

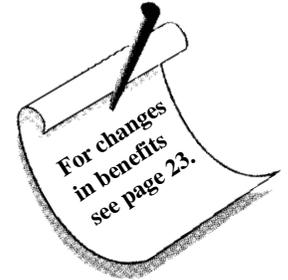


Group Health Cooperative of Puget Sound

1998



A Health Maintenance Organization



This plan has full accreditation from the NCQA. See the *FEHB Guide* for more information on NCQA.

Serving: Most of Western Washington

Enrollment code:

High Option

- 541 Self Only
- 542 Self and Family

Standard Option

- 544 Self Only
- 545 Self and Family

Service area: Services from Plan providers are available only in the following area:

The counties of Clallam, Island, King, Kitsap, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Thurston, Whatcom; the following cities in Grays Harbor County—Elma, Malone, McCleary, Oakville, Porter; and the following cities in Jefferson County—Brinnon, Chimacum, Gardner, Hadlock, Nordland, Port Ludlow, Port Townsend, Quilcene, which are east of a line drawn southward from Port Angeles.

Authorized for distribution by the:



**United States
Office of
Personnel
Management**



**Federal Employees
Health Benefits Program**

RI 73-012

Group Health Cooperative

Group Health Cooperative of Puget Sound, 521 Wall Street, Seattle, Washington 98121, has entered into a contract (CS1043) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called Group Health Cooperative, GHC, or the Plan.

This brochure is based on text included in the contract between OPM and this Plan and is intended to be a complete statement of benefits available to FEHB members. A person enrolled in the Plan is entitled to the benefits stated in this brochure. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1998, and are shown on the inside back cover of this brochure.

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Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital or pharmacy, charged your plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation - sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at 206/448-4140 and explain the situation.
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE

202/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, D.C. 20415

The inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

General Information

Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confidential and will be used only: 1) by the Plan and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education.

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. **As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor except in the case of emergency as described on pages 15 and 16.** If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See "If you are hospitalized" on page 4.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

General Information *continued*

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about: when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan; if you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers, except for emergency benefits.
- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Plan promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. **Before** you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

You may also remain enrolled in this Plan when you join a Medicare prepaid plan.

Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. See page 21 for information on the Medicare prepaid plan offered by this Plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

General Information *continued*

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she generally will be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date and coverage may not exceed the 18 or 36 month period noted above.

Notification and election requirements

Separating employees — Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

Children — You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.

Former spouses — You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

General Information *continued*

Conversion to individual coverage

When none of the above choices are available — or chosen — when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Facts about this Plan

This Plan is a comprehensive medical plan, sometimes called a health maintenance organization (HMO). When you enroll in an HMO, you are joining an organized system of health care that arranges in advance with specific doctors, hospitals and other providers to give care to members and pays them directly for their services. Benefits are available **only** from Plan providers except during a medical emergency. **Members are required to select a personal doctor from among participating Plan primary care doctors.** Services of a specialty care doctor can only be received by referral from the selected primary care doctor. There are no claim forms when Plan doctors are used.

Your decision to join an HMO should be based on your preference for the plan's benefits and delivery system, not because a particular provider is in the plan's network. You cannot change plans because a provider leaves the HMO.

Because the Plan provides or arranges your care and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan emphasizes preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness.

Who provides care to Plan members?

Group Health Cooperative of Puget Sound is a Mixed Model Prepayment (MMP) plan. The Plan provides medical care by doctors, nurse practitioners, and other skilled medical personnel working as medical teams. Specialists in most major specialties are available as part of the medical teams for consultation and treatment.

For Whatcom Division Members only: All participating doctors are established medical practitioners who provide routine care within their private office settings in the community.

Role of a primary care doctor

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when there has been a written referral by the member's primary care doctor, with the following exception: a woman may see a participating General and Family Practitioner, Physician's Assistant, Gynecologist, Certified Nurse Midwife, Doctor of Osteopathy, Obstetrician and Advanced Registered Nurse Practitioner who provides women's health care services directly, without a referral from their primary care doctor, for medically appropriate maternity care, covered reproductive health services, preventive care and general examination, gynecological care and medically appropriate follow-up visits for the above services. If your chosen provider diagnoses a condition that requires more extensive covered care outside the practice scope of your women's health care provider the primary care doctor must be contacted for authorization and care coordination.

Choosing your doctor

The Plan's provider directory lists Puget Sound area health centers and, for the Whatcom Division, lists primary care doctors (family practitioners, pediatricians and internists), with their locations and phone numbers. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Member Services Department at 206/448-4140 or, for Whatcom and Skagit Division members, the Whatcom Division Administrative Office at 360/647-7200. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important note: **When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider cannot be guaranteed.**

If you enroll, you will be asked to let the Plan know which primary care doctor(s) you've selected for you and each member of your family by sending a selection form to the Plan. Members may change their doctor selection by notifying the Plan in writing. The change will be effective the first of the month following notification.

If you are receiving services from a doctor who leaves the Plan, the Plan will pay for covered services until the Plan can arrange with you for you to be seen by another participating doctor.

Facts about this Plan *continued*

Referrals for specialty care

Except in a medical emergency, or when a primary care doctor has designated another doctor to see his or her patients, you must receive a referral from your primary care doctor before seeing any other doctor or obtaining special services. Referral to a participating specialist is given at the primary care doctor's discretion; if non-Plan specialists or consultants are required, the primary care doctor will arrange appropriate referrals.

When you receive a referral from your primary care doctor, you must return to the primary care doctor after the consultation unless your doctor authorizes additional visits. All follow-up care must be provided or authorized by the primary care doctor. Do not go to the specialist for a second visit unless your primary care doctor has arranged for, and Plan has issued an authorization for, the referral in advance.

For new members

If you are already under the care of a specialist who is a Plan participant, you must still obtain a referral from a Plan primary care doctor for the care to be covered by the Plan. For new Whatcom and Skagit Division members only; if the doctor who originally referred you to this specialist is now your Plan primary care doctor, you need only call to explain that you are now a Plan member and ask that you be referred for your next appointment.

If you are selecting a new primary care doctor and want to continue with this specialist, you must schedule an appointment so that the primary care doctor can decide whether to treat the condition directly or refer you back to the specialist.

Hospital care

If you require hospitalization, your primary care doctor or authorized specialist will make the necessary arrangements and continue to supervise your care.

Out-of-pocket maximum

Copayments are required for a few benefits. However, copayments will not be required for the remainder of the calendar year after your out-of-pocket expenses for services provided or arranged by the Plan reach \$750 per Self Only enrollment or \$1,500 per Self and Family enrollment. This copayment maximum does not include charges for: infertility treatment services; orthopedic and temporomandibular joint (TMJ) appliances; the nasal CPAP device; post mastectomy bras; dental care; or the \$100 non-Plan emergency care deductible; the 20% coinsurance for ambulance services; and the outpatient mental health care copayment.

You should maintain accurate records of the copayments made, as it is your responsibility to determine when the copayment maximum is reached. You are assured a predictable maximum in out-of-pocket costs for covered health and medical needs. Copayments are due when service is rendered, except for emergency care.

Deductible carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible will be covered by your old plan if they are for care you got in January **before** the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Submit claims promptly

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. The Plan will not pay benefits for claims submitted later than December 31 of the calendar year following the year in which the expense was incurred unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Other considerations

Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you will be able to accept treatment or procedures that may be recommended by Plan providers.

Facts about this Plan *continued*

The Plan's service area

The service area for this Plan, where Plan providers and facilities are located, is described on the front cover of this brochure and on this page. You may enroll in this Plan if you live or work inside the service area or live in the geographic area described below.

The service area for this Plan includes the following areas:

In Washington State: The counties of Clallam, Island, King, Kitsap, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Thurston, and Whatcom; the following cities in Grays Harbor County - Elma(98541), Malone (98559), McCleary (98557), Oakville (98568), Porter (98573); and the following cities in Jefferson County - Brinnon (98320), Chimacum (98325), Gardner (98334), Hadlock (98339), Nordland (98358), Port Ludlow (98365), Port Townsend (98368), Quilcene (98376), which are east of the line drawn southward from Port Angeles.

The Plan accepts enrollments from these additional geographic areas:

The counties of Grays Harbor and Jefferson.

Benefits for care outside the service area are limited to emergency services, as described on pages 15 and 16.

If you or a covered family member move outside the service area, or farther away from the service area, or you no longer work in the service area, you may enroll in another approved plan. It is not necessary to wait until you move or for the open season to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

Plan members who temporarily reside outside the service area of this Plan may have access to care with Plans that have Reciprocity Agreements with this Plan. The Plans are as follows: Group Health Northwest (GHNW); Kaiser Permanente Northwest in Oregon; the American Association of Health Plans (AAHP); and The HMO Group (THMOG).

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan.** This brochure is based on text included in the contract between OPM and this Plan and is intended to be a complete statement of benefits available to FEHB members. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control.

Circumstances beyond Plan control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Plan and complete all necessary documents and authorizations requested by the Plan.

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, benefits will be coordinated with Medicare according to Medicare's determination of which coverage is primary. Generally, you do not need to take any action after informing the Plan of your or your family member's eligibility for Medicare. Your Plan will provide you with further instructions if a Medicare claim needs to be filed.

Group health insurance and automobile insurance

This coordination of benefits (double coverage) provision applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Plan.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan.

One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of a prepaid plan, special limitations on your CHAMPUS coverage apply; your primary care provider must authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable by OWCP (or the agency).

General Limitations *continued*

**DVA facilities,
DoD facilities,
and Indian
Health Service**

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

**Other Government
agencies**

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

**Liability insurance
and third party
actions**

If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. If you need more information about subrogation, the Plan will provide you with its subrogation procedures.

General Exclusions

All benefits are subject to the limitations and exclusions in this brochure. **Although a specific service may be listed as a benefit, it will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose or treat your illness or condition.** The following are excluded:

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see Emergency Benefits);
- Expenses incurred while not covered by this Plan;
- Services furnished or billed by a provider or facility barred from the FEHB Program;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Procedures, treatments, drugs or devices that are experimental or investigational;
- Procedures, services, drugs and supplies related to sex transformations; and
- Procedures, services, drugs and 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.

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; **you pay** a \$5 office visit copay under both options, but no additional copay for laboratory tests and X-rays. Within the service area, house calls will be provided if, in the judgment of the Plan doctor, such care is necessary and appropriate; **you pay** nothing for a doctor's house call and nothing for home visits by nurses and health aides.

The following services are included and are subject to the office visit copay unless stated otherwise:

- Preventive care, including periodic check-ups according to well care schedule and well-baby care (copay waived)
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters (copay is waived)
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning counseling services
- Diagnosis and treatment of diseases of the eye
- Blood derivatives and the administration of blood
- Allergy testing and treatment, including testing and treatment materials
- Cornea, heart, heart/lung, kidney, liver, lung (single or double) and pancreas/kidney, transplants; 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. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan, and are limited to procurement center fees, travel costs for a surgical team, excision fees, and matching tests. Transportation and living expenses are excluded.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Surgical treatment of morbid obesity
- Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you
- Routine nutritional counseling
- Therapeutic and nontherapeutic sterilization procedures
- Oxygen and oxygen equipment for home use
- Total parenteral nutritional therapy
- Enteral nutritional therapy when necessary due to malabsorption
- Ostomy supplies necessary for the removal of bodily secretions or waste

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Medical and Surgical Benefits *continued*

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including the lengthening or shortening of the mandible or maxillae for cosmetic purposes or correction of malocclusion. Services to correct temporomandibular joint (TMJ) pain dysfunction may include medical and surgical procedures including the lengthening or shortening of the mandible or maxillae and are covered; **you pay** 50% of charges. **You pay** 50% of the charges for all TMJ appliances. Any dental care involvement in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome, including TMJ appliances, and additional TMJ services needed because of dental treatment are excluded.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery. Following mastectomy, internal and external breast prostheses are covered—**you pay** nothing under both options. External breast prostheses are limited to one every two years. Post-mastectomy bras are limited to two (2) every six (6) months. **You pay** 50% of charges under both options.

Short-term rehabilitative care is provided on an inpatient and outpatient basis for the following services: physical therapy; occupational therapy; and speech therapy to restore function following illness, injury or surgery. Coverage is limited to: two months per condition per calendar year for combined inpatient services and 60 visits per condition per calendar year for combined outpatient services. **You pay** a \$5 copay per outpatient session under both options. Services are limited to those necessary to restore or improve functional abilities when impairment exists due to injury or illness, and those for which significant improvement can be expected within two months as a consequence of intervention by therapy services. Subject to the above limits, services for the restoration and improvement of function for neurodevelopmentally disabled children age six (6) and under are covered, including maintenance in cases where significant deterioration of the child's condition would result without such services.

The insertion of internal prosthetic devices is limited to artificial joints, intraocular lenses, cochlear implants and cardiac devices, such as pacemakers, but no coverage is provided for artificial or mechanical hearts, or for penile implants.

Orthopedic appliances, such as braces. **You pay** 50% of charges under both options. Corrective shoes and arch supports are excluded.

Nasal CPAP device. **You pay** 50% of charges under both options. Replacement of the initial supplies is excluded, also replacement of the device due to loss, breakage or damage is excluded.

Diagnosis and treatment of infertility is covered. For nonexperimental infertility services that are limited to general diagnostic services, **you pay** a \$5 copay per outpatient visit under both options. For specific diagnostic services, medical and surgical treatment, including the following types of artificial insemination; intravaginal insemination (IVI), intracervical insemination (ICI), and intrauterine insemination (IUI), and drug therapy, **you pay** 50% of charges under both options. Donor expenses for infertility treatment, including donor sperm are not covered. Fertility drugs are also covered under the Prescription Drug Benefit. Other assisted reproductive technology (ART) procedures, such as in vitro fertilization and embryo transfer, are not covered.

Chiropractic services (without a referral) up to a maximum of ten (10) visits per member per calendar year for manipulative therapy of the spine and extremities by Plan providers. The medical necessity for manipulative therapy must meet Plan protocol. **You pay** a \$5 copay per visit under both options.

Podiatric services which meet Plan protocol and are authorized in advance by the member's primary care doctor; excluded is treatment of flat feet or other misalignments of the feet; removal of corns and calluses; and hygienic foot care, except in the presence of a non-related medical condition affecting the lower limbs. **You pay** a \$5 copay per visit under both options.

Naturopathic services which meet Plan protocol and are authorized in advance by the member's primary care doctor; excluded are botanical/herbal medicines, vitamins, and food supplements. **You pay** a \$5 copay per visit under both options.

Acupuncture services which meet Plan protocol and are authorized in advance by the member's primary care doctor; excluded are botanical and herbal medicines. **You pay** a \$5 copay per visit under both options.

Medical and Surgical Benefits *continued*

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Diagnostic testing and treatment of sexual dysfunction
- Reversal of therapeutic or nontherapeutic sterility
- Plastic surgery primarily for cosmetic purposes
- Hearing aids
- Transplants not listed as covered
- Foot orthotics
- Homemaker services
- Prosthetic devices, such as artificial limbs and artificial eyes
- Durable medical equipment, such as wheelchairs and hospital beds
- Routine circumcision
- The cost of blood
- Long-term rehabilitative therapy
- Cardiac rehabilitation programs

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay nothing. All necessary services are covered**, including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care.
- Specialized care units, such as intensive care or cardiac care units.

Extended care

The Plan provides a comprehensive range of benefits for up to 30 days per calendar year with no dollar limit when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. **You pay nothing. All necessary services are covered**, including:

- Bed, board and general nursing care
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or a hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance service

Benefits are provided for ground and air ambulance transportation to a Plan facility, Plan designated facility, or non-Plan designated facility, ordered or authorized by a Plan doctor. **You pay 20%** of charges.

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for a medical condition totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 17 for nonmedical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Blood not replaced by the member
- Custodial care, rest cures, domiciliary or convalescent care

Emergency Benefits

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that 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 the Plan may determine are medical emergencies — what they all have in common is the need for quick action.

Emergencies within the service area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. It is your responsibility to ensure that the Plan has been timely notified.

Emergency Benefits *continued*

Emergencies within the service area

Continued

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 24 hours by calling the Plan notification line at 206/326-7666, unless it was not reasonably possible to notify the Plan within that time. Collect calls are accepted. If you are hospitalized in non-Plan facilities and a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full. If you have questions about acute illness other than emergencies, you should call your primary care doctor.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Plan pays...

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay...

At a facility not designated by the Plan, **you pay** a deductible of \$100 per member per visit under both options. At a Plan hospital or Plan designated emergency facility, **you pay** a \$50 copay per member per visit under both options. If more than one covered member of an enrollee's immediate family requires emergency care as a result of the same accident, only one emergency copay or deductible will apply. If you are admitted to an in-Plan hospital or designated facility directly from the emergency room, the in-Plan copayment is waived.

Emergencies outside the service area

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

If you need to be hospitalized, the Plan must be notified within 24 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Plan pays...

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay...

Same as within the service area

What is covered

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance (ground and air) service approved by the Plan; **you pay** 20% of charges.

What is not covered

- Elective care or nonemergency care
- Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area
- Follow-up care that is not approved by the Plan

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card.

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 22.

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered

To the extent shown below, the Plan provides the following medically necessary services, as determined by the Plan providers, for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders limited to:

- Diagnostic evaluation and consultation services
- Psychological testing as part of the treatment program
- Psychiatric medical services including medical management (including individual, family, and group therapy) and medications (see Prescription Drug Benefits)
- Hospitalization (including inpatient professional services)

Outpatient care

All necessary outpatient visits to Plan providers each calendar year; **you pay** nothing for the first 20 visits — a \$15.70 copay per visit thereafter.

Inpatient care

Up to 30 days of hospitalization each calendar year; **you pay** 20% of charges for the first 30 days—all charges thereafter. The member's 20% copay applies to the out-of-pocket maximum of \$750 per Self Only enrollment or \$1,500 per Self and Family enrollment.

What is not covered

- Care for psychiatric conditions for which, in the professional judgment of Plan providers, improvement or stabilization is not expected to occur
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
- Psychological testing that is not medically necessary to determine the appropriate treatment of a short-term psychiatric condition

Substance abuse

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition and, to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient care

All necessary outpatient substance abuse visits are covered. **You pay** nothing.

Inpatient care

Covered under Mental conditions benefit.

What is not covered

- Treatment that is not authorized by a Plan doctor

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply or 100-unit supply, whichever is less; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin).

You pay a copay per prescription unit or refill for generic drugs or for name brand drugs when generic substitution is not permissible. When generic substitution is permissible (i.e., a generic drug is available and the prescribing doctor does not require the use of a name brand drug), but you request the name brand drug, you pay the price difference between the generic and name brand drug as well as the copay per prescription unit or refill.

Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. Nonformulary drugs will be covered when prescribed by a Plan doctor.

High Option—You pay a \$4 copay per prescription unit or refill.

Standard Option—You pay a \$7 copay per prescription unit or refill.

Covered medications and accessories include:

- Drugs (including injectables) for which a prescription is required by Federal law
- Insulin
- Insulin pumps and diabetic monitoring equipment
- Diabetic supplies, including needles, syringes, urine and blood glucose testing reagents and visual strips; a copay charge applies per item per each 30-day supply
- Contraceptive drugs and devices (for Norplant device, **you pay** an \$80 copay under High Option; a \$140 copay under Standard Option)
- Compound dermatological preparations
- Disposable needles and syringes needed to inject covered prescribed medication
- Allergy serum
- Injectable contraceptive drugs

Limited benefits

- Drugs to aid in smoking cessation. Participation in the Plan's Smoking Cessation Program is required in order to receive coverage for one course of nicotine replacement therapy per calendar year, subject to the \$4 pharmacy copay for High option and the \$7 pharmacy copay for Standard option.
- Fertility drugs, subject to 50% of charges under both options

Intravenous fluids and medication for home use, implantable drugs, and some injectable drugs are covered under Medical and Surgical Benefits.

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Drugs obtained at a non-Plan pharmacy
- Vitamins and nutritional substances, including dietary formulas and special diets, except for the treatment of phenylketonuria (PKU) and total parenteral and enteral nutrition therapy
- Medical supplies such as dressings, antiseptics, etc.
- Experimental drugs, devices and biological products
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance

Other Benefits

Dental care

High Option only (no benefits are provided for dental services under the Standard Option).
IMPORTANT: The following is a summary of the Plan's dental benefits. Please call the Plan's Member Services Department at 206/448-4140 for more information on additional exclusions and limitations.

What is covered

This dental program will pay a percentage of the reasonable and customary charge for dental services listed below and will reimburse any dentist, dental hygienist (under the supervision of a dentist), or denturist, that you select. **YOU ARE NOT REQUIRED TO RECEIVE YOUR CARE FROM SPECIFIED DENTAL PROVIDERS. You pay** an annual deductible of \$50 per member and \$150 per family per year up to \$1,000 maximum benefit per member per year as well as any amounts over Plan payment. The lifetime maximum amount payable per covered dependent child for covered orthodontic expense is \$500, with NO deductible. **Important:** Benefits are provided only for services included in the list of covered dental services and no charges will be paid in excess of the reasonable and customary charge. No dental benefit will be paid for any dental service or supply which is incomplete or temporary.

Covered preventive dental expenses are paid at 100% of the reasonable and customary charge; **you pay** nothing

- Prophylaxis (cleaning, scaling, and polishing of teeth)
- Routine oral examinations, except for orthodontics
- Fluoride treatment for children under age 16
- Dental X-rays, except for orthodontics
- Bacteriologic cultures and biopsies of tissue
- Emergency palliative treatment for relief of dental pain
- Space maintainers, except for orthodontics

Covered basic dental expenses are paid at 50% of the reasonable and customary charge; **you pay** 50% of charges:

- Endodontic treatment as follows: root canal therapy, pulpotomy, apicoectomy, and retrograde filling
- Simple extractions
- Oral surgery
- Basic periodontal services
- Study models
- Crown build-up on non-vital teeth
- Pin retention of fillings
- Fillings (restorations)
- Recementing inlays, onlays, and crowns
- Recementing bridges
- Repairs to full and partial dentures and bridges
- General anesthetics and analgesics
- Injectable antibiotics

Covered major dental expenses are paid at 30% of the reasonable and customary charge; **you pay** 70% of charges:

- Major periodontal treatment of the gums and supporting structure of the teeth
- Bridges and dentures
- Crowns and gold restorations
- Replacement of damaged appliances

Covered orthodontic expenses are paid at 50% of the reasonable and customary charge for covered dependent children who are under age 19 when the first orthodontic appliance is placed, up to a lifetime maximum of \$500 per covered dependent child provided that treatment begins after the child's effective date of coverage; **you pay** 50% of charges:

- Cephalometric film
- Removable, fixed, or cemented appliance for minor treatment for tooth guidance
- Removable, fixed or cemented appliance for interceptive orthodontic treatment
- Comprehensive (full banded) orthodontic treatment of transition or permanent dentition

Dental benefits for covered orthodontic expenses are paid as the charges for the orthodontic treatment are incurred, but not before the date the initial appliance is placed.

What is not covered

Other dental services not shown as covered

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Other Benefits *continued*

Vision care

What is covered In addition to the medical and surgical benefits provided for the diagnosis and treatment of diseases of the eye, the Plan provides certain vision care benefits from Plan providers.

- Routine eye examinations and refractions, including eyeglass lens prescription, limited to once every 12 months, except when medically necessary. **You pay** a \$5 copay per visit under both options.
- When dispensed through Plan facilities, one contact lens per diseased eye, including exam and fitting, for members following cataract surgery performed by a Plan doctor, in lieu of an intraocular lens. Replacement of covered contact lenses will be provided only when needed due to change in the member's medical condition and will be replaced only one time within any 12 month period.

What is not covered

- Eyeglasses
- Contact lenses and related supplies, including examination and fitting, except as provided above
- Orthoptic (eye) training

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all enrollees and family members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium and any charges for these services do not count toward any FEHB deductibles, or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedure.

Group Health Cooperative Resource Line

The Group Health Resource Line is a free information and referral service available to all GHC consumers. Volunteer staff provides up-to-date information about health education, community resources and senior services. The Line includes information on a wide variety of health promotion and disease-oriented topics. It also includes information about Take Care store products, classes within GHC, support groups and pamphlets. This service is available by calling 206-326-2800 or 1-800-992-2279 outside the Seattle dialing areas.

- **Seniors:** The Resource Line specializes in information for seniors, including listings on home care, transportation and other resources in your community. In addition, pamphlets are available on coping with stress and depression, routine foot care, medication tips, and sleeping better.
- **Health promotion:** The Group Health Resource Line has pamphlets to help you learn how to reduce fat in your diet, manage stress, and keep track of your medications. Call and ask for the Fats of Life packet, Managing Everyday Stress workbook, or the Medication Record wallet card.

Group Health Cooperative Health Promotion Programs

- **The Free and Clear Program:** Group Health's smoking cessation program is offered as an individual phone-based program or as a group program with classes. Free & Clear is a medically proven program shown to double your chances of successful quitting. Participants receive a Free & Clear kit with program and support materials. Individual program participants receive five phone calls from a smoking cessation specialist. Group participants attend eight classes taught by a qualified instructor. Call the Center for Health Promotion today for more information, to register for the Free & Clear program, or to request a program brochure, 287-2527 or 1-800-462-5327 outside the Seattle dialing area.
- **Advance Directive Program:** Public programs are available throughout the area to educate people about Living Wills, Durable Power of Attorney for Healthcare and other advance directives. Group Health and Senior Rights Assistance schedule volunteers who work individually with people to explain how to use these documents. For more information or to request a copy of advance directives, call the Group Health Resource Line.
- **Senior Caucus:** All Group Health enrollees who are seniors are invited to chapter meetings for interesting programs on health promotion topics such as: self-care, exercise, humor and chronic conditions. To receive a mailed announcement of the location, time and topic of the chapter nearest you, call the Group Health Resource Line.

Medicare prepaid plan enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 4, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those **without** Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. **Before** you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 901-4600 or toll-free at 1-888-901-4600 for information on the Medicare prepaid plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 901-4600 or toll free at 1-888-901-4600 for information on the benefits available under the Medicare HMO.

Benefits on this page are not part of the FEHB contract

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Marketing Office at 206/448-4140 or the TDD number 206/287-2366 or you may write to the Plan at 521 Wall Street, Seattle, Washington 98121. For Whatcom Division members only: contact the Plan at 360/647-7200, or write to the Plan at 2211 Rimland Dr., Suite 114, Bellingham, Washington 98226.

Disputed claims review

Plan reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing and within six months of the date of the denial, to reconsider its denial before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided.

Within 30 days after receipt of your request for reconsideration, the Plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If the Plan asks a provider for information it will send you a copy of this request at the same time. The Plan has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Plan will base its decision on the information it has on hand.

OPM review

If the Plan affirms its denial, you have the right to request a review by OPM to determine whether the Plan's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (if the Plan failed to respond, provide instead (a) the date of your request to the Plan or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim, such as doctors' letters, operative reports, bills, medical records, and explanation of benefit (EOB) forms; and
- Your daytime phone number.

Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, P.O. Box 436, Washington, DC 20044.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

How to Obtain Benefits *continued*

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement—If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Plan to determine if the Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan in support of OPM's decision on the disputed claim.

How Group Health Cooperative Changes January 1998

Do not rely on this page; it is not an official statement of benefits.

Benefit changes

Program-wide Changes:

This year the Office of Personnel Management (OPM) instituted minimum benefit levels in all plans for normal delivery (48 hours of inpatient care), cesarean sections (96 hours of inpatient care) and mastectomies (48 hours of inpatient care). See page 12 for this Plan's benefits.

The mammogram screening schedule is shown on page 12.

Changes to this Plan:

- Mental health/substance abuse inpatient care is provided for up to 30 days per year subject to a member copay of 20% of charges for the first 30 days — all charges thereafter. The member's 20% copay now applies to the out-of-pocket maximums. Previously, the member's 20% copay did not apply to the out-of-pocket maximums. See page 17.
- Women are now able to self refer to certain providers for specific women's health care services. See page 7.
- Individual and group Smoking Cessation Programs are now covered in full, subject only to the \$4 copay (High option) or \$7 copay (Standard option), when the member is a participant in the Plan's Smoking Cessation Program. Previously, the member had to pay 50% of the total charges for one individual or group program per calendar year. See page 18.
- Enteral nutrition therapy when necessary due to malabsorption is now covered. See page 12.
- Ostomy supplies necessary for the removal of bodily secretions or waste is covered. See page 12.
- Insulin pumps and diabetic monitoring equipment are covered subject to the prescription drug copay of \$4 (High option) and \$7 (Standard option). Previously, they were not covered. See page 18.
- Diabetic supplies, including needles, syringes, urine and blood glucose testing reagents and visual strips are covered for up to a 30 day supply, subject to a \$4 copay (High option) and a \$7 copay (Standard option) per prescription unit or refill, per item. Previously, diabetic supplies were not covered. See page 18.

Summary of Benefits for Group Health Cooperative—1998

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important

expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure).

ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.

Benefits	High Option pays/provides	Page	Standard Option pays/provides	Page
Inpatient Hospital care	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. You pay nothing	15	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. You pay nothing	15
	Extended care All necessary services, for up to 30 days. You pay nothing	15	All necessary services, for up to 30 days. You pay nothing	15
	Mental conditions Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. You pay 20% of charges	17	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. You pay 20% of charges	17
	Substance abuse Covered under Mental conditions	17	Covered under Mental conditions	17
Outpatient care	Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; laboratory tests and X-rays; complete maternity care. You pay a \$5 copay per office visit; nothing per house call by a doctor; nothing for preventive care, including periodic check-ups and routine immunizations ..	12-14	Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; laboratory tests and X-rays; complete maternity care. You pay a \$5 copay per office visit; nothing per house call by a doctor; nothing for preventive care, including periodic check-ups and routine immunizations ..	12-14
	Home health care All necessary visits by nurses and health aides. You pay nothing	12	All necessary visits by nurses and health aides. You pay nothing	12
	Mental conditions All necessary outpatient visits per year. You pay nothing for visits 1-20; a \$15.70 copay thereafter ...	17	All necessary outpatient visits per year. You pay nothing for visits 1-20; a \$15.70 copay thereafter .	17
	Substance abuse All necessary visits. You pay nothing	17	All necessary visits. You pay nothing	17
Emergency care	Reasonable charges for services and supplies required because of a medical emergency. You pay a \$100 deductible for each emergency visit to a non-Plan facility, a \$50 copay at Plan facility and any charges for services that are not covered by this Plan	15-16	Reasonable charges for services and supplies required because of a medical emergency. You pay a \$100 deductible for each emergency visit to a non-Plan facility, a \$50 copay at Plan facility and any charges for services that are not covered by this Plan ...	15-16
Prescription drugs	Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. You pay up to a \$4 copay per prescription unit or refill	18	Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. You pay up to a \$7 copay per prescription unit or refill	18
Dental care	Preventive dental care; wide range of restorative and other services. Comprehensive range of services. You pay a \$50 annual deductible per member (\$150 per family), variable copays for most care, and any charges beyond the Plan payment	19	No current benefit	
Vision care	Routine eye exam and refractions for eyeglasses. You pay a \$5 copay per outpatient visit	20	Routine eye exam and refractions for eyeglasses. You pay a \$5 copay per outpatient visit	20
Out-of-pocket maximum	Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of \$750 per Self Only or \$1,500 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include charges for: infertility treatment services; orthopedic and temporomandibular joint (TMJ) appliances; the nasal CPAP device; post mastectomy bras; dental care; or the \$100 non-Plan emergency care deductible; the 20% coinsurance for ambulance services; and the outpatient mental health care copayment	8	Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of \$750 per Self Only or \$1,500 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include charges for: infertility treatment services; orthopedic and temporomandibular joint (TMJ) appliances; the nasal CPAP device; post mastectomy bras; or the \$100 non-Plan emergency care deductible; the 20% coinsurance for ambulance services; and the outpatient mental health care copayment	8