



Unity Health Plans Insurance Corporation

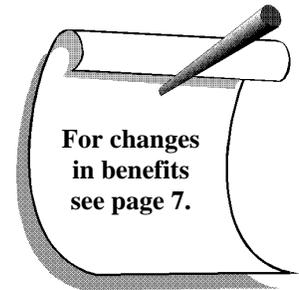
<http://www.unityhealth.com>

2002

A Health Maintenance Organization

Serving: South and Central Wisconsin

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 6 for requirements.



Enrollment codes for this Plan:

**W41 Self Only
W42 Self and Family**

Authorized for distribution by the:



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



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Introduction

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

This brochure describes the benefits of Unity Health Plans under our contract (CS 2268) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 7. Rates are shown at the end of this brochure

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures 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 Unity Health Plans.
- 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 fehwebcomments@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.

Inspector General Advisory

Stop health care fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 800/362-3310 and explain the situation.
- If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

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

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

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

How we pay providers

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

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

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

Who provides my health care?

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

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

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.

Unity Health Plans is licensed in the State of Wisconsin as an insurance corporation. The articles of incorporation for HMO of Wisconsin, Inc. were filed and approved by the state on April 1, 1987, and modified with the name change to Unity Health Plans Insurance Corporation on March 3, 1995. Prior to incorporation, HMO of Wisconsin was a not for profit chapter 613 service insurance corporation established in 1983.

- Unity is an Insurance Corporation, organized pursuant to Chapter 611 of the Wisconsin Revised Statutes and has been in existence for 14 years.
- We are a for-profit company.

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

Service Area

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

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

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.

Section 2. How we change for 2002

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

- We changed the address for sending disputed claims to OPM. (Section 8)

Changes to this Plan

- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We now cover certain intestinal transplants. (Section 5(b))
- Your share of the non-Postal premium will increase by 44.8% for Self Only or 51.0% for Self and Family.
- We now have a mail order pharmacy. The copay for a 90-day supply is two and a half times the 30-day retail pharmacy copay.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800/362-3310.

Where you get covered care

- **Plan providers**

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

Plan providers 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. Your provider’s clinic may assist you with specific questions regarding the board certification status, residency, and educational background of a particular provider.

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

- **Plan facilities**

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

What you must do to get covered care

- **Primary care**

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. To select your primary care physician, call Customer Service at 800/362-3310 and tell them whom you have chosen.

Your primary care physician can be family or general practitioner, internal medicine doctor, OB-GYN physician, or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one. If we receive your request to change your primary care physician on or before the 20th day of the month, the change will become effective on the first day of the following month.

- **Specialty care**

Your primary care physician will make a written referral request and submit it to Unity’s Medical Management for you when specialty care is needed. It is your responsibility to make sure the referral request is approved before you receive care. However, you may see Unity Health Plans chiropractors, OB-GYN physicians (for your annual check-up), and ophthalmologists/optometrists (for your annual eye exam) that are listed in the same section of the provider directory as your PCP, without a referral request from your primary care physician.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will work with Unity Health Plans' Medical Management to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
 - terminate our contract with your specialist for other than cause; or
 - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
 - reduce our service area and you enroll in another FEHB Plan,you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

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

• **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800/362-3310. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

Circumstances beyond our control

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

Services requiring our prior approval

Your primary care physician must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. We call this review and approval process prior authorization or pre-authorization. Your physician must obtain prior authorization for services such as treatment from a specialist, human growth hormone treatment or durable medical equipment and supplies.

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

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

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

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

Section 4. Your costs for covered services

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

- **Copayments**

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

Example: When you see your primary care physician you pay a copayment of \$10 per office visit.

- **Deductible**

We do not have a deductible.

- **Coinsurance**

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

Example: In our Plan, you pay 20% of our allowance for durable medical equipment and supplies.

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

We do not have an out-of-pocket maximum

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Section 5. Benefits -- OVERVIEW

(See page 7 for how our benefits changed this year and page 48 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 800/362-3310 or at our website at www.unityhealth.com.

(a) Medical services and supplies provided by physicians and other health care professionals.....	12-20
•Diagnostic and treatment services	
•Lab, X-ray, and other diagnostic tests	
•Preventive care, adult	
•Preventive care, children	
•Maternity care	
•Family planning	
•Infertility services	
•Allergy care	
•Treatment therapies	
•Physical and occupational therapies	
•Speech therapy	
•Hearing services (testing, treatment, and supplies)	
•Vision services (testing, treatment, and supplies)	
•Foot care	
•Orthopedic and prosthetic devices	
•Durable medical equipment (DME)	
•Home health services	
•Chiropractic	
•Alternative treatments	
(b) Surgical and anesthesia services provided by physicians and other health care professionals	21-24
•Surgical procedures	
•Reconstructive surgery	
•Oral and maxillofacial surgery	
•Organ/tissue transplants	
•Anesthesia	
(c) Services provided by a hospital or other facility, and ambulance services	25-26
•Inpatient hospital	
•Outpatient hospital or ambulatory surgical center	
•Extended care benefits/skilled nursing care facility benefits	
•Hospice care	
•Ambulance	
(d) Emergency services/accidents	27-28
•Medical emergency	
•Ambulance	
(e) Mental health and substance abuse benefits	29-30
(f) Prescription drug benefits	30-32
(g) Special features	33
• Flexible benefits option	
• Services for the deaf and hearing impaired	
(h) Dental benefits	34
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Section 5 (a). Medical services and supplies provided by physicians and other health care professionals

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

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- 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.

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Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician's office 	\$10 per office visit
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • Office medical consultations • Second surgical opinion 	\$10 per office visit
<ul style="list-style-type: none"> • At home • During a hospital stay • In a skilled nursing facility 	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> • Hearing aid exams • Homemaker services and private duty nursing 	<i>All charges.</i>

Lab, X-ray and other diagnostic tests	You pay
<p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG 	<p>Nothing, if you receive these services during your office visit; otherwise, \$10 per visit</p>
Preventive care, adult	You pay
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 • Prostate Specific Antigen (PSA test) – one annually for men age 40 and older 	<p>\$10 per office visit</p>
<p>Routine pap test</p> <p>Note: The office visit is covered if pap test is received on the same day; see <i>Diagnosis and Treatment</i>, above.</p>	<p>\$10 per office visit</p>
<p>Routine mammogram –covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> • 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 	<p>\$10 per office visit</p>
<p><i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i></p>	<p><i>All charges.</i></p>

Preventive care, adult (<i>continued</i>)	You Pay
Routine immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually 	\$10 per office visit
Preventive care, children	You pay
Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
<ul style="list-style-type: none"> • Well-child care charges for routine examinations and care (through age 17) • Examinations, such as: <ul style="list-style-type: none"> – 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 17) 	\$10 per office visit
Maternity care	You pay
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 9 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	\$10 for the initial maternity office visit; nothing for all other maternity related visits
<i>Not covered:</i> <ul style="list-style-type: none"> • Routine sonograms to determine fetal age, size or sex • Expenses related to surrogate mother services 	<i>All charges.</i>

Family planning	You pay
<p>A broad range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>NOTE: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling</i> • <i>Contraceptive medications or devices that are available without a prescription</i> 	<p><i>All charges.</i></p>
Infertility services	You pay
<p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> — <i>intravaginal insemination (IVI)</i> — <i>intrauterine insemination (IUI)</i> 	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> — <i>in vitro fertilization</i> — <i>embryo transfer, gamete GIFT and zygote ZIFT</i> — <i>Zygote transfer</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> • <i>Fertility drugs</i> 	<p><i>All charges.</i></p>

Allergy care	You pay
Testing and treatment Allergy injection	\$10 per office visit
Allergy serum	Nothing
<i>Not covered: provocative food testing and sublingual (under the tongue) allergy desensitization, testing or treatment</i>	<i>All charges.</i>
Treatment therapies	You pay
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 24.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We will only cover GHT when we preauthorize the treatment. Have your doctor submit a written referral request to Medical Management 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 <i>Services requiring our prior approval</i> in Section 3.</p>	\$10 per office visit
Physical and occupational therapies	You pay
<ul style="list-style-type: none"> • Up to 40 combined visits for physical and occupational therapy per contract year for the services of the following: <ul style="list-style-type: none"> – Plan physical therapists and – Plan occupational therapists. <p>Note: Therapy is covered for conditions that are the result of an acute illness or injury and are medically necessary. When physical and occupational therapy is rendered in conjunction with speech therapy 40 combined visits will apply.</p> <ul style="list-style-type: none"> • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 36 sessions in a 12 week period. 	Nothing

<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs 	<p><i>All charges.</i></p>
<p>Speech therapy</p>	<p>You pay</p>
<ul style="list-style-type: none"> • Up to 40 visits for speech therapy per contract year for the services of the following: <ul style="list-style-type: none"> — Plan speech therapists. <p>Note: Therapy is covered for conditions that are the result of an acute illness or injury and are medically necessary. When speech therapy is rendered in conjunction with physical or occupational therapy, 40 combined visits will apply.</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy 	<p><i>All charges.</i></p>
<p>Hearing services (testing, treatment, and supplies)</p>	<p>You pay</p>
<ul style="list-style-type: none"> • Hearing testing 	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Hearing aids, testing and examinations for them • Cochlear implants 	<p><i>All charges.</i></p>
<p>Vision services (testing, treatment, and supplies)</p>	<p>You pay</p>
<ul style="list-style-type: none"> • Annual eye refraction without a referral. More than one (1) exam in a one-year period requires a written referral from your PCP. <p>Note: See Preventive care, children for eye exams for children.</p>	<p>\$10 per office visit</p>
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) 	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Eyeglasses, contact lenses and, fittings for contact lenses • Dispensing fees • Eye exercises and orthoptics • Kerato-refractive eye surgery including, but not limited to tangential, radial keratotomy and other refractive surgery 	<p><i>All charges.</i></p>

Foot care	You pay
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>See orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except when performed by your PCP.</i> • <i>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).</i> 	<p><i>All charges.</i></p>
Orthopedic and prosthetic devices	You pay
<ul style="list-style-type: none"> • The initial acquisition of artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implants following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	<p>20% coinsurance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Prosthetic replacements, unless the member's condition has changed so as to make the original equipment inappropriate</i> 	<p><i>All charges.</i></p>

Durable medical equipment (DME)	You pay
<p>Rental or purchase, at our option, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • hospital beds; • wheelchairs; we will only cover one (1) power/motorized/customized wheelchair per lifetime; • splints, crutches, trusses, orthopedic braces and appliances; • walkers; • blood glucose monitors; and • insulin pumps. <p>Note: Call us at 800/362-3310 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	20% coinsurance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Customization of vehicles and/or lifts for the wheelchairs and/or scooters</i> • <i>Supplies and equipment which are not primarily intended for medical use, such as air conditioners, exercise bicycles, filter vacuum cleaners, etc.</i> • <i>Disposable supplies and equipment, such as batteries, antiseptics, and tape</i> • <i>Any and all types of modifications to your home and the items associated with the modifications, including but not limited to ramps, grab bars, stair lifts and chair lifts</i> • <i>Repair of DME</i> • <i>Replacement of DME unless the item is no longer useful; the original equipment is no longer appropriate for the member's condition. The replacement must not be a deluxe model or more advanced technology model than required; and the replacement request has been prior authorized by us.</i> • <i>Blood pressure monitoring equipment</i> 	<i>All charges.</i>
Home health services	You pay
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<i>All charges.</i>

Chiropractic	You pay
<ul style="list-style-type: none"> • Manipulation of the spine and extremities 	\$10 per office visit
<p><i>Not covered: maintenance therapy for chronic conditions</i></p>	<p><i>All charges.</i></p>
Alternative treatments	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Naturopathic services</i> • <i>Acupuncture</i> • <i>Massage therapy</i> • <i>Hypnotherapy</i> • <i>Biofeedback</i> 	<p><i>All charges.</i></p>

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

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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.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

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Benefit Description	You pay After the calendar year deductible...
<p>Surgical procedures</p> <p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • 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 • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization • Treatment of burns <p>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 the insertion of the pacemaker.</p>	<p>\$10 per office visit; nothing for hospital visits</p>

Surgical procedures continued on next page.

<p>Surgical procedures (continued)</p> <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization and related procedures</i> • <i>Plastic Surgery primarily for cosmetic purposes</i> • <i>Transplants not listed as covered and anti-rejection and immunosuppressive drugs, and follow-up care which is received as a result of treatment for non-covered transplant procedures</i> • <i>Breast augmentation and any treatment for complications resulting from these procedures. This exclusion does not apply to the reconstruction of affected tissues incident to a mastectomy.</i> • <i>Routine treatment of conditions of the foot; see Foot care.</i> 	<p style="text-align: center;">You pay</p> <p><i>All charges.</i></p>
<p>Reconstructive surgery</p> <ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> — the condition produced a major effect on the member's appearance and — the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> — 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) <p>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.</p>	<p style="text-align: center;">You pay</p> <p>\$10 per office visit; nothing for hospital visits</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges.</i></p>

Oral and maxillofacial surgery	You pay
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • 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; • Cutting of accessory sinuses, salivary glands, or ducts; • Surgical removal of bony or impacted teeth; • Removal of exostosis of the jaw and hard palate; • External and internal incision and drainage of cellulitis; • Frenectomy; • Vestibuloplasty – surgical modification of the gingival-mucous membrane relationship in the vestibule of the mouth; and • Residual root removal or root amputation. 	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> • <i>Oral surgical procedures which are related to the correction of functional deformities of the mandible or maxillae</i> • <i>Procedures that reposition the mandible or maxillae</i> • <i>Procedures to correct malocclusion</i> • <i>Non-surgical procedures such as the extraction of teeth by pulling, root canal procedures, and filling, capping, recapping, or dental implants.</i> 	<p><i>All charges.</i></p>

Organ/tissue transplants	You pay
<p>Limited to human to human transplants:</p> <ul style="list-style-type: none"> • 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 <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> • <i>Retransplantation – more than one transplant per organ per member during the lifetime of the policy with Unity Health Plans, except as required by law, e.g. the treatment of kidney disease.</i> 	<p><i>All charges.</i></p>
Anesthesia	You pay
<p>Professional services provided in-hospital (inpatient)</p> <p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office <p>Dental anesthesia services for dental care are covered under certain circumstances and subject to referral and prior authorization. These services are available if any of the following apply:</p> <ul style="list-style-type: none"> • The member is a child under 5 years of age. • You have a chronic disability that meets all of the conditions under s.230.04(9r)(a)2 of Wisconsin state law. • You have a medical condition that requires hospitalization or general anesthesia for dental care. 	<p>Nothing</p>

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

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Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

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Benefit Description	You pay
Inpatient hospital	
<p>Room and board, such as</p> <ul style="list-style-type: none"> • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. <p>NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p> <p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • 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 	<p>Nothing</p>

Inpatient hospital continued on next page.

Inpatient hospital (continued)	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • 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 • Take-home drugs and supplies dispensed at the time of hospital discharge that can be purchased on an outpatient basis whether billed directly or separately by the hospital 	<p><i>All charges.</i></p>
Outpatient hospital or ambulatory surgical center	You pay
<ul style="list-style-type: none"> • 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 <p>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.</p>	<p>Nothing</p>
<p><i>Not covered: blood and blood derivatives not replaced by the member</i></p>	<p><i>All charges.</i></p>
Extended care benefits/skilled nursing care facility benefits	You pay
<p>Extended care benefit: Limited to 90 days per covered confinement when you are admitted within 24 hours of discharge from a hospital. The care must be for continued treatment of the same condition when confinement in a skilled nursing facility is medically necessary as determined by a plan doctor and approved by us.</p>	<p>Nothing</p>
<p><i>Not covered: custodial care</i></p>	<p><i>All charges.</i></p>
Hospice care	You pay
<p>The hospice benefit is medically necessary supportive and palliative care for members in the terminal stage of an illness whose life expectancy is six months or less. Services must be authorized by us in advance and provided under the direction of a plan doctor through a licensed hospice care provider.</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • independent nursing, • homemaker services 	<p><i>All charges.</i></p>

Ambulance	You pay
<ul style="list-style-type: none"> Local professional ambulance service when medically appropriate and medical attention is required in route. Air ambulance requires prior authorization by us. 	Nothing

Section 5 (d). Emergency services/accidents

I M P O R T A N T	<p>Here are some important things to keep in mind about these benefits:</p> <ul style="list-style-type: none"> Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure. Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. 	I M P O R T A N T
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What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area:

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

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

Emergencies outside our service area:

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

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

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> • 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 <p>Note: If you use a non-participating provider for emergency care services and do not notify us within three (3) business days of receiving the care, your benefit will be reduced by \$500.</p> <p>If you are admitted as an inpatient directly from the emergency room, your emergency room copay will be waived.</p>	<p>\$10 per office visit</p> <p>\$10 per office visit</p> <p>\$50 per hospital emergency room visit</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>
Emergency outside our service area	
<ul style="list-style-type: none"> • 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 	<p>\$10 per office visit</p> <p>\$10 per office visit</p> <p>\$50 per hospital emergency room visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges.</i>
Ambulance	
<ul style="list-style-type: none"> • Professional ambulance service when medically appropriate. See 5(c) for non-emergency service. • Air ambulance services require prior authorization by us. 	Nothing

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

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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 illness and conditions.

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

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

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Benefit Description	You pay
Mental health and substance abuse benefits	
<p>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.</p> <p>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.</p>	Your cost sharing responsibilities are no greater than for other illness or conditions.
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management • Diagnostic tests 	\$10 per office visit
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment. 	Nothing

Not covered: Services we have not approved.

Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

All charges.

Preauthorization

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

If your PCP is in Dane County (except for the communities of Black Earth or Cambridge) you must call Behavioral Health Consultation System (BHCS) at 800/683-2300 for prior authorization of your behavioral health care. BHCS will help you determine the type of behavioral health practitioner that can best address your personal needs and make an appointment in a timely manner.

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

Section 5 (f). Prescription drug benefits

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.
- Some prescriptions require prior authorization from Unity Health Plans. Both formulary and non-formulary medications may be in this category. The ordering physician must submit a request for the medication and a clinical pharmacist, based on criteria established by the Unity P&T Committee, will make a decision. If you want to check the status of a prior authorization request, contact our Pharmacy Services Department at 800/788-2949. They are available 24-hours per day, 365 days per year.
- 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.

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy or by mail for a long-term maintenance medication. Unity currently has an agreement with the University of Wisconsin Hospital and Clinics Outpatient Pharmacy to provide members, who require long-term maintenance medication, the ability to receive these prescriptions by mail order. This service will provide professional expertise and advice by telephone; fast and convenient service; and a 90-day supply of most long-term maintenance medications for only 2.5 copays. To find out if you qualify for this service call 866/894-3784 (Monday through Friday, 8:00 a.m.-5:00 p.m.) to request an enrollment form and discuss your medication needs with the telepharmacist. A registered pharmacist will work with your physician to determine if you meet eligibility requirements. A toll-free automated refill line (866/894-3784) is available 24-hours per day to take prescription refill requests. Payment for this service is by MasterCard/Visa/Discover with free delivery or optional overnight delivery for \$12.
- **We use a formulary.** Our prescription drug formulary is a tool used by our participating clinic providers and pharmacists. The formulary is a list of prescription drugs covered at the lower generic or name brand copay level. This formulary assists in the management of drug selection and promotes proper use of prescription drugs. When you use a formulary medication your copay will be either \$6 for generic medications or \$12 for name brand medications. If you use a non-formulary medication you will pay a \$24 copay.

Unity's Pharmacy and Therapeutics (P&T) Committee updates the formulary periodically. Participating physicians and pharmacists serve on this committee. In reviewing and selecting which medications to include on the formulary, the P&T Committee considers quality, safety, effectiveness, and affordability. Medications on the formulary are subject to change. To obtain a current list of the formulary, call Customer Service at 800/362-3310.

Unity does not cover all prescriptions. In addition, some drugs may require prior authorization from Unity Health Plans. Both formulary and non-formulary medications may be in this category. In either situation, the ordering physician must submit a request for the drug and a decision will be made by a pharmacist within Unity's pharmacy program. You can also begin this request process or check on the status of a request, by calling our Pharmacy Services Department at 800/788-2949.

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

A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic, in addition to the \$12 name brand copay.

- **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.** Mail to: 10680 Trenea Street 5th floor, San Diego, CA 92131

Benefit Description	You pay
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin, with one copay charged per vial • Insulin syringes and glucose test strips • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction limited to four (4) dosage units per 30 days and requires prior authorization by us. • Oral Contraceptive drugs – up to a three month supply may be obtained for a single copay • Contraceptive drugs and devices 	<p>Plan Retail Pharmacy:</p> <p>\$6 per generic drug</p> <p>\$12 per name brand drug</p> <p>\$24 per non-formulary drug</p> <p>Plan Mail Order Pharmacy:</p> <p>\$15 per generic drug</p> <p>\$30 per name brand drug</p> <p>\$24 per non-formulary drug</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance, including anabolic steroids</i> • <i>Fertility drugs</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients, nutritional products and special feedings even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> • <i>Appetite suppressants including anti-obesity medications and anorexients</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Medications used to prevent or treat hair loss</i> • <i>Any irrigation solutions or supplies</i> • <i>Smoking cessation drugs and medications, except for one 3-month course of treatment for Zyban or prescription generic nicotine patches. Note: see Special features 5(g). Smoking cessation</i> 	<p><i>All charges.</i></p>

Section 5 (g). Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Smoking Cessation	<p>We will cover Zyban or prescription generic nicotine patches that are prescribed by your PCP for the purpose of achieving smoking cessation for up to one three (3) month course of treatment per calendar year. You pay the drug copay of \$6 for generic formulary prescriptions, \$12 for name brand formulary drugs, and \$24 for non-formulary prescriptions. We will cover the office visit to your PCP for counseling and to obtain the prescription. You pay \$10 for the office visit. In addition, Unity's Wellness First program will reimburse you 50% up to \$50 per year for approved health education classes, including smoking cessation. You must attend at least 75% of the classes to be eligible for reimbursement. Contact Unity's Health Educator at 800/362-3308 for a listing of all approved classes and additional details about the Wellness First program.</p>
Services for deaf and hearing impaired	<p>TDD is available by contacting us at 608/643-1421.</p>

Section 5 (h). Dental benefits

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

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

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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. Coverage for injuries resulting from eating accidents is excluded. Treatment must begin within 90 days after the accident and will be covered for a maximum of twelve months after treatment begins.	Nothing up to \$1,000 per accident and all charges thereafter.

Dental benefits

We have no other dental benefits.

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under *What Services Require Our Prior Approval* on page 10.**

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 800/362-3310.

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

- Covered member's name and ID number;
- Name and address 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: Unity Health Plans, 840 Carolina Street, Sauk City, WI 53583

Prescription drugs

Submit your claims to: 10680 Treena Street 5th floor, San Diego, CA 92131

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	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">(a) Write to us within 6 months from the date of our decision; and(b) Send your request to us at: 840 Carolina Street, Sauk City, WI 53583; and(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and(d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none">(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	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">• 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. <p>Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, DC 20415-3630.</p>

The Disputed Claims process (*Continued*)

Send OPM the following information:

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

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

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must 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.

6 If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies 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 800/362-3310 and we will expedite our review; or
- (b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You can call OPM's Health Benefits Contracts Division 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. Your PCP must continue to submit necessary written referrals for authorization by Medical Management. On occasion you may need to send us your Explanation of Medicare Benefits (EOMB). We will not waive any of our copayments and coinsurance.

(Primary payer chart begins on this 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		✓

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 800/362-3310

We do not waive any costs when you have Medicare.

• **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan -- 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 and coinsurance. 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

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

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related 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.

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. We reserve the right to be provided notice of any claim against a third party and you agree to protecting our interest and providing necessary information to us upon request. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See page 10.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 10.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Custodial care includes room and board, nursing care, personal care or other care which is designed to assist an individual in the activities of daily living, e.g., eating, dressing, help in walking, supervision of meals. It is care and treatment that generally is received by an individual who has reached the maximum level of recovery in the opinion of his/her physician. In the case of an institutionalized person, custodial care also includes room and board, nursing care, or other such care which is provided to an individual for whom it cannot reasonably be expected, in the opinion of the attending physician, that medical or surgical treatment will enable that person to live outside an institution. Custodial care also includes rest care, respite care, and home care provided by family members. Care may still be considered custodial care, as determined by us, even if: a.) the member is under the care of a physician; b.) the physician prescribes services to support and maintain the member's condition; and c.) services and supplies are being provided by a registered nurse or licensed practical nurse.
Experimental or investigational services	Experimental or investigational treatment or services are those drugs, procedures, surgeries, equipment and devices that do meet each of the criteria below, as determined by Unity Health Plans: 1.) the services must have FDA approval; 2.) scientific evidence must permit conclusions concerning the effect on health outcome; and 3.) the research and experimental stage of the development of the treatment or service must be completed. These types of treatment or services are subject to review by Unity Health Plans in accordance with the policies and procedures of the Unity Health Plans Technology Assessment Sub-Committee. Copies of the policies and procedures may be obtained by calling Unity Health Plans' Customer Service at 800/362-3310.
Medical necessity	Services, treatments, or supplies that are provided by a hospital, physician, or licensed health care provider. These services or treatment must be necessary in order to identify or treat sickness or injury. Your attending physician in conjunction with our Medical Director must determine them to be: 1.) consistent with the symptoms or diagnosis and treatment of your sickness or injury; and 2.) appropriate with regard to standards of acceptable medical practice; and 3.) not solely for the convenience of you, a physician, hospital, or other health care provider; and 4.) the most appropriate supply or level of service that can be safely provided to you; and 5.) not primarily for cosmetic improvement of your appearance regardless of psychological benefit.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services.
Us/We	Us and we refer to Unity Health Plans
You	You refers to the enrollee and each covered family member

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you 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.

Your medical and claims records are confidential

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

- OPM, this Plan, and subcontractors when they administer this contract;

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

When you retire

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

When you lose benefits

•When FEHB coverage ends

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

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

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

• Spouse equity coverage

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

•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

You may be entitled to continued coverage through the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Federal law offers limited Federal protections for health coverage availability and continuity to 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.

Get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. It highlights 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 it has information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG!*
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. LTC insurance can supplement care provided by family members, reducing the burden you place on them.

I'm healthy. I won't need long term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. Many people now consider long term care insurance to be vital to their financial and retirement planning.

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed \$50,000. Home care for only three 8- hour shifts a week can exceed \$20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*
- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

When will I get more information on how to apply for this new insurance coverage?

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

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

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Summary of benefits for Unity Health Plans - 2002

- **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	\$10 per visit	12
Services provided by a hospital: • Inpatient.....	Nothing	25
• Outpatient	Nothing	26
Emergency benefits: • In-area.....	\$50 per emergency room visit	28
• Out-of-area	\$50 per emergency room visit	28
Mental health and substance abuse treatment.....	Regular cost sharing.	29
Prescription drugs		30
Up to a 30-day supply from Plan Retail Pharmacy	\$6 per generic prescription; \$12 per name brand formulary prescription; \$24 per name brand non-formulary prescription	
Up to a 90-day supply from Mail Order Pharmacy	\$15 per generic prescription; \$30 per name brand formulary prescription; \$60 per name brand non-formulary prescription	
Dental Care	Nothing up to \$1000 per accident and all charges thereafter for restorative services necessary to repair sound natural teeth .	34
Vision Care	\$10 per office visit for one (1) refraction annually	17
Special features: Flexible benefits option; Smoking cessation; Services for the deaf and hearing impaired		
Protection against catastrophic costs (your out-of-pocket maximum).	We do not have an out of pocket maximum	

2002 Rate Information for Unity Health Plans

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

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

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

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	W4	\$ 97.86	\$ 39.47	\$212.03	\$ 85.52	\$115.52	\$ 21.81
High Option Self & Family	W4	\$223.41	\$140.53	\$484.06	\$304.48	\$263.75	\$100.19