs.
- Provide or coordinate your care.
- Maintain quality standards for your care.
- Explain to you treatment options regardless of insurance coverage or cost.
- Inform you of the risks and benefits of treatment options.
- Encourage you to be active in the decisions about your treatment.

Valley Health Plan's Role:

- Provide identification cards and a benefit handbook.
- Provide information to explain what is covered and what is not covered under your policy.
- Provide assistance to help you understand your coverage.
- Tell you about the doctors, clinics, and hospitals that make up the provider network for Valley Health Plan.
- Ensure high quality of care.
- Manage your bills and claims.
- Allow you to voice concerns or problems you may have with Valley Health Plan or our providers by calling our Member Service Department.
- Allow you to appeal a decision you do not agree with.

Your Employer's Role:

- Select a health plan for employees.
- Provide help for you to understand your health plan.
- Communicate with Valley Health Plan if there are any problems.

Shared Responsibilities:

- Valley Health Plan will treat you with respect and dignity regardless of your race, age, sex or creed. We require our providers and their staff to do the same.
- We ask our members to also show respect and consideration to health care providers, provider staff, nurses, receptionists, etc., and to the staff at Valley Health Plan.
- We will ensure that information about your health and other information will be kept confidential to the extent required by the law.

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.

If you want more information about us, call 715/836-1254 or 800/472-5411, or write to Valley Health Plan, Inc., PO Box 3128, Eau Claire, WI 54702-3128. You may also contact us by fax at 715/836-1298.

Service Area

To enroll with us, you must live in our service area. This is where our providers practice. Our service area is:

The *Wisconsin* counties of Chippewa, Dunn, and Eau Claire.

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.

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 our Member Service Department at 715/836-1254 or 800/472-5411 **or** checking our website www.uwz.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 referenced only women.

Changes to this Plan

- Your share of the non-postal premium will increase by 68.8% for Self only or 54.3% for Self and Family.
- Valley Health Plan has reduced the service area to the following Wisconsin counties: Chippewa, Dunn and Eau Claire.
- Prescription Drugs: You pay a $10 copayment for brand name drugs and a $5 copayment for generic name drugs per prescription unit or refill.

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 715/836-1254 or 800/472-5411, extension 1254.

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.

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

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

- **Primary care**

Your primary care physician can be an internists, pediatrician, family practitioner or gynecologist. 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**

Referrals to a participating provider of the Plan for specialty care do not require prior written authorization from Valley Health Plan. A woman may see her plan gynecologist for her annual routine exam without a referral. Prior written authorization from Valley Health Plan is required when receiving care through providers not affiliated with Valley Health Plan except in the case of an emergency.

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 develop a treatment plan that allows you to see your Plan specialist without a referral.

- 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 usor, 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 715/836-1254 or 800/472-5411, extension 1254. If you are new to the FEHB Program, we will arrange for you to receive care.

Hospital Care (continued)

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 physician must get our approval before referring you to a non-Plan specialist. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice.

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 and when you go to the emergency room, you pay a $25 copayment. You have a $5 copay for generic prescriptions and $10 copay for brand name prescriptions.

- **Coinsurance**

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

Example: In our Plan, you pay 20% per purchase or rental on durable medical equipment and diabetic supplies up to your maximum out-of-pocket of $500. Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor up to $300 per occurrence, then 20% member coinsurance. Air ambulance is paid in full up to $1000 per occurrence, then 20% member coinsurance.

Your out-of-pocket maximum for coinsurance

After your coinsurance for Durable Medical Equipment (DME) and Diabetic Supplies total $500 per person in any calendar year, you do not have to pay any more for covered services.

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

Section 5. Benefits -- OVERVIEW

(See page 8 for how our benefits changed this year and page 51 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 715/836-1254.

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have 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.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Physician's home visit	 $10 per office visit $20 per visit
Professional services of physicians • In an urgent care center • Office medical consultations • Second surgical opinion	$10 per office visit
Lab, X-ray and other diagnostic tests	**You pay**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI (MRI's may require prior written VHP authorization, please contact VHP's Member Service Department) • Ultrasound • Electrocardiogram and EEG	Nothing if you receive these services during your office visit; otherwise, $10 per office visit
Preventive care, adult	**You pay**
Routine annual examination to include: • Prostate Specific Antigen (PSA test) – one annually • Routine pap test • Routine mammogram	$10 per office visit

Preventive care, adult – continued on next page

Preventive care, adult *(Continued)*	**You pay**
Not covered: Physical exams required for obtaining or continuing employment or insurance, pilot license, attending schools or camp, or travel.	*All charges.*
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years • Influenza/Pneumococcal vaccines, annually	$10 copay will apply to associated visit
Preventive care, children	**You pay**
Well-child care charges for routine examinations, immunizations and care (through age 22)	$10 per office visit
Maternity care	**You pay**
Complete maternity (obstetrical) care, such as: • Routine Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay 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 for routine prenatal care $10 per office visit for non-routine prenatal visits due to complications
Not covered: • *Tests solely for determination of fetal sex* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside of the VHP service area.*	*All charges*
Family planning	**You pay**
• Voluntary sterilization • Surgically implanted contraceptives (eg: Norplant) • Injectable contraceptive drugs (eg: Depo-Provera) • Intrauterine devices (eg: IUDs) • Genetic counseling	$10 copay will apply to associated visit

Family Planning – continued on next page

Family planning *(Continued)*	**You pay**
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)*	$10 per office visit
Not covered: • *Fertility drugs* • *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*	*All charges.*
Allergy care	**You pay**
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges*
Treatment therapies	**You pay**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 27. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis	Nothing

Treatment Therapies – continued on next page

Treatment therapies *(Continued)*	**You pay**
• Growth hormone therapy (GHT) Note: – We will only cover GHT when we preauthorize the treatment. ask your VHP physician to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date approved by VHP. 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.	Prescription drug copays apply (See 5 (f), pages 33-34)
• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy – Covered under Durable Medical Equipment benefit.	$10 copay per visit
Rehabilitative therapies	**You pay**
Short-term rehabilitative therapy (physical therapy, occupational therapy and speech therapy) using qualified physical therapists, speech therapists and occupational therapists. • Provided on an inpatient or outpatient basis for up to two months per condition if significant improvement can be expected within two months. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. 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. • Phase I (inpatient)and Phase II (outpatient) Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction. Phase II rehabilitation is covered three sessions a week for up to 12 weeks.	$10 per office visit
Not covered: • *long-term rehabilitative therapy* • *exercise programs* • *phase III cardiac rehabilitation*	*All charges.*

Hearing services (testing, treatment, and supplies)	You pay
• Hearing testing for medical diagnosis only • Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per office visit
Not covered: • *all other hearing testing (eg: for the purpose of hearing aids)* • *hearing aids, testing and examinations for them*	*All charges.*
Vision services (testing, treatment, and supplies)	**You pay**
One routine vision exam per calendar year • Annual eye refractions	$10 per office visit
Not covered: • *Eyeglasses, contact lenses and fittings* • *Internal Ocular Photographs* • *Vision therapy* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery(corrective eye surgeries)*	*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 office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*

Orthopedic and prosthetic devices	You pay
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses (one every two years) and surgical bras (four per year), following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Custom made orthotics • Elastic support hose (four pair per year) • Corsets • 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. Note: – We will only cover Orthopedic and prosthetic devices when you receive prior written VHP authorization. Ask your VHP physician to submit information that establishes that the device is medically necessary. Ask us to authorize the device before you begin treatment; otherwise, we will only cover services from the date the device is authorized. If the device is not medically necessary, we will not cover the device or related services and supplies.	You pay 20% up to a $500 annual maximum.
Not covered: • *Over-the-counter supplies/devices, even if purchased with a prescription* • *Cochlear implants* • *Over-the-counter orthopedic and corrective shoes* • *arch supports* • *over-the-counter foot orthotics* • *heel pads and heel cups* • *lumbosacral support* • *trusses* • *prosthetic replacements provided less than 3 years after the last one covered by VHP*	*All charges.*

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician. Prior written VHP authorization is required for some equipment, please contact VHP's Member Service Department to determine if prior authorization is required. Equipment may be subject to review to assure condition meets VHP's criteria. Under this benefit, we also cover: • oxygen and dialysis equipment • nebulizers; • bi-pap and c-pap machines; • hospital beds; • standard manual wheelchairs; • crutches; • walkers; • blood glucose monitors; • insulin pumps; • diabetic supplies, including insulin syringes, needles, gluose test tablets and tape, Benedict's solution or equivalent and acetone test tablets; • disposable needles and syringes needed to inject covered prescribed medication Note: –Ask us to authorize the device before you begin treatment; otherwise, we will only cover services from the date the DME is authorized. If the DME is not medically necessary, we will not cover the DME or related services and supplies.	You pay 20% up to a $500 annual maximum
Not covered: • *Motorized wheelchairs and scooters* • *Motor vehicles (e.g. cars, vans) or customization of vehicles, lifts for wheelchairs and scooters, and stair lifts* • *Whirlpools* • *Batteries or battery chargers* • *Over-the-counter equipment, even if purchased with a prescription* • *Eyeglasses or contact lenses expect as specified in this contract* • *Dentures* • *Medical supplies and durable medical equipment for comfort, person hygiene, and convenience items, such as, but not limited to, air conditioners, air cleaners, humidifiers; or physical fitness equipment; physicians equipment; disposable supplies; alternative communication devices; and self-help devices not medical in nature.* • *Equipment, models, or devices which have features over and above that which are medically necessary for the participant will be limited to the standard model as determined by VHP.*	*All charges.*

Home health services	You pay
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. Note: – We will only cover home health services when you receive prior written VHP authorization. Ask your VHP physician to submit information that establishes that the home health services are medically necessary. Ask us to authorize the services before you begin treatment; otherwise, we will only cover services from the date the home health services are authorized. If the services are not medically necessary, we will not cover the home health services or related charges.	$10 per home 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, dressing, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All charges.*
Alternative treatments	**You pay**
• chiropractic services • biofeedback, prior written VHP authorization required	$10 per office visit
Not covered: • *Acupuncture;* • *dry needling;* • *naturopathic services;* • *hypnotherapy;* • *massage therapy;* • *rolfing;* • *music therapy;* • *recreational therapy;* • *sensory integration treatment/therapy;* • *prolotherapy;* • *yoga therapy*	*All charges.*
Educational classes and programs	**You pay**
Coverage is limited to: • Diabetes self-management	$10 per office 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.
- 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. Look in Section 5 (c) for charges associated with the facility charge (i.e. hospital, surgical center, etc.).
- YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please contact VHP's Member Service Department.

IMPORTANT

Benefit Description	You pay …
Surgical procedures	**You Pay**
• 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. Prior written VHP authorization is required. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information. • Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) • 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.	Nothing, if services are provided in a hospital or outpatient surgical facility. $10 per office visit
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*

Reconstructive surgery	You pay
• 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.	Nothing, if services are provided in a hospital or outpatient surgical facility.
• 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.	.
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 office 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)* • *Periodontic care* • *General dental care* • *Orthodontics*	*All charges.*

Temporomandibular Joint Dysfunction (TMJ)	You pay
Diagnostic procedures and non-surgical treatment including: • Evaluations • Physical therapy • Chiropractic services Note: prior written VHP authorization is not required for the above TMJ services.	$10 copay per office visit
• Biofeedback, prior written VHP authorization required	$10 copay per office visit
• Splint therapy Note: prior written VHP authorization is required.	You pay 20% up to a $500 annual maximum.
• Surgical treatment Note: prior written VHP authorization is required.	Covered under the hospital benefit, you pay nothing, coverage is 100%
Not covered: • *Orthodontics* • *Periodontic care* • *General dental care*	*All charges.*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Parathyroid and musculoskeletal • 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 • National Transplant Program (NTP) - Note: Prior written VHP authorization is required. Coverage is limited to one transplant per organ per lifetime, except kidney. 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)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including 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 • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items used during a hospital confinement	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*	*All charges.*
Outpatient hospital or ambulatory surgical center	**You pay**
• 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, subject to VHP criteria Prior written VHP authorization is required. We do not cover the dental procedures.	Nothing
Extended care benefits/skilled nursing care facility benefits	**You pay**
Skilled nursing facility (SNF): 120 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate. Note: Prior written VHP authorization is required.	Nothing
Not covered: custodial care	*All charges*

Hospice care	You pay
Covers hospice care if the primary care provider certifies that the participants life expectancy is six months or less, the care is palliative in nature and authorized by VHP. Hospice care is provided by an inter-disciplinary team consisting of, but not limited to: registered nurses, home health or hospice aids, LPNs, and counselors. Hospice care includes, but is not limited to, medical supplies and services, counseling, bereavement counseling for one year after the participants death, durable medical equipment rental, home visits, and emergency transportation. Coverage may be continued beyond a six month period if authorized by VHP. Facility hospice does not include coverage for the room and board charges. Note: Prior written VHP authorization is required.	Nothing
Not covered: Independent nursing, homemaker services	*All charges*

Ambulance	You pay
Non-emergency ambulance transfers from one facility to another may be eligible for coverage by VHP, prior written VHP authorization is required.	Ground ambulance; You pay 20% of all charges over the first $300 Air ambulance; You pay 20% of all charges over the first $1,000
Not covered: Non-emergency ambulance services (eg: non-emergency van transportation, ambulance services where medical attention is not required en route)	*All charges*

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:

Emergencies within our service area: Seek emergency care from a VHP hospital provider whenever possible. If the emergency is life-threatening, go to the closest facility. You or a family member must notify VHP, unless it is not reasonably possible to do so, within 48 hours of the services, 715-836-1254 or 1-800-472-5411.

Emergencies outside our service area: Seek emergency care from the closest facility. You or a family member must notify VHP, unless it is not reasonably possible to do so, within 48 hours of the services, 715-836-1254 or 1-800-472-5411.

Follow-up care:

Follow-up care to an emergency needs to be provided by VHP providers to be covered by VHP.

Benefit Description	You pay
Emergency within our service area	**You pay**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$10 per office visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: *Waived if admitted as an inpatient directly from the ER.	$25 Emergency room copay per visit.*
Not covered: Elective care or non-emergency care with a non-VHP provider inside our service area.	*All charges.*

Emergency outside our service area	You pay
• Emergency care at a doctor's office • Emergency care at an urgent care center	$10 per office visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: *Waived if admitted as an inpatient directly from the ER.	$25 Emergency room copay 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* • *Follow-up to emergency care received with non-VHP providers*	*All charges.*

Ambulance	You pay
Professional ambulance service when medical attention is required en route. See 5(c) for non-emergency service.	Ground ambulance-You pay 20% of all charges over the first $300 Air ambulance; You pay 20% of all charges over the first $1,000
Not covered: ambulance services where medical attention is not required en route	*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.

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	Outpatient visits - $10 copayment per visit Transitional Care – 100% coverage, prior written VHP authorization is required when using non-VHP provider Inpatient Care – 100% coverage, prior written VHP authorization is required when using non-VHP provider
• Diagnostic tests	$10 copay will apply to associated visit.

Mental Health and substance abuse benefits – continued on next page

Mental Health and substance abuse benefits (Continued)	You pay
• Services provided by a Plan hospital or other Plan 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.*

Preauthorization

To be eligible to receive these mental health and substance abuse benefits you must follow your treatment plan and all of our network authorization processes. This includes:

Any Services with non-VHP providers require prior written VHP authorization. VHP is an HMO, in order for benefits to apply, you need to use VHP providers. If your VHP provider refers you to a non-VHP provider, you are responsible for obtaining prior authorization from VHP. To do this, contact the referring VHP provider and ask that they forward a request for authorization for services to VHP. We will review and will notify you in writing of the decision.

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 for reasons other than retirement, move from our service area, or misconduct, you may continue to receive care for up to 90 days.

If this condition applies to you, we will allow you reasonable time to transfer your care to a network mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider. This transitional period will begin with our notice to you. The transitional period will last for up to 90 days from the date you receive our notice. You may receive this notice prior to January 1, 2001, and the 90 day period begins with receipt of the notice.

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.
- There is not a calendar year deductible for prescriptions.
- Some medications may require prior written VHP authorization, please check with VHP's Member Service Department if you have any questions.
- 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 plan physician or licensed dentist must write the prescription .
- **Where you can obtain them.** You must fill the prescription at a VHP pharmacy. If you are out of the VHP service area and have an emergency care visit, we will cover the **initial** fill at a non-VHP pharmacy written by that emergency care provider.
- **We use a formulary.** VHP's drug formulary is used by our network providers. The formulary includes a large enough range of drugs, with sufficient information about them to enable health practitioners, physicians, and nurse practitioners to prescribe treatment that is medically appropriate. The drug formulary is the cornerstone of drug therapy quality assurance and cost containment efforts. The drug formulary process has been successfully used by hospitals and managed care organizations to provide comprehensive, cost-effective pharmacy services. Non-Formulary drugs will be dispensed if medically necessary and the formulary drugs are not suitable for the participant as determined by the VHP physician. Non-formulary drugs must be prior authorized by VHP. The formulary may be revised as deemed necessary by VHP.
- **These are the dispensing limitations.** A 34 day supply may be dispensed for a $5/generic or $10/brand copayment. VHP does have a limited maintenance drug list where a three-month supply may be obtained for one $5/generic or $10/brand copayment. Not all maintenance drugs are included on the maintenance drug listing. VHP determines the list by usage and cost factors. VHP does reserve the right to alter the maintenance drug listing or eliminate it at any time.
- **When you have to file a claim.** Eligible prescriptions written by VHP providers and filled at a VHP pharmacy will be submitted to us by the VHP pharmacy. You will be responsible for your copayment. If you have a receipt for an initial prescription fill as the result of emergency care received out of the VHP service area, please submit that receipt to VHP for reimbursement, less the appropriate copayment. Again, VHP will only cover the initial fill of a prescription from out-of-area emergency care, refills must be rewritten by your VHP physician and filled at a VHP pharmacy to be eligible for coverage.

Prescription drug benefits begin on the next page.

Benefit Description	You pay After the calendar year deductible
Covered medications and supplies	**You pay**
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. • Insulin • Drugs for sexual dysfunction (dosage limits apply, you pay applicable copayment up to the dosage limit established by VHP) • Contraceptive drugs Note: If there is no generic equivalent available, you will still have to pay the brand name copay.	$5 per 34 day supply of generic medications $10 per 34 day supply of brand medications
• Disposable needles and syringes for the administration of covered medications (See Section 5 (b), page 20).	Covered under the DME benefits. You pay 20% up to a $500 annual maximum.
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 have 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.	
Not covered: • *Appetite suppressants* • *Costs of any medication that exceeds VHP's dosage limitation* • *Replacement of lost, stolen, forgotten or destroyed prescriptions* • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Medications that have an over-the-counter equivalent available*	*All Charges*

Section 5 (g). Special Features

Feature	Description
24 hour line	For any of your health concerns, 24 hours a day, 7 days a week, you may call the on-call physician at your clinic. Please contact your clinic for on-call phone numbers.
Travel benefit/ services overseas	Valley Health Plan provides coverage world-wide for initial emergency care. Please contact VHP as soon as possible if you have an emergency out of our service area.

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.
- Benefit: preventive dental benefit for children ages 11 and under. Coverage includes annual oral exam, prophylaxis (cleaning) , annual topical application of fluoride, preventive dental instructions, bitewing x-rays.
- 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. Subject to VHP criteria Prior written VHP authorization is required. We do not cover the dental procedures.

IMPORTANT

Accidental injury benefit

Dental services rendered by a VHP Network Provider or with prior written VHP authorization to promptly repair, but not to replace, sound natural teeth., if the dental services are required as the result of non-occupational accidental injury. If services are required following the original emergency visit, a pretreatment estimate must be submitted to VHP for approval. Services completed within six months of the accident will be covered by VHP. Excludes coverage for damage done to natural teeth as a result of biting or eating. Sound natural teeth are those teeth without fillings or crowns, with a healthy viable root. You pay 20% of the first $500 in charges, nothing thereafter.

Dental Benefits

Service	You pay
Preventive dental for children ages 11 and under including: • Annual oral exam • Prophylaxis (cleaning) • Annual topical application of fluoride • Preventive dental instruction • Bitewing x-rays	$10 per office visit

Not Covered:

- *No other dental services are covered.*

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

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

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies for cosmetic or beautifying purposes;
- Therapies, as determined by VHP, for the evaluation, diagnosis or treatment of educational problems; or
- Hospital stays which are extended for reasons other than medical necessity, i.e. lack of transportation, lack of care-giver, inclement weather or other like reasons.

Section 7. Filing a claim for covered services

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

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

Medical, 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 715/836-1254 or 800/472-5411, extension 1254.

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: **Valley Health Plan**
PO Box 3128
Eau Claire, WI 54702-3128

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim within 12 months of the date of 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. Write to us at: 2270 EastRidge Center, PO Box 3128, Eau Claire, WI 54702-3128. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Valley Health Plan, Inc., 2270 EastRidge Center, PO Box 3128, Eau Claire, WI 54702-3128.; 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 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 715/836-1254 or 800/472-5411, extension 1254, 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 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 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 authorized by your Plan PCP, or precertified as required.

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

(Primary payer chart begins on next page.)

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

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when…		
a) The position is excluded from FEHB, 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……...……	……..	…….✓

- **Claims process**

You probably will never have to file a claim form when you have both our plan and Medicare and you are using VHP providers.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 715/836-1254 or 800/472-5411.
- We do not waive costs when you have Medicare.

- **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 our Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles.

Suspended FEHB coverage and a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare 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 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 12.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 12.

Covered services

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

Custodial care

Provision of room and board, nursing care, or personal care designed to assist an individual who, in the opinion of a plan physician, has reached the maximum level of recovery. In the case of confinement in a Hospital or nursing facility, Custodial Care also includes room and board, nursing care, or such other care which is provided to an individual for whom it cannot reasonably be expected, in the opinion of the Plan physician, that the medical or surgical treatment will enable that person to live outside an institution. Custodial care also includes rest cures, respite care, and home care provided by family members.

Experimental or investigational services

The use of any service, treatment, procedure, facility, equipment, drug, device or supply for a participant's illness or injury that, as determined by the Plan: (a) requires the approval by the appropriate federal or other governmental agency that has not been granted at the time it is used; or (b) isn't yet recognized as acceptable medical practice to treat that illness or injury for a Participant's illness or injury. The criteria that the Plan uses for determining whether or not a service, treatment, procedure, facility, equipment, drug, device or supply is considered to be experimental or investigative include, but are not limited to: (a) whether the service, treatment, procedure, facility, equipment, drug, device or supply is commonly performed or used on a widespread geographic basis; (b) whether the service, treatment, procedure, facility, equipment, drug, device or supply is generally accepted to treat that illness or injury by the medical profession in the United States; (c) the failure rate and side effects of the service, treatment, procedure, facility, equipment, drug, device or supply; (d) whether other, more conventional methods of treating the illness or injury have been exhausted by the Participant; (e) whether the service, treatment, procedure, facility, equipment, drug, device or supply is medically indicated; (f) whether the service, treatment, procedure, facility, equipment, drug, device or supply is recognized for reimbursement by Medicare, Medicaid and other insurers and self-funded plans.

Medical necessity

A service, treatment, procedure, equipment, drug, device or supply provided by a Hospital, physician or other health care provider that is required to identify or treat a Participant's illness or injury and which is, as determined by the Plan: (1) consistent with the symptom(s) or diagnosis and treatment of the Participant's illness or injury; (2) appropriate under the standards of acceptable medical practice to treat that illness or injury; (3) not solely for the convenience of the Participant, physician, Hospital or other health care provider; (4) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the Participant and accomplishes the desired end result in the most economical manner.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. We determine our allowance as follows: An amount for a treatment, service or supply provided by a non-plan health care provider that is reasonable, as determined by the Plan, when taking into consideration, among other factors determined by the Plan, amounts charged by health care providers for similar treatment, services and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care provider as full payment for similar treatment, services and supplies. In some cases the amount the Plan determines as reasonable may be less than the amount billed. In these situations the Participant is held harmless for the difference between the billed and paid charge(s), other than the Copayments or Coinsurance specified on the Schedule of Benefits, unless he/she accepted financial responsibility, in writing, for specific treatment or services prior to receiving services. Charges for Hospital or other institutional Confinements are incurred on the date of admission. All others are incurred on the date a Participant receives the service or item. The benefit levels that apply on the Hospital admission date apply to the charges for the covered expenses incurred for the entire Confinement regardless of changes in benefit levels during the Confinement.

Us/We

Us and we refer to Valley Health Plan, Inc.

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 Eligibility

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 715/836-1254 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 the Valley Health Plan – 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.	26- 28
Emergency benefits: • In-area ..... • Out-of-area ..... (*Emergency room copay is waived, if admitted to the hospital)	$10 for an office visit or *$25 copay to the hospital for an emergency room visit	29- 30
Mental health and substance abuse treatment	Regular cost sharing.	31- 32
Prescription drugs.....	$5/generic and $10/brand	33- 34
Dental Care (Accidental injury benefit).....	20% of first $500 in charges.	36
Preventive Dental for children ages 11 and under.	$10 per office visit	
Vision Care (one routine vision exam per calendar year).....	$10 per office visit	18
Special Features…….		35
Protection against catastrophic costs (your out-of-pocket maximum)	Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated copayments/coinsurance which are required for a few benefits.	12

2001 Rate Information for
Valley Health Plan

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 Wisconsin							
Self Only	**VH1**	**$86.59**	**$63.53**	**$187.61**	**$137.65**	**$102.22**	**$47.90**
Self and Family	**VH2**	**$195.82**	**$188.49**	**$424.28**	**$408.39**	**$231.17**	**$153.14**