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Healthcare you can feel good about.

Universal Care

2001

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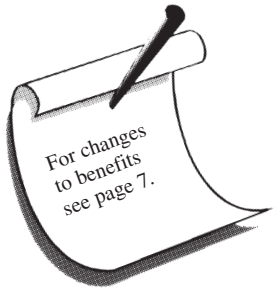
A Health Maintenance Organization



Serving: *Southern California*

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

Enrollment codes for this Plan:
6Q1 Self Only
6Q2 Self and Family

This plan has received a one (1) year Full Accreditation from the National Committee for Quality Assurance (NCQA). See the 2001 Guide for more information on NCQA.

Authorized for distribution by the:

OPM

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT

RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

FEHB
Federal Employees
Health Benefits Program

RI 73-796

Table of Contents

Introduction

Universal Care
1600 East Hill Street
Signal Hill, California 90806-3682
800- 635-6668

This brochure describes the benefits of Universal Care under our contract (CS2855) 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 55. 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 Universal Care.

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

Universal Care contracts with individual physicians, medical groups, and hospitals to provide the FEHBP benefits. 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?

Universal Care provides covered services through the Universal Care Contracted Medical Groups and Primary Care Physicians. The location, telephone number and hours of service of the Contracted Medical Groups and Primary Care Physicians are listed in the Universal Care Provider Directory accompanying this Brochure. Emergency Services are available on a 24-hour basis, seven (7) days a week.

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.

- Universal Care began its operations in 1983 and has been providing quality health care services for 17 years to Southern California residents.
- Universal Care is a privately held, family-owned health plan.
- Universal Care currently has approximately 270,000 commercial (group, individual), government programs (Medicaid, Access for Infants and Mothers, Healthy Families, CalPERS, and FEHBP) enrollees.
- Universal Care's focus is on quality and patient satisfaction, as reflected in routinely high scores in annual state medical audits.
- Universal Care complies with State, Federal, and private accreditation standards that assure confidentiality of medical records and orderly transfer of medical records to caregivers.
- Universal Care encourages all of its members to fully participate in all decisions related to their health care.

If you want specific information about us, call 800-635-6668 or write to 1600 E. Hill St., Signal Hill, CA 90806. You may also contact us by fax at 562-490-9419 or visit our website at www.universalcare.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 includes: Los Angeles, Orange, Riverside, San Bernardino, San Diego, Kern and Ventura counties.

Usually, 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 services. We will not pay for any other health care services.

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

Section 2. 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 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 *800-635-6668*, **or** checking our website *www.universalcare.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 5.1% for Self Only or 15.6% for Self and Family.
- We now provide benefits for one eye refraction per member per year to determine the need for vision correction. See page 21.
- We eliminated the copay for obstetrical (maternity) care for all covered females. See page 17.
- We eliminated the copay for well-baby care for all covered children up to age 2. See page 16.
- We eliminated coverage for In Vitro Fertilization. See page 18.
- We expanded our service area into the remainder of Ventura County, California. See page 6.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call our Member Services Department at 800-635-6668.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." Universal Care provides covered services through the Universal Care Contracted Medical Groups and Primary Care Physicians (PCP). The location, telephone number and hours of service of the Contracted Medical Groups and Primary Care Physicians are listed in the Universal Care Provider Directory accompanying this Brochure. Emergency Services are available on a 24-hour basis, seven (7) days a week. You will only pay copayments, deductibles, 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. Universal Care's Plan providers include Primary Care Physicians, specialty physicians, physician assistants and nurse practitioners.

We list Plan providers in the provider directory, which we update periodically. The list is also available on our website (www.universalcare.com).

- **Plan facilities**

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

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. Call our Member Services Department at 800-635-6668 to select your primary physician. The location, telephone number and hours of service of the Primary Care Physicians are listed in the Universal Care Provider Directory accompanying this Brochure.

- **Primary care**

Your Primary Care Physician can be a family practitioner, general practitioner, internist or pediatrician. Your Primary Care Physician will provide most of your health care, or give you a referral to see a specialist. Your Primary Care Physician is responsible for directing and coordinating all of your health care needs for Covered Services. Your Primary Care Physician will arrange for laboratory tests, x-rays, referrals to specialists, hospitalization, and any other Medically Necessary Covered Services. In order to be covered under this health plan, all referrals to specialists must be coordinated by your Primary Care Physician.

To select your Primary Care Physician, call our Member Services Department at 800-635-6668 or complete the Primary Care Physician Selection Form included in your Universal Care Enrollment Packet.

If you want to change Primary Care Physicians or if your Primary Care Physician leaves the Plan, call us. We will help you select a new one.

•Specialty care

Your Primary Care Physician will refer you to a specialist for needed care. However, you may see an OB/GYN or an Internist without a referral. Generally, your Primary Care Physician will refer you to a specialist within your Contracted Medical Group. If you require services that are not available within your Contracted Medical Group, the Primary Care Physician will arrange for a referral to a Contracted Provider within Universal Care's network.

To order certain services, the Primary Care Physician will give you a written referral authorizing such services. For certain specialty services, the referral is submitted by the Primary Care Physician for review for Prior Authorization to Universal Care or to the Contracted Medical Group's Utilization Review Committee.

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 specialist for a certain number of visits without additional referrals. Your Primary Care Physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

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

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

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

  •• Terminate our contract with your specialist for other than cause; or

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

  •• Reduce our service area and you enroll in another FEHB Plan,

  You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can

continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our Member Services Department immediately at 800-635-6668. If you are new to the FEHB Program, we will arrange for you to receive care.

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

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

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

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process Prior Authorization. Your physician must obtain prior authorization for all authorization requests, which may include, but not be limited to the following:

- Referral to specialists
- Laboratory services
- Radiology
- Elective procedures - inpatient or outpatient
- Home health care
- Durable Medical Equipment
- Transportation.

Your physician must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Prior Authorization means that your Primary Care Physician must contact Universal Care (or in some cases, the Contracted Medical Group with which your Primary Care Physician is affiliated) to request that the service be approved for coverage before services are rendered. Requests for Prior

Authorization will be denied if the requested services are determined to be not Medically Necessary. Requests for Prior Authorization of coverage for services by non-Contracted Providers will also be denied if Universal Care determines that comparable or more appropriate services are available through Universal Care's Contracted Providers.

The majority of requests for Prior Authorization of coverage are responded to within 72 hours of their receipt, and urgent matters are expedited. Those requests which require investigation and/or physician review sometimes take longer as there may be need for additional information and communication with the requesting Primary Care Physician or specialist. Requests for coverage that are approved by Universal Care are communicated directly to you and your Primary Care Physician and the referral specialist along with an authorization number. Requests for Prior Authorization of coverage that are denied by Universal Care are communicated in writing to your Primary Care Physician and you.

In the event that Prior Authorization of coverage has been denied by Universal Care (or in some cases, the Utilization Review Committee of your Contracted Medical Group), you, or your Primary Care Physician on your behalf may appeal the denial by following the appeals process outlined on page 43 of this brochure. If you would like a more detailed description of Universal Care's Criteria for Authorizing or Denying Health Care Services, you may contact Universal Care's Member Services Department at 800-635-6668.

- **Experimental & Investigational treatments**

For Universal Care to determine if a service or supply is experimental or investigational , we refer to evidence from the national medical community, which may include one or more of the following sources:

National Centers for Health Services Research; Peer-reviewed medical and scientific literature; Publications from organizations such as the American Medical Association; Professionals, specialists and experts; and written protocols and consent forms used by the proposed treating facility or other facility administering substantially the same drug, device or medical treatment.

In addition, the service or supply must meet all of the following criteria:

If it is a drug or device which cannot be lawfully marketed without the approval of the United States Food and Drug Administration ("FDA"), final approval must have been obtained at the time the drug or device is furnished. Interim FDA approvals for a Phase I, II or III trial, pre-market approval applications and investigational exemptions are not sufficient. The evidence must show conclusively that the service or supply is safe, effective and medically appropriate for use in the treatment of the illness, injury or condition at issue as compared to the conventional means of treatment or diagnosis.

The service or supply must be recognized or approved in accordance with generally accepted professional medical standards. Any required approval of any federal government or agency, or any state government or agency, must have been obtained prior to the time of use.

To obtain additional information concerning how we determine whether a particular service or treatment is experimental or investigational or to obtain information on how to appeal our decision to deny a service or treatment as Experimental or Investigational, please call our Member Services Department at 800-635-6668.

Section 4. Your costs for covered services

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

- **Copayments** — A copayment is a fixed amount of money You Pay when you receive services.

  Example: When you see your Primary Care Physician You Pay a copayment of $10 per office visit.

- **Deductible** — A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. You do not have a deductible with Universal Care.

- **Coinsurance** — Coinsurance is the percentage of our negotiated fee that you must pay for your care. You do not have coinsurance with Universal Care.

Your out-of-pocket maximum

After your copayments total $1,000 per person or $3,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription drugs
- Durable Medical Equipment
- Diagnosis and treatment of infertility

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

Section 5. Benefits -- OVERVIEW

(See page 7 for how our benefits changed this year and page 55 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 800-635-6668 or visit us at our website at www.universalcare.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.
- 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	**You Pay**
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 visits by physician, nurse or health aide	$5 per visit

Diagnostic and treatment services -- Continued on next page

Diagnostic and treatment services *(Continued)*	**You Pay**
Not covered • Transplants not listed as covered • Long-term rehabilitative therapy • Shoes or foot orthotics • Chiropractic services	All Charges.

Lab, X-ray and other diagnostic tests	**You Pay**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	No charge if you receive these services during your office visit; otherwise, $10 per visit

Preventive care, adult	**You Pay**
Annual Physical Examinations	$10 per visit
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 • Venereal Disease testing • Breast Cancer Screening	$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

Preventive care, adult *(Continued)*	**You Pay**
Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	$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/Pneumococcal vaccines, annually, age 65 and over • Travel immunizations not covered unless they are required by the country of entry.	$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 19 to determine the need for vision correction. ••Ear exams through age 19 to determine the need for hearing correction ••Examinations done on the day of immunizations (through age 19)	$10 per visit
• Well-child care charges for routine examinations, immunizations and care (up to age 2)	No Charge
• Well-child care charges for routine examinations, immunizations and care (from age 2-19)	$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 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).	No Charge
Not covered: Routine sonograms to determine fetal age, size or sex	All charges.

Family planning	You Pay
• Voluntary sterilization ••Vasectomy ••Tubal Ligation ••Injection for Depo Provera • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs) • Abortion only when the life of the mother would be endangered if fetus is carried to term or if the pregnancy is a result of an act of rape or incest.	 $100 copay $100 copay $30 copay $10 per visit $10 per visit $10 per visit $150 copay
Not covered: • Reversal of voluntary surgical sterilization, genetic counseling.	All charges.

Infertility services	You Pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: ••*Intravaginal insemination (IVI)* ••*Intracervical insemination (ICI)* ••*Intrauterine insemination (IUI)* • Embryo Transplants • Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	50% of charges 50% of charges 50% of charges
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	All charges.
Allergy care	**You Pay**
Testing and treatment Allergy injection	$10 per 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 is limited to those transplants listed under Organ/Tissue Transplants on page 27. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: – We will only cover GHT when we preauthorize the treatment. GHT is covered under the Plan's medical benefit. Call your Primary Care Physician for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services 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 -- • 2 consecutive months per condition if significant improvement can be expected within 2 months for the services of each of the following: ••Qualified physical therapists; ••Speech therapists; and ••Occupational therapists. Note: Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided	$10 per visit
Not covered: • Long-term rehabilitative therapy • Exercise programs	All charges.
Hearing services (testing, treatment, and supplies)	**You Pay**
• Hearing aid and testing only when necessitated by accidental injury, or natural hearing loss. • Hearing testing for children through age 19 (see *Preventive care, children*)	$10 per visit
Not covered: • All other hearing testing • Hearing aids, testing and examinations for them	All charges.

Vision services (testing, treatment, and supplies)	You Pay
• If you require an eye examination to determine the need for vision correction, the Plan provides for one (1) eye refraction a year.	$10 per visit
• Eye exam to determine the need for vision correction for children through age 19 (see preventive care)	$10 per visit
Not covered: • Corrective eyeglasses, frames or contact lenses, including fitting of contact lenses, except as necessary for the first pair of corrective lenses following cataract surgery • Eye exercises and orthoptics • 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. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per visit
Not covered: • Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above • Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)	All charges.

Orthopedic and prosthetic devices	You Pay
• Artificial limbs • Lenses following cataract removal. • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints and pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Orthopedic devices, such as braces .	Nothing
Not covered: • Orthopedic and corrective shoes • Foot orthotics • Heel pads and heel cups • Corsets, trusses, elastic stockings, support hose, lumbosacral supports, arch supports, and other supportive devices. • Prosthetic replacements provided less than 3 years after the last one we covered are only covered when it is medically necessary.	All charges.

Durable medical equipment (DME)	You Pay
• Wheelchairs • Hospital beds • Wigs are covered only for members undergoing chemotherapy or radiation treatment. • Blood Glucose Monitors • Insulin Pumps	Nothing
Not covered: • Motorized wheel chairs	All charges.

Home health services	You Pay
• Home health care ordered by a Plan physician and provided by a nurse or home health aide. • Services include intravenous therapy and medications when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need.	$5 per visit

Home health services *(Continued)*	**You Pay**
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	**You Pay**
• No current benefit	All charges.
Educational classes and programs	**You Pay**
Coverage is limited to health education for: • Weight Loss • Cholesterol control • Diabetes management • Exercise • Parenting • Healthy kids • Breast feeding • Healthy Living: Fast foods/Dining out • Hypertension management • Stress Management • Healthy Living Back • Self-help smoking cessation • Asthma control: Children (ages 4-8) Teens (ages 9-14) Adults (ages 15+)	Nothing

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 (i.e. hospital, surgical center, etc.).
- YOU MUST GET PRIOR AUTHORIZATION FOR ALL SURGICAL PROCEDURES.

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. Surgery for morbid obesity will be performed only as a last resort, when the member's health is endangered and more conservative medical measures, including prescription drugs such as appetite suppressants, have not been successful. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information.	$10 per visit

Surgical procedures continued on next page.

Surgical Procedures *(Continued)*	**You Pay**
• Voluntary sterilization. See 5(a) • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are not covered • 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
Not covered: • Reversal of voluntary sterilization • Routine treatment of conditions of the foot; see Foot care. • Orthopedic and corrective shoes • Foot orthotics • Heel pads and heel cups	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.	$10 per visit

Reconstructive surgery *(Continued)*	**You Pay**
• All stages of breast reconstruction surgery following a mastectomy, such as: •• Surgery to produce a symmetrical appearance on the other breast; •• Treatment of any physical complications, such as lymphedemas; •• Breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$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	**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. • Treatment of TMJ, including surgical and non-surgical intervention Note: For other covered oral surgeries, see 5(h), dental benefits.	$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) • Orthopedic appliances	All charges.

Organ/tissue transplants	You Pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogenic 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 Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	$10 per visit
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) • 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.
- Universal Care has 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 the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).
- **YOU MUST GET PRIOR AUTHORIZATION FOR ALL HOSPITAL STAYS.**

IMPORTANT

Benefit Description	You Pay
Inpatient hospital	**You Pay**
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • Private rooms only when medically necessary, • Special duty nursing only when medically necessary, • 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 donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home • Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure.	Nothing
Not covered: • Custodial care • Non-covered facilities, such rest cures, domiciliary or convalescent care. • Blood and blood derivatives not replaced by the member. • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care unless prescribed by the doctor.	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 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
Extended care benefit: Subacute care is provided in either a designated area of an acute care hospital, in a comprehensive freestanding rehabilitation facility, or in a specially designed unit within a skilled nursing facility. Subacute care is considered a lower level of care in terms of nursing and physician contact time with the patient, and yet is still a comprehensive level of care for patients whose condition is likely to continue to improve and who: • Have had an acute illness of injury for which acute care is no longer medically necessary. • Have experienced a recurrence of a chronic disease process for which acute care is no longer necessary. • Though stable, may still require some diagnostic and/or invasive procedures and nursing care and/or monitoring.	Nothing
Skilled nursing facility (SNF): The Plan provides a comprehensive range of benefits with no dollar limit, for up to 100 days per calendar year, when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. All necessary services are covered, including: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	Nothing
Not covered: custodial care	All charges.
Hospice care	**You Pay**
Supportive and palliative care for a terminally ill member is covered in the home or a hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. Services must be authorized by a Plan doctor and approved by the Plan.	Nothing
Not covered: Independent nursing, homemaker services	All charges.
Ambulance	**You Pay**
• Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor.	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 n this brochure.
- 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

What is a medical emergency?

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

What to do in case of emergency:

If you are in an emergency situation, immediately call "911" or go directly to the nearest emergency room for treatment. Be sure to tell the emergency room personnel that you are a Universal Care member so they can notify the Plan. You or a family member must telephone your Universal Care medical group within 24 hours (unless it was not reasonable possible to do so). It is your responsibility to ensure that the Plan has been timely notified.

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

Benefit Description	You Pay
Emergency within our service area	**You Pay**
• Emergency care at a doctor's office	$10 per visit
• Emergency care at an urgent care center	$25 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$25 per visit If the emergency results in admission to a hospital, the copay is waived.
Not covered: Elective care or non-emergency care	All charges.
Emergency outside our service area	**You Pay**
• Emergency care at a doctor's office	$10 per visit
• Emergency care at an urgent care center	$25 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$25 per visit If the emergency results in admission to a hospital, the copay is waived.
Emergency Services *(Continued)*	**You Pay**
Not covered: • Elective care or nonemergency 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	**You Pay**
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	Nothing
Not covered: air ambulance	All charges.

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

IMPORTANT

Parity

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

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

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

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

IMPORTANT

Benefit Description	You Pay
Network mental health and substance abuse benefits	**You Pay**
Diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 copay for each covered visit
• Diagnostic tests	$10 copay for each covered (visit or test)
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, halfway house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment.	Nothing

Network mental health and substance abuse benefits (*Continued)*	**You Pay**
Not covered: Services we have not approved.	All charges.

Preauthorization

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

- To get a referral, contact your Primary Care Physician. If you have an emergency and are unable to contact your PCP, call the Triage service at 800-377-7012. In order to obtain a provider directory, call our Member Services Department at 800-635-6668.

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.
- 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

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

- **Who can write your prescription.** A licensed Plan or referral physician must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy. Universal Care approved maintenance drugs for chronic conditions can be ordered through the mail.
- **We use a formulary.** Universal Care uses a comprehensive formulary as a method of evaluating various drug products available to treat illnesses. The formulary is a list of covered and preferred medications that are:
  - FDA approved for specified indications;
  - Reviewed by Universal Care with participation by practicing physicians;
  - Safe and effective as well as being medically necessary for the treatment of maintenance of a medical condition; and
  - Cost effective for the treatment of the medical condition.

  The Pharmaceutical & Therapeutic (P&T) Committee meets every-other-month to review and update medications for inclusion or exclusion from the formulary. Results from these meetings are published and distributed to contracting physicians via newsletters and updates.

  The formulary is available upon request. Simply contact your Member Services Representative at 800-635-6668. Please be advised that your physician will determine when you require a particular medication along with the correct dosage.

  A prescriber or pharmacist must request an exception process for those drugs not listed on the Universal Care formulary should he/she believe that a particular medication is required by an enrollee. This provider must obtain prior authorization from Universal Care via a medical exception review process. This means that he/she must complete a non-formulary drug request form and submit it to Universal Care for review. Either a pharmacist or physician will look over the request within two days of receipt from the plan provider. Once the determination for the non-formulary request is complete, written notification will be forwarded to the plan physician and member.

- **These are the dispensing limitations.** Up to a one-month supply of a prescription drug will be dispensed. Certain drugs such as vitamins with fluoride for infants may be dispensed for up to one year. A 90-day supply of a prescription drug for chronic conditions ordered through the mail. There is no difference in copay between brand name and generic drugs. If a member sends in an order too soon after the last one was filled, the new order will not go through. Only maintenance medications for conditions such as hypertension, diabetes, etc. are available through mail order.

When you have to file a claim. Submit all claims to: Universal Care
P.O. Box 16420
Signal Hill, CA 90806

Prescription drug benefits begin on the next page.

Benefit Description	You Pay After the calendar year deductible…
Covered medications and supplies	**You Pay**
Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan contracted pharmacy will be dispensed for up to a one month supply. Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. Nonformulary drugs will be covered when prescribed by a Plan doctor but require prior authorization.	$5 copay (generic drugs or name brand drugs) per prescription unit or refill for up to a one-month supply.
Universal Care approved maintenance drugs for chronic conditions can be ordered through the mail.	$7.50 for a 90 day supply
Covered medications and accessories include: • Drugs for which a prescription is required by Federal law • Oral contraceptive drugs • Insulin; a copay charge applies to each vial • Disposable needles and syringes needed to inject covered prescribed medication • Insulin syringes, needles and blood glucose monitoring strips • Prenatal Vitamins • Vitamins with fluoride for infants up to one year of age • Intravenous fluids and medication for home use, implantable drugs, such as Norplant, and some injectable drugs, such as Depo Provera, are covered under Medical and Surgical Benefits. DepoProvera has a $30 copay per injection. • "Off-label" medication will be covered only if the Prescribing Plan Physician provides pre-reviewed medical literature or if the "off-label" medication has become a community standard. • Non-injectable Fertility drugs	

Covered medications and supplies *(Continued)*	**You Pay**
Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic in addition to the copay. If a physician requires a name brand then medical documentation must be provided for the drug to be covered. • To order a formulary, call your Member Services Representative at 800-635-6668.	
Not covered: Drugs available without a prescription or for which there is a nonprescription equivalent available • Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies • Vitamins and nutritional substances that can be purchased without a prescription • Medical supplies such as dressings and antiseptics • Drugs for cosmetic purposes • Drugs to enhance athletic performance • Diabetic supplies, except for insulin syringes, needles and blood glucose monitoring strips • Smoking cessation drugs and medication	All charges.

Section 5 (g). Special Features

Feature	Description
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call 800-377-7012 and talk with a registered nurse who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired	The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (**1-800-735-2929 (TTY) or 1-888-877-5378 (TTY)**)
High risk pregnancies	Universal Care has a Maternal Health Department that monitors and manages high-risk pregnancies.
Centers of excellence for transplants/heart surgery/etc	Universal Care has contracts with centers of excellence including UCLA Medical Center, Loma Linda University Medical Center, and Cedars Sinai Medical Center.
Travel benefit/ services overseas	Universal Care covers all travel immunizations required for travel by the country of destination

Section 5 (h). Dental benefits

No current benefit

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

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

Dental Benefits:

You and your family can receive Dental benefits for an annual fee payable to Universal Care.

- Subscriber $42.00 per year
- Subscriber and Dependent $84.00 per year
- Subscriber and Family $134.40 per year

You and each covered member of your family are entitled to enrollment in our Dental Plan. You must enroll in Universal Care's Dental plan to receive these benefits. The following sample copayments apply.

- Adult Oral Examination No charge
- Child Oral Examination No charge
- Adult Cleaning $20.00
- Child Cleaning $15.00

The Dental Plan is currently available to all members. To receive further information and enroll in Universal Care's Dental 700 Plan, please call (800) 257-3087.

Alternative Treatments

You and your family can receive Chiropractic, Acupuncture and Herbal Remedies benefits for an annual fee payable to Universal Care. You must enroll in Universal Care's medical benefit plan to receive these additional benefits.

- Subscriber $42.24 per year
- Subscriber and Dependent $88.68 per year
- Subscriber and Family $135.12 per year

The following sample copayments apply.

- Acupuncture – You Pay $10 per visit. Limited to 20 visits per year by a doctor of medicine or osteopathy for: anesthesia, pain relief.
- Chiropractic services – You Pay $10 per visit. Limited to 20 visits per year.
- Herbal Remedies -- You Pay $5 copay.

This document is intended to be used as a summary only. The supplemental benefit booklets for these benefits should be consulted for a detailed description of covered benefits and limitations. Other charges may apply.

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

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

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

Medical, hospital, and drug benefits

In most cases, Providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 800-635-6668.

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

- Covered member's name and ID number;
- Name and address of 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: Universal Care
PO Box 16420
Signal Hill, CA 90806

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: Universal Care Attn: Grievance Unit 1600 E. Hill Street Signal Hill, CA 90806 and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or if applicable arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, D.C. 20044-0436.

The Disputed Claims process (continued)

Send OPM the following information:

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

Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must provide a copy of your specific written consent with the review request.

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

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

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

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800-635-6668 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 202-606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

When we are the primary payer, we will pay the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

- **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.

(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.

- 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 800-635-6668.
- When Medicare is the primary payer, we waive all out-of-pocket costs.

•Medicare managed care plan

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

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

TRICARE

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for any expenses we paid. 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.

If you have a malpractice claim

If you have a malpractice claim because of services you did or did not receive from a plan provider, it must go to binding arbitration. Contact Universal Care at 800-635-6668 about how to begin the binding arbitration process.

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

Personal services required to assist a Member in meeting the requirements of daily living. Such services include, without limitation, assistance in walking, getting in or out of bed, bathing, dressing, feeding, or using the lavatory, preparation of special diets and supervision of medication schedules. Custodial Care does not require the continuing attention of trained medical or paramedical personnel.

Experimental and Investigational Services

For Universal Care to determine if a service or supply is experimental or investigational, we refer to evidence from the national medical community, which may include one or more of the following sources:

National Centers for Health Services Research; Peer-reviewed medical and scientific literature; Publications from organizations such as the American Medical Association; Professionals, specialists and experts; and written protocols and consent forms used by the proposed treating facility or other facility administering substantially the same drug, device or medical treatment.

In addition, the service or supply must meet all of the following criteria:

If it is a drug or device, which cannot be lawfully marketed without the approval of the United States Food and Drug Administration ("FDA"), final approval must have been obtained at the time the drug or device is furnished. Interim FDA approvals for a Phase I, II or III trial, pre-market approval applications and investigational exemptions are not sufficient.

The evidence must show conclusively that the service or supply is safe, effective and medically appropriate for use in the treatment of the illness, injury or condition at issue as compared to the conventional means of treatment or diagnosis

The service or supply must be recognized or approved in accordance with generally accepted professional medical standards. Any required approval of any federal government or agency, or any state government or agency, must have been obtained prior to the time of use.

To obtain additional information concerning how we determine whether a particular service or treatment is experimental or investigational or to obtain information on how to appeal our decision to deny a service or treatment as Experimental **or Investigational, please call our Member Services Department at 800-635-6668.**

Group health coverage	Health benefit coverage for a group that has met the program required eligibility requirements for participation and has health care provided by Universal Care.
Medical necessity	The medical treatment or services are required and are necessary to maintain the health of an Enrollee consistent with professionally recognized standards of care in the judgment of the physician in charge of the Enrollee's care. However, in the event the medical director must determine whether or not medical treatment or services are, or were, a Medical Necessity, (1) he shall confer with the physician in charge of such patient's care, and (2) he shall base his decision upon the standards of the medical community as they would apply to the specific situation.
Us/We	Us and we refer to *Universal Care,* a California Corporation that operates a health care service plan licensed by the State of California under the Knox-Keene Health Care Service Plan Act of 1975.
You	You refer to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

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

Your medical and claims records are confidential

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

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

When you retire

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

When you lose benefits

•When FEHB coverage ends

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

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

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

• Spouse equity coverage

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

•TCC

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

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

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

•Converting to individual coverage

You may convert to a non-FEHBP 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 800-635-6668 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 Universal Care - 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	14
Services provided by a hospital: • Inpatient ..... • Outpatient.....	Nothing	28 29
Emergency benefits: • In-area ..... • Out-of-area.....	$25 per emergency room visit $25 per emergency room visit	32 32
Mental health and substance abuse treatment	Regular cost sharing	33
Prescription drugs.....	$5 copay	35
Dental Care.....	No benefit.	39
Vision Care.....	One annual eye refraction: $10	21
Special features: 24 hour nurse line, Services for deaf and hearing impaired, High risk pregnancies, Centers of excellence for transplants/heart surgery/etc., Travel benefit/services overseas		38
Protection against catastrophic costs (your out-of-pocket maximum).....	Nothing after $1,000/Self Only or $3,000/Family enrollment per year Some costs do not count toward this protection	12

2001 Rate Information for
UNIVERSAL CARE

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 most career U.S. Postal Service employees. In 2001, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee but not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees," RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		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
Southern California							
Self Only	6Q1	$57.35	$19.12	$124.27	$41.42	$67.87	$8.60
Self and Family	6Q2	$151.46	$50.48	$328.16	$109.38	$179.22	$22.72