Universal Care®
Healthcare you can feel good about.

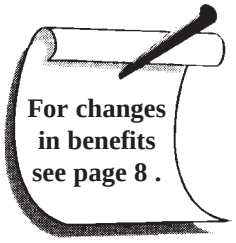
Universal Care 2003

http://www.universalcare.com

A Health Maintenance Organization

Serving: *Southern California*

Enrollment in this Plan is limited. You must live in or work in our Geographic service area to enroll. See page 7 for requirements.



This Plan has a three (3) year commendable accreditation from the NCQA. See the 2003 Guide for more information on NCQA.

Enrollment codes for this Plan:

6Q1 Self Only
6Q2 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

FEHB
Federal Employees
Health Benefits Program

RI 73-796

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

Kay Coles James
Director

Notice of the Office of Personnel Management's

Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM may use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).

- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice will be effective April 14, 2003.

Table of Contents

Introduction

This brochure describes the benefits of Universal Care under our contract (CS 2855) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for Universal Care administrative offices is:

Universal Care1600 East Hill Street, Signal Hill, California 90755-3612

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in 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, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and changes are summarized on page 8. Rates are shown at the end of this brochure .

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; “we” means Universal Care.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, DC 20415-3650.

Stop Health Fraud

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (FEHB) Program premium.
OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud - Here are some things you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider 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 1-800-635-6668 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

- Do not maintain as a family member on your policy:
    - your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
    - your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed or with OPM if you are retired.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

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

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

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

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. Universal Care provides covered services through the Universal Care Contracted Participating Medical Groups and Primary Care Physicians. The location, telephone number and hours of service of the Contracted Participating 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.

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. Emergency Services are available on a 24-hour basis, seven (7) days a week.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. 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 361,000 commercial (group, individual), government programs (Medicaid, Medicare, Healthy Families, 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 has received 3-year full accreditation from NCQA.
- Universal Care encourages all of its members to fully participate in all decisions related to their health care.

If you want more information about us, call 800-635-6668, or write to 1600 E. Hill Street, Signal Hill, CA 90755-3612. You may also contact us by fax at 562-490-9419 or visit our website at www.universalcare.com.

Service Area
To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is:

Los Angeles, Orange, Riverside, San Bernardino, San Diego, Kern, and Ventura counties.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

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

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Section 2. How we change for 2003

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- A Notice of the Office of Personnel Management's Privacy Practices is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

Changes to this Plan

- Your share of the non-Postal premium will increase by 23.9% for Self Only or 23.8% for Self and Family.
- The copay for injectable contraceptive drugs (such as Depo Provera) decreases from $30 to $10
- The outpatient hospital or ambulatory surgical care copay is $100 per visit
- The outpatient services provided by a hospital copay is $100 per visit
- You now pay 10% of charges for durable medical equipment
- You now pay 10% of charges for orthopedic and prosthetic devices
- The prescription drugs copays are $10 for generic drugs and $20 for brand name drugs
- The inpatient hospital, mental health and skilled nursing care copay is $100 per day for 3 days, with a maximum of $300 per person per calendar year.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-635-6668.

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, and deductiblesand 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 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 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. To select your Primary Care Physician, call our Member Services Department at 800-635-6668.

- **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.

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 or, if we drop out of the Program, contact your new plan.

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-635-6668. 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.

Section 4. Your costs for covered services

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

- **Copayments** — A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

  Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go in the hospital, you pay nothing for admission.

- **Deductible** — We do not have a deductible.

- **Coinsurance** — We do not have coinsurance.

Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

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 8 for how our benefits changed this year and page 54 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. 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	
Professional services of physicians • In physician's office	$10 per office visit
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion	$10 per office visit
At home visits by physician, nurse or health aide	Nothing
Lab, X-ray and other diagnostic tests	**You pay**
Tests, such as: • Blood tests • Urinalysi • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing if you receive these services during your office visit; otherwise, $10 per office visit

Preventive care, adult	You pay
Annual Physical Examination Routine screenings, such as: • Blood Lead Level - One annually • Blood Cholesterol - once every three years • Colorectal Cancer Screening, including – Fecal occult blood test – Sigmoidoscopy, screening - every five years starting at age 50 • Venereal Disease testing, including screening for chlamydial infection • Breast Cancer Screening	$10 per office visit $10 per office visit
Prostate Specific Antigen (PSA test) - one annually for men age 40 and older	$10 per office 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 office visit
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	$10 per office visit
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccines, annually, age 65 and over • Travel immunizations not covered unless they are required by the country of entry	$10 per office visit

Preventive care, children	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per office visit
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: – eye exams through age 17 to determine the need for vision correction. – ear exams through age 17 to determine the need for hearing correction – examinations done on the day of immunizations (through age 22)	$10 per office visit $10 per office visit
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 27 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
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b) • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms • 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. NOTE: We cover oral contraceptives under the prescription drug benefit.	 $10 per office visit $10 per office visit $10 per office visit $10 per office visit $150 copay
Not covered: • *Reversal of voluntary surgical sterilization, genetic counseling,* • *Any procedures, services, drugs and supplies related to "Induced interruption of pregnancy" (abortion) unless under the circumstances stated above.*	*All charges.*
Infertility services	**You pay**
Diagnosis and treatment of infertility, such as: • Artificial insemination: – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI) • Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* – *in vitro fertilization* – *embryo transfer, gamete GIFT and zygote ZIFT* – *zygote transfer* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges.*

Allergy care	You Pay
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 30. • Respiratory and inhalation therapy • Dialysis - hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy - Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: - We will only cover GHT when we preauthorize the treatment. 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 office visit

Physical and occupational therapies	You pay
• 60 visits per condition for the services of each of the following: – qualified physical therapists and – occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 60 sessions	$10 per outpatient visit Nothing per visit during covered inpatient admission
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges.*
Speech therapy	
60 visits per condition	$10 per outpatient visit
Hearing services (testing, treatment, and supplies)	
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 19 (see *Preventive care, children)*	$10 per office visit
Not covered: • *All other hearing testing* • *Hearing aids, testing and examinations for them*	*All charges.*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Diagnosis and treatment of diseases of the eye. • If you require an eye examination to determine the need for vision correction, the Plan provides for one (1) eye refraction a year. Note: See Preventive care, children for eye exams for children	$10 per office visit
Not covered: • *Eyeglasses or contact lenses and, after age 19, examinations for them* • *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 office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Orthopedic devices, such as braces • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	10% of allowed charges
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *prosthetic replacements provided less than 3 years after the last one we covered*	*All charges.*

Durable medical equipment (DME)	You Pay
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Hospital beds; • wheelchairs; • crutches; • walkers; • blood glucose monitors; and • insulin pumps. • Wigs are covered only for members undergoing chemotherapy or radiation treatment. Note: Call us at 800-635-6668 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	10% of allowed charges
Not covered: • *Motorized wheel chairs*	*All charges.*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	$10 per visit
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges.*
Chiropractic	
No Benefit	*All charges.*

Alternative treatments	You pay
No benefit	*All charges.*
Educational classes and programs	
Coverage is limited to: • Smoking Cessation - Up to $100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. • Diabetes self-management • Weight Loss • Cholesterol control • Exercise • Parenting • Healthy kids • Breast feeding • Healthy Living: Fast foods/Dining out • Hypertension management • Stress Management • Healthy Living Back • 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	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • 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 and prosthetic devices for device coverage information.	$10 per office visit
• Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • 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.	$100 per office visit
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*

Reconstructive surgery	You Pay
Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: – the condition produced a major effect on the member's appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.	$10 per office visit
• All stages of breast reconstruction surgery following a mastectomy, such as: – surgery to produce a symmetrical appearance on the other breast; – treatment of any physical complications, such as lymphedemas; – breast prostheses and surgical bras and replacements (see prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	See above.
Not covered: • *Cosmetic surgery - any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges.*
Oral and maxillofacial surgery	
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	$10 per office visit
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Orthopedic appliances*	*All charges.*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas. 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.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges.*
Anesthesia	
Professional services provided in - • Hospital (inpatient)	Nothing
Professional services provided in - • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	$10 per office visit

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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- 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 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 Sections 5(a) or (b).
- **YOU MUST GET PRIOR AUTHORIZATION FOR ALL HOSPITAL STAYS.**

IMPORTANT

Benefit Description	You pay
Inpatient Hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$100 per day for the first 3 days, with a maximum of $300 per person per calendar year.
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	$100 per day for the first 3 days, with a maximum of $300 per person per calendar year.
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*

Outpatient hospital or ambulatory surgical center	You Pay
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$100 per visit
Not covered: blood and blood derivatives not replaced by the member	*All charges.*
Extended care benefits/skilled nursing care facility benefits	
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.	$100 per day for the first 3 days, with a maximum of $300 per person per calendar year.
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 twelve 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	
• Local professional ambulance service when medically appropriate	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- 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.

Emergencies within our service area: You or a family member must telephone your Universal Care medical group within 24 hours (unless it was not reasonably possible to do so). It is your responsibility to ensure that the Plan has been timely notified. Continuing treatment shall be covered for only so long as the Medical Director of the Plan, after reviewing any medical records or other relevant information and conferring with the physician in charge of the patient care, determined that the member cannot be transferred to the care of a Universal Care Medical Group or contracting provider.

Emergencies outside our service area: You or a family member must telephone your Universal Care medical group within 24 hours (unless it was not reasonably possible to do so). It is your responsibility to ensure that the Plan has been timely notified. Continuing treatment shall be covered for only so long as the Medical Director of the Plan, after reviewing any medical records or other relevant information and conferring with the physician in charge of the patient care, determined that the member cannot be transferred to the care of a Universal Care Medical Group or contracting provider.

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	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$10 per visit $25 per visit $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	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$10 per visit $25 per visit $25 per visit If the emergency results in admission to a hospital, the copay is waived.
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges.*
Ambulance	
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	Nothing
Not covered: air ambulance	*All charges.*

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

IMPORTANT

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:

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

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per visit
• Diagnostic tests	Nothing if you receive these services during your office visit; otherwise, $10 per office visit.
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$100 per day for the first 3 days, with a maximum of $300 per person per calendar year.
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Preauthorization	To be eligible to receive these benefits you must obtain a treatment plan and follow all the following authorization processes: 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.
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 preferred list of generic & name brand drugs that we have selected to meet patient needs at a lower cost and 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.

Your physician may prescribe a name brand drug or a generic drug from a formulary list. A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If your physician prescribes a drug that is not on our formulary, you pay the non-formulary copay. Non-formulary drugs that are prior approved by us will be subject to the applicable formulary copay.

To order a prescription drug formulary, call 800-635-6668.

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 limited for up to one year. A 90-day supply of a prescription drug for chronic conditions ordered through the mail. 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.

- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you — and us — less than a name brand prescription.
- **When you have to file a claim.** Submit all claims to: Universal Care
  P.O. Box 16420
  Signal Hill, CA 90755-3612

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program. • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • 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. • "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. • Oral fertility drugs • Drugs for sexual dysfunction Note: Implantable drugs, such as Norplant, and some injectable drugs, such as Depo Provera, are covered under Medical and Surgical Benefits	$ 10 for generic drugs listed on our formulary $ 20 for brand name drugs with no generic equivalent listed on our formulary $30 for generic or brand name drugs not listed on our formulary <u>Mail Order:</u> 90-day supply of prescribed maintenance drugs obtained through our mail order program: $7.50 for generic drugs $15 for brand name drugs Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them, except for prenatal vitamins and vitamins with fluoride for infants up to one year of age* • *Medical supplies such as dressings and antiseptics* • *Diabetic supplies, except for insulin syringes, needles and blood glucose monitoring strips* • *Smoking cessation drugs and medication* • *Over the counter medications prescribed by a physician*	*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 Universal Care's toll-free telephone number **(866)-321-5955 (TTY)**.
High risk pregnancies	Universal Care has a Women's 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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	$35 for initial stabilization services $10 for follow-up visits
Dental benefits	
We have no other dental benefits.	

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

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

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

- Subscriber $48.00 per year
- Subscriber and Dependent $96.00 per year
- Subscriber and Family $144.00 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.

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.
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

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

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 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 the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer — such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to: Universal Care
PO Box 16420
Signal Hill, CA 90755-3612

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

Send your request to us at: Universal Care
Attn: Grievance Unit
1600 E. Hill Street
Signal Hill, CA 90755-3612

and

(b) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

(c) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

2 We have 30 days from the date we receive your request to:

(a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or

(b) Write to you and maintain our denial — go to step 4; or

(c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request- go to step 3.

3 You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

4 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us — if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, DC 20415-3630.

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 more than one claim, 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 include 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.

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 or from the year in which you were denied precertification or prior approval. 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 3 at 202-606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities, under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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 (Part A or Part B)**

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

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. When Medicare is the primary payer, we waive all out-of-pocket costs.

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

- 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 claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 800-635-6668.

We waive all costs when you have the Original Medicare Plan – When Original Medicare is the primary payer, we will waive all out-of-pocket costs.

(Primary payer chart begins on next page.)

The following chart illustrates whether the Original Medicare Plan 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, or		✔
c) Are a former spouse of an annuitant, or	✔	
d) Are a former spouse of an active employee		✔

- **Medicare managed care plan** If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benefits that Original Medicare covers. 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. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

  Suspended FEHB coverage to enroll in 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's service area.

- **If you do not enroll in Medicare Part A or Part B** If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disable Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribut to any applicable plan premiums.) 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 under the program.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related illness 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 care. You must use our providers.

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB 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 under the State program.

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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.

Coinsurance

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

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. 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.Custodial care that lasts 90 days or more is sometimes known as Long term care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12.

Experimental or 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 refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the Federal Employees Health Benefits (FEHB) Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option,
- if you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- if you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot make any changes after retirement. Contact you employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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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. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). 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. You can also download the guide from OPM's website, www.opm.gov/insure.

- **Temporary continuation of coverage (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, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

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

Enrolling in TCC. 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. It explains what you have to do to enroll.

- **Converting to individual coverage**

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

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

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

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

- **Getting a Certificate of Group health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuityto people who lose employer group 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. For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Is Still Available!

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, your premiums are based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called “custodial care”, long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

You Can Also Apply Later, But...

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action - you won't receive an application automatically. You must request one through the toll-free number or website listed below.
- Open Season ends December 31, 2002 - act NOW so you won't miss the abbreviated underwriting available to employees and their spouses, and the July 1 “age freeze”!

Find Out More - Contact LTC Partners by calling **1-800-LTC-FEDS (1-800-582-3337) (TDD for the hearing impaired: 1-800-843-3557)** or visiting www.ltcfeds.com to get more information and to request an application.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of benefits for Universal Care - 2003

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

Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $10 specialist	15
Services provided by a hospital:	$100 per day upto 3 days, with a maximum of $300 per person per calendar year$100 copay per visit	
• Inpatient		26
• Outpatient		27
Emergency benefits:		
• In-area	$25 per emergency room visit	30
• Out-of-area	$25 per emergency room visit	30
Mental health and substance abuse treatment	Regular cost sharing.	31
Prescription drugs		34
Generic drugs	$10	
Brand name drugs	$20	
Non-formulary drugs	$30	
Mail order drugs - generic	$7.50	
Mail order drugs - brand name	$15	
Dental Care	No benefit.	36
Vision Care	$10 copay	19
Special features: 24-hour nurse line, services for the deaf, high risk pregnancies, centers of excellence, travel benefit		35
Protection against catastrophic costs (your catastrophic protection 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

Notes

Notes

2003 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 career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

		Non-Postal Premium				***Postal Premium***	
		Biweekly		**Monthly**		**Biweekly**	
Type of Enrollment	**Code**	Gov't Share	Your Share	Gov't Share	Your Share	**USPS Share**	**Your Share**
Southern California							
High Option Self Only	**6Q1**	**$78.05**	**$26.01**	**$169.10**	**$56.36**	**$92.35**	**$11.71**
High Option Self & Family	**6Q2**	**$206.05**	**$68.68**	**$446.44**	**$148.81**	**$243.82**	**$30.91**