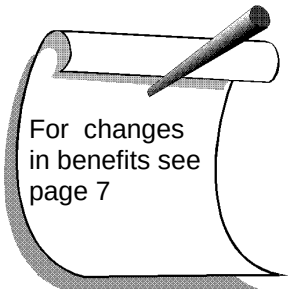
NATIONAL HEALTH PLANS

National HMO 2001

http://www.nationalhmo.com

A Health Maintenance Organization



Serving: *Central California*

Enrollment in this Plan is limited; see page 5 for requirements.

ACCREDITED
Health
Utilization
Management
Standards

Enrollment codes for this Plan:

MN1 Self Only
MN2 Self and Family

Authorized for distribution by the:

OPM
UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

FEHB
Federal Employees
Health Benefits Program

RI 73-512

Table of Contents

Introduction

National Health Plans
National HMO
1005 West Orangeburg Avenue, Suite B
Modesto, CA 95350

This brochure describes the benefits of National HMO under our contract (CS 2508) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means National HMO.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this HMO plan

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

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

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

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

In arranging for the provision of health care delivery services to our Plan Members, National Health Plans utilizes the most efficient and cost effective methods of provider reimbursement for delivered medical services. National Health Plans contracts both with individual physicians and with Independent Practice Associations (IPAs) to provide medical services and with hospitals to provide hospital services to our Members. In turn, the IPAs contract with individual physicians in the community. These contractual relationships include the way physicians are paid and could affect the Member's referrals and other services provided to Members. The following terms that you will need to be acquainted with in order to understand contractual arrangements are:

- Physician Contracts – A Health Maintenance Organization (HMO) contracts with Individual Practice Associations or individual physicians to provide health care services to Members. The providers are reimbursed by the HMO through a capitated fee arrangement or on a fee-for-service basis or a capitated basis.

- Fee-For-Service – Physicians are paid a scheduled amount for each service they provide. Both the physician and the IPA agree on this amount each year. This amount may be different than the amount the physician receives from other payers.

- Capitation - Physicians are paid a fixed amount of money each month by an IPA to provide specific services to the Members they see. This capitation payment may be either a fixed dollar amount for each Member or a percentage of the monthly fee received from the health plan.

- Bonus - At the beginning of each year, both physicians and the IPA agree on a goal for the amount of services or cost of services patients will use. At the end of the year, the IPA pays physicians an extra amount of money if patient care cost less money or patients used fewer services than the budgeted goal agreed to at the beginning of the year.

National HMO has contracted directly with IPAs and Hospitals. They have a variety of these types of financial arrangements with their Physicians and providers.

To receive additional information regarding the compensation arrangement a particular provider network has arranged with National HMO and its providers, a member may call their provider, physician, IPA, or a Member Services Representative at National HMO.

Who provides my health care?

This Plan is an Independent Practice Association (IPA) model HMO that contracts with physicians and other healthcare providers operating out of their own private offices and facilities. Each member enrolling in the Plan may select his/her own primary care physician from the Plan's participating provider roster. All specialty care (except OB/GYN specialists) must be arranged through the member's primary care physician. Members may change their

doctor selection by notifying the Plan by the 25th of each month. The change will then be effective the first day of the following month.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. This requirement allows you to 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.

- Years in Existence
- Profit Status
- Disenrollment rates for 2000
- Compliance with State and Federal licensing or certification requirements and the dates met. If non-compliant, the reason for noncompliance.
- Accreditations by recognized accrediting agencies and the dates received.
- Carrier's type of corporate form and years in existence.
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

If you want more information about us, call 800-468-8600 extension 3109, or write to: National Health Plans, 1005 West Orangeburg Avenue, Suite B, Modesto, CA 95350-4163. You may also contact us by fax at (209) 576-0242 or visit our website at www.nationalhmo.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 are Stanislaus County and San Joaquin County-Partial only. Our service area includes the following zip codes:

County	City	Zip Code
San Joaquin	Escalon	95320
San Joaquin	Manteca	95336-37
San Joaquin	Ripon	95366
Stanislaus	Ceres	95307
Stanislaus	Crows Landing	95313
Stanislaus	Denair	95316
Stanislaus	Empire	95319
Stanislaus	Grayson	95363
Stanislaus	Hickman	95323
Stanislaus	Hughson	95326
Stanislaus	Keyes	95328
Stanislaus	Knights Ferry	95361
Stanislaus	La Grange	95329
Stanislaus	Modesto	95350-58
Stanislaus	Newman	95360
Stanislaus	Oakdale	96361
Stanislaus	Patterson	95363
Stanislaus	Riverbank	95367
Stanislaus	Salida	95368
Stanislaus	Turlock	95380-82
Stanislaus	Valley Home	95384
Stanislaus	Vernalis	95385
Stanislaus	Waterford	95386
Stanislaus	Westley	95387

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care. We will not pay for any other health care services that are not coordinated by your primary care physician.

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.

National HMO offers a Student Plan rider for students temporarily residing outside of our service area. Please call 800-468-8600 or 209-527-3350 extension 3109 for more information. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling Judy Powell at 800-468-8600 or 209-527-3350, **or** checking our website www.nationalhmo.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:

  •• Speak up if you have questions or concerns.
  •• Keep a list of all the medicines you take.
  •• Make sure you get the results of any test or procedure.
  •• Talk with your doctor and health care team about your options if you need hospital care.
  •• Make sure you understand what will happen if you need surgery.

- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- Your share of the non-Postal premium will increase by 21.4% for Self Only or 20.9% for Self and Family.
- We reduced our service area. The following counties are no longer included: Alameda, Contra Costa, Fresno and Merced. Service is partially reduced in the county of San Joaquin.
- Non-formulary prescriptions are now covered at 50% of the drugs cost.
- Therapeutic injections are now covered with a $10 member copayment.

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 800-468-8600 or 209-527-3350.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and you will not have to file claims.

• Plan providers

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards. We list Plan providers in the provider directory, which we update periodically. 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

It depends on the type of care you need. First, you and each family member must choose a primary care physician. Each member enrolling in the Plan may select his/her own primary care physician from the Plan's participating provider roster. This decision is important since your primary care physician provides or arranges for most of your health care.

•Primary care

Your primary care physician can be a family practitioner, internist, obstetrician/gynecologist 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.

• Specialty care

Your primary care physician will arrange your referral to a specialist. A woman may see her plan obstetrician/gynecologist for unlimited visits without a referral.

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 your specialist to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Do not go to the specialist unless your primary care physician has arranged for the visit, and the plan has issued an authorization for the referral in advance.

- 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 Member Services Department immediately at 800-468-8600.

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.

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

We call this review and approval process *referral authorization.* An authorization is National HMO's formal documentation that a particular service rendered by specialist physicians or facilities will be paid for, if it is a covered benefit. In order for these services to be authorized, you must be referred by your PCP, National HMO, or your PCP's network administrator can directly grant the Authorization. In other situations, the authorization must be issued before your PCP can refer you.

How are Authorization Decisions Made?

The key point to remember is that your PCP must decide whether a referral is appropriate, and then discuss your situation with the National HMO Network Administrator when required. In order for the PCP concept to work, your physician will not be able to refer you based solely upon your request.

You may need to be examined by your primary care physician and discuss any medical findings before a referral decision can be made. If a referral is appropriate, then your physician will contact the National HMO Medical Department, or the network administrator, when necessary to obtain an authorization for you. In some cases the PCP will directly issue an authorization. In all cases, your PCP will coordinate this process for you. However, you need to be aware of the authorization guidelines.

What services do not require authorization?

Some pharmacy, lab and routine x-ray services provided by participating facilities and ordered by participating physicians do not require authorization. Services provided by your PCP in his or her office may not require authorization. The network your PCP is affiliated with will determine which services require authorization.

A gynecological exam and pap test performed by a Plan Obstetrician, Gynecologist, Family Practice Specialist or Surgeon does not require a referral authorization. However, you must choose a participating Obstetrician, Gynecologist, Family Practice Physician or surgeon within your primary care physician's Network.

How are authorizations communicated?

The approved authorization must be issued prior to services being rendered. National HMO, the Network Administrator, or your primary care physician will either phone the specialist provider with an authorization, mail an authorization form to the specialist provider, or give you the authorization form to present to the specialist provider.

No Retroactive Authorizations

If you receive services without a prior authorization, neither National HMO nor your Primary care physician will give you an authorization after the fact. You may have to pay for any such services.

Authorization Limitations

Authorizations for most services are limited to a specific number of treatments as well as a specific time frame. These limitations may be indicated on the authorization form. If you have questions about the terms of your authorization, you may discuss them with your PCP, specialist or the National HMO Member Services Department. National HMO will not cover services rendered beyond these limitations except when an additional advance authorization is made to extend the treatments.

Authorizations Apply Only To You

Each member of a family needing specialty services needs a separate authorization. An authorization intended for one person cannot be used by another person, even another member of the family.

Non-participating Providers

The use of providers not participating with National HMO must be requested by your PCP and approved by National HMO's Medical Department, or Network Administrator, before receiving medical care (except in emergencies or urgently needed services). You should call National HMO before receiving services from a non-participating provider to ensure that authorization has been given.

All medical services must be provided or arranged by your National HMO PCP. As a rule, the use of non-participating providers is not a covered benefit except in the case of an Emergency or Urgently Needed Services situation. Any exceptions must be authorized in advance by the National HMO Medical Department or Network Administrator.

Section 4. Your costs for covered services

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

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

  Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go in the hospital, you pay $25 copay per day up to $100 per admission.

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

  Example: In our Plan, you pay 50% of our allowance for infertility services and durable medical equipment.

Your out-of-pocket maximum for copayments

After your copayments total $750 per person or $2250 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments for these services:

- *Maximum Copayment Liability limit does not include Copayments for Chiropractic, Prescription Drugs and Supplemental Benefits.*

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

Section 5. Benefits -- OVERVIEW

(See page 7 for how our benefits changed this year and page 56 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 more information about our benefits, contact us at 1-800-468-8600 or 209-527-3350 or our website at www.nationalhmo.com.

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
Diagnostic and treatment services	
Professional services of physicians In physician's office (primary care physician and specialist visits)	$10 per office visit
Professional services of physicians, such as:	
• During a hospital stay	Nothing
• In a skilled nursing facility	Nothing
• Office medical consultation	$10 per office visit
• Second surgical/medical opinion	$10 per office visit
• Home Visit	$10 per office visit
Not covered: • *Blood and blood derivatives not replaced by the member* • *Experimental, investigative, or unproven procedures, drugs, devices or medical treatment*	*All charges.*

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: • *Blood tests* • *Urinalysis* • *Non-routine pap tests* • *Pathology* • *X-rays* • *Non-routine mammograms* • *CAT Scans/MRI* • *Ultrasound* • *Electrocardiogram and EEG*	Nothing
Preventive care, adult	
Routine screenings, such as: • Physical examinations after age (2), when ordered by your primary care physician • Allergy tests • Annual gynecological exam/pap test	 $10 per office visit $25 per series $10 per office visit
• Routine mammogram	Nothing
• Routine Immunizations • Hepatitis B	$10 per office visit $10 per office visit
Not covered: *Physical examinations and reports for the purpose of obtaining or continuing employment, insurance, government licensure, school admissions, premarital purposes, camp or school physicals, or by court order, if not otherwise Medically Necessary.*	*All charges.*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics • Hepatitis B	$10 per office visit $10 per office visit
• Examinations, such as: ••Eye exams through age 17 to determine the need for vision correction. ••Ear exams through age 17 to determine the need for hearing correction ••Examinations done on the day of immunizations (through age 22) • Well-child care charges for routine examinations, immunizations and care (through age 22)	$10 per office visit

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • 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 per office visit *Refer to Prenatal Program listed in Section 5A, page 21 - Educational classes & programs
Not covered: Routine sonograms solely to determine sex.	*All charges*
Family planning	
• Tubal Ligation • Norplant - Insertion - Removal • Intrauterine devices (IUD's) • Vasectomy • Injectable Contraceptive drugs	$100 $300, Nothing in Hospital $100, Nothing in Hospital $25 $50 $10
Not covered: reversal of voluntary surgical sterilization or genetic counseling.	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Fertility drugs provided in conjunction with Infertility Services Note: Infertility services (except where excluded) with Referral Authorization Form, if necessary, including treatment, testing, medical practice. Plan will determine whether service complies with accepted medical practice, based on an objective review consistent with generally accepted medical standards.	$10 per office visit 50% copay
Not covered: *In-Vitro Fertilization including all treatments, procedures, drug therapies and processes associated with In-Vitro Fertilization, are excluded from coverage. Artificial Insemination is excluded except when used in the course of treatment for infertility. Any procedure involving ovum and sperm outside the body, and the cost of sperm for any purpose, are not covered. Charges for sperm purchase, collection, or preservation are excluded, except sperm "washing" which is covered. G.I.F.T. (Gamete Intra-Fallopian Transfer), ova sticks, and ovum transplant are excluded from coverage. Z.I.F.T. (Zygote Intra-Fallopian Transfer), including all treatments, procedures, drug therapies and processes associate with Z.I.F.T., are excluded from coverage.*	*All charges.*
Allergy care	
Testing Allergy injection treatment	$25 copay $10 copay
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*

Treatment therapies	You pay
• Chemotherapy and radiation therapy • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	Nothing
• Growth hormone therapy (GHT)	Covered under prescription drug plan. Refer to pages 33-35
Rehabilitative therapies	
Physical therapy, occupational therapy and speech therapy -- • Short term physical therapy not to exceed 60 days: ••qualified physical therapists; ••speech therapists; ••occupational therapists.	$10 per office visit
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 12 weeks.	$20 per office visit
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges.*
Hearing services (testing, treatment, and supplies)	
• Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per office visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges.*

Vision services (testing, treatment, and supplies)	You pay
• Eye exam to determine the need for vision correction for children through age 17 (see preventive care)	$10 per office visit
Not covered: • *Eye examination over age 18* • *Eyeglasses or contact lenses* • *Eye exercises and orthotics* • *Radial keratotomy and other refractive surgery*	*All charges.*
Foot care	
Podiatry Services: Podiatry services, provided according to Medicare guidelines, require a Referral Authorization by a Plan Physician and exclude routine foot care. The Plan will pay for foot care if required as a result of a medical condition affecting the lower limbs (e.g., severe diabetes).	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose	50% copay
• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy	50% copay
• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5 (c) for payment information. See 5(b) for coverage of the surgery to insert the device.	Nothing
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	50%
Note: Orthopedic, prosthetic devices and Durable medical equipment are combined benefits subject to a maximum of $2500 per calendar year	

Orthopedic and prosthetic devices *(Continued)*	**You pay**
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges.*
Durable medical equipment (DME)	
Durable Medical Equipment means equipment that can withstand repeated use; is primarily and usually used to serve a medical purpose; is generally not useful to a person in the absence of illness or injury; and is appropriate for use in your home.	
To be covered, Durable Medical Equipment must be Medically Necessary in accordance with Medicare law, regulations and guidelines and prescribed by a participating physician such as: • oxygen equipment • hospital beds; • wheel chairs; • crutches; • walkers; • blood glucose monitors; and • insulin pumps Note: Durable medical equipment, Orthopedic and prosthetic devices are combined benefits subject to a maximum Copayment of $2500 per calendar year.	50% copay
Not covered: • *Motorized wheel chairs* • *Foot orthotics*	*All charges.*

Home health services	You pay
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	Nothing
• Total parenteral nutrition up to 30 days per calendar year	20% copay
Home health services	
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All charges.*
Alternative treatments	
Chiropractic Care – services must be provided by a Plan provider. Copayment amounts do not accumulate toward the copayment maximum for covered services. Services covered include manipulations and adjustment and diagnostic radiology and laboratory services. Up to three visits per calendar year may be used for maintenance care. The Benefit maximum is $1000 per calendar year.	$10 per office visit
Not covered: • *acupuncture* • *naturopathic services* • *hypnotherapy* • *biofeedback*	*All charges.*
Educational classes and programs	
Coverage is limited to: • Smoking cessation drugs and medication according to Formulary guidelines, including nicotine patches, are covered only while you attend a smoking cessation program and only for one such program of up to 90 days per lifetime.	50% of charges
• Diabetes self-management	Nothing
• Prenatal Program	Nothing

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5 (c) for charges associated with the facility (i.e. hospital, surgical center, etc).
- YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
Surgical procedures	
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. Note: Surgery for Morbid obesity should be performed only as a last resort, when the member's health is endangered and more conservative medical measures, including prescription drugs have not been successful. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information.	Nothing
• Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a). • Treatment of burns Note: Generally, we pay for internal prosthetic (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	See page 16 (Family Planning) for charges Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*

Reconstructive surgery	You pay
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: ••the condition produced a major effect on the member's appearance and ••the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.	Nothing
• All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; •• breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing
Not covered: • *Cosmetics, dietary supplements, health or beauty aids* • *Cosmetic, plastic, or reconstructive surgery, and complications directly resulting from such surgeries, except (a) to correct or repair abnormal structures of the body that are caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease; (b) Medically Necessary reconstructive surgery performed incident to a mastectomy; or (c) complications from a mastectomy.* • *Transsexual surgery and related services.*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing

Oral and maxillofacial surgery *(Continued)*	You pay
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*
Organ/tissue transplants	
Limited to: • Cornea • Heart • Heart/Lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advance 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 Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient/outpatient) • Skilled Nursing Facility • Ambulatory Surgical Center • Office	Nothing

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

IMPORTANT

Here are some important things to remember about these benefits:

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

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as: • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets.	$25 per day to a maximum of $100 per admission ($750 annual maximum per person $2250 annual maximum per family)
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, extended care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*

Outpatient hospital or ambulatory surgical center	You pay
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$25 per surgical procedure ($750 annual maximum per person $2250 annual maximum per family)
Not covered: Blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/skilled nursing care facility benefits	
Skilled nursing facility (SNF): The plan provides a comprehensive range of benefits for up to 60 days per calendar year when full-time skilled nursing care is necessary, and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. All necessary services are covered, including: • Bed, board and general nursing care; • Drugs, biologicals, supplies, including intravenous fluids and medications, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	$25 per day to maximum of $100 per admission
Not covered: custodial care	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member is covered in the home. 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.	Nothing
Not covered: Independent nursing, homemaker services	*All charges*

Ambulance	You pay
▪ Local professional ambulance service when medically appropriate ▪ Emergency ambulance service Non-emergency ambulance services in the service area are benefits when requested by a Plan physician and authorized by Plan. Authorization is not required if ambulance service are used in an emergency situation. Members are encouraged to use the 911 emergency response system if an emergency medical condition requires an emergency response.	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area

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. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 24 hours. It is your responsibility to ensure that the Plan has been timely notified.

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 you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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 Plan or non-Plan providers must be coordinated through your Primary Care Physician or approved by National HMO.

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

You pay…$25 copay per hospital emergency room visit, or a $10 copay per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, you pay a $25 copay per day up to $100 per admission, if you have not met the annual inpatient copay maximum. The emergency room visit copay will apply to this maximum**.**

Emergencies outside our 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 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If 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 Plan on non-Plan providers must be coordinated through your Primary Care Physician or approved by National HMO.

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

You pay…$25 copay per hospital emergency room visit, or a $25 copay per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, you pay a $25 copay per day up to $100 per admission, if you have not met the annual inpatient copay maximum. The emergency room visit copay will apply to this maximum.

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

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

IMPORTANT

Parity

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

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

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

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

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per office visit

Mental health and substance abuse benefits – Continued on next page

Mental health and substance abuse benefits *(Continued)*	You pay
• Diagnostic tests	Nothing
• 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	$ 25 per day to a maximum of $100 per admission
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 follow your treatment plan and all the following authorization processes:

All care will be coordinated through your Primary Care Physician. Present your National HMO Membership Card when seeking services. Your Plan mental health or substance abuse provider will seek eligibility and authorization for treatment from National HMO.

If you do not present your National HMO Membership Card, your Plan provider may not know to contact National Health Plans. If National Health Plans is not contacted, authorization may not be given, possibly resulting in denial of benefits. Services rendered by non-plan providers are not a covered benefit.

To obtain information regarding participating mental health or substance abuse providers and benefits, please contact National HMO at (800) 468-8600.

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following conditions:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause.

If this condition applies to you, we will allow you reasonable time to transfer your care to a Plan mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.

Limitation

We may limit your benefits if you do not follow your treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** A Plan physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy or by mail for maintenance medication.
- **We use a formulary.** The National HMO's Formulary is a list of prescription medications that provides physicians with choices of therapeutically effective medications to be prescribed when members require prescription drugs. National HMO's Pharmacy and Therapeutic Committee provides clinical input regarding the drugs on the formulary as well as recommendation for the addition or deletion of drugs. The drug formulary contains both brand name drugs and generic drugs, all of which have Federal Drug Administration (FDA) approval.
- **These are the dispensing limitations.** You pay a $5 generic/$10 brand name copay per prescription up to 30-day supply. Up to a 90-day supply of most drugs is available through a mail order service; you pay a $13 generic/$26 brand name. Non-formulary drugs are covered at 50% of cost or the cost of the drugs which ever is less.
- **You do not have to file a claim for prescriptions filled in our service area or obtained from a Plan pharmacy.**

Prescription drug benefits begin on the next page.

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs for which a prescription is required by Federal Law. • Oral contraceptive drugs and contraceptive devices; injectable contraceptive drugs are covered as part of a doctor's office visit. • Insulin, with a copayment charge applied to each vial. • Diabetic supplies limited to insulin syringes, needles and chem strips. 50% of the cost of chem strips if purchased through Plan pharmacies are covered under DME. • Disposable needles and syringes needed to inject covered prescribed medication. Subject to generic copay. • Prescription drugs for the treatment of Acquired Immune Deficiency Syndrome are covered. Subject to formulary guidelines. • Drugs to treat sexual dysfunction are limited and subject to formulary guidelines. Please contact the Plan for the dose limits. • Fertility drugs preauthorized by the Plan are covered. You pay 50% of charges. • Smoking cessation drugs and medication according to Formulary guidelines are covered only while you attend a smoking cessation program and only for one such program of up to 90 days per lifetime. You pay 50% of charges. • Injectable drugs for home use, and pre-authorized by the Plan, are covered subject to formulary guidelines. • Prescriptions filled out of the service area, required in conjunction with an approved out of area emergency service, will be reimbursed according to the Plan Pharmacy copayment requirements. If you are charged for the prescription, you should pay in full and submit the pharmacy receipt to National HMO within 30 days of the date the prescription was filled. Coverage for these prescriptions is limited to a 10-day supply. Out of area locations of contracted chain pharmacies may be able to provide service under your prescription coverage. Note: If there is no generic equivalent available, you will still have to pay the brand name copay.	**30 day supply/Plan pharmacies** $ 5 copay - generic $ 10 copay – brand 50% non formulary **90-day mail order** $13 copay – generic $26 copay - brand name per 90-day supply

Covered medications and supplies *(Continued)*	**You pay**
Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available. • We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 1-800-468-8600 or 1-209-527-3350.	
Not covered: • *Drugs available without a prescription or for which there is a nonprescription equivalent available.* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies.* • *Vitamins and nutritional substances that can be purchased without a prescription.* • *Medical supplies such as dressings and antiseptics* • *Drugs for cosmetic purposes* • *Drugs to enhance athletic performance*	*All Charges*

Section 5 (g). Special Features

Feature	Description
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-800-667-2563 and talk with a registered nurse who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired	1-800-735-2929 1-800-855-3000 – Spanish TTY Between 8:00 a.m. – 5:00 p.m. (PST) Monday through Friday

Section 5 (h). Dental benefits

IMPORTANT

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

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

IMPORTANT

Accidental injury benefit	You Pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury, and not from biting or chewing, only services rendered within 24 hours of the injury are covered.	$25 per office visit $25 per emergency room visit

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.**

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.
- Reduction mammoplasty, unless medically required according to guidelines determined by the Plan
- Sleep therapy and sleep study except to determine the presence of anoxia during sleep.

Section 7. Filing a claim for covered services

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

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

Medical, Hospital and Drug Benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-800-468-8600 or 209-527-3350.

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

- Covered member's name and ID number;
- Name and address physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer --such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to: **National Health Plans,**
PO Box 5356
Modesto, CA 95352

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. Write to us at National Health Plans, 1005 West Orangeburg Avenue, Suite B, Modesto, CA 95350-4163. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: National Health Plans, 1005 West Orangeburg Avenue, Suite B, Modesto, CA 95350-4163. (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division IV, P.O. Box 436, Washington, D.C. 20044-0436.

The Disputed Claims process (Continued)

Send OPM the following information:

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

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

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

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

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

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

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at – 1-800-468-8600 or 209-527-3350 and we will expedite our review; or

(b) We denied your initial request for care or pre-authorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division III at 202-606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

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

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

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

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

•What is Medicare?

Medicare is a Health Insurance Program for:

•• People 65 years of age and older.

•• Some people with disabilities, under 65 years of age.

•• People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

•• Part A (Hospital Insurance). Most people do not have to pay for Part A.

•• Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

•The Original Medicare Plan

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

(Primary payer chart begins on next page.)

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

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when… a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB Ask your employing office which of these applies to you.		✓
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and a) Are an annuitant, or	✓	
b) Are an active employee		✓

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 800-468-8600 or 209-527-3350 or on the web at www.nationalhmo.com.

- **Medicare managed care plan**

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

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do/do not waive any of our copayments, coinsurance, or deductibles for your FEHB coverage.

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

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

TRICARE

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

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or

- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

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

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 12.

Coinsurance

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

Covered services

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

Custodial care

Custodial Care that is usually related to nursing home care; any care which does not require skilled nursing services on a continuing basis.

Experimental or investigational services

Experimental or investigational means a drug, device, medical treatment or procedure is experimental or investigative if:

a. The drug or device is subject to approval by the U.S. Food and Drug Administration (FDA) and does not have FDA approval, or has FDA approval only under its Treatment Investigation New Drug Regulation or a similar regulation;

b. The provider's Institutional Review Board has acknowledged that the use of the procedure, drug, device or treatment is Experimental or Investigative and subject to the Board's approval; or if Federal Law requires such review and approval; or, the provider's Institutional Review Board or Federal Law require that the patient, parent or guardian give an informed consent stating that the procedure, drug, device or treatment is Experimental or Investigative, or is part of a research project or study;

c. Reliable Evidence establishes that the drug, device, medical treatment or procedure is the subject of on-going Phase I, Phase II or Phase III clinical trials or is otherwise under study utilizing protocols which indicate that the procedure, drug, device or treatment is Experimental or Investigative, whether or not said protocols are utilized by the patient's provider or by any other providers studying the same procedure, drug, device or treatment;

d. Reliable Evidence shows that the prevailing opinion within the appropriate specialty of the United States medical profession regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or,

e. It is not Experimental or Investigative in and of itself, but would not be Medically Necessary but for the provision of a drug, device, treatment or procedure which is Experimental or Investigative, as defined herein.

Group health coverage

Group health coverage means an employee welfare plan providing medical care to participants or beneficiaries directly or through insurance, reimbursement, or otherwise.

Medical necessity

Medical necessity means required for and consistent with the diagnosis, care and treatment of a condition, disease ailment or injury which is covered and which service or supply is not provided primarily for the convenience of the enrollee or a Provider. Medical necessity shall be determined by National HMO in consultation with both the members physician and, if requested by National HMO, by other competent medical authorities designated by National HMO at its expense. Medical necessity shall be determined according to generally accepted principles of good medical practice and professionally recognized standards in relation to: (a) appropriate for the symptoms, diagnosis or treatment of the injury or disease; and (b) the most appropriate supply or level of service needed to provide safe and adequate care and treatment of the injury or disease.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. We determine our allowance as follows: National HMO negotiates rates with network providers which will be accepted as payment in full by such provider.

Us/We

Us and we refer to National HMO.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

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

Your medical and claims records are confidential

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

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

When you retire

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

When you lose benefits

•When FEHB coverage ends

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

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

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

• Spouse equity coverage

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

•TCC Eligibility

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

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

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

•Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

Inspector General Advisory

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 800-468-8600 or 209-527-3350 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE--202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

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

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

NOTES:

Summary of benefits for National HMO Health Plan - 2001

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

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office.....	Office visit copay: $10 primary care; $10 specialist	14
Services provided by a hospital:		
• Inpatient.....	$25 per day, $100 max per admission	25
• Outpatient.....	$25 per surgery	26
Emergency benefits:		
• In-area	Emergency Room - $25 per visit Urgent Care Center - $10 per visit	30
• Out-of-area	Emergency Room - $25 per visit Urgent Care Center - $25 per visit	30
Mental health and substance abuse treatment	Regular cost sharing.	32
Prescription drugs.....		
30-day supply (Non-formulary only)	$5 generic $10 brand Non-Formulary 50%	34
Mail order 90 day supply (Formulary only)	$13 generic $26 brand Formulary only	34
Dental Care.....	No benefit.	37
Special features: Flexible benefits option, 24 hour nurse line, Services for deaf and hearing impaired		36
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $750/Self Only or $2,500/Family enrollment per year Some costs do not count toward this protection	12

2001 Rate Information for
National HMO

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

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

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

		Non-Postal Premium				**Postal Premium**	
		Biweekly		**Monthly**		**Biweekly**	
Type of Enrollment	**Code**	**Gov't Share**	**Your Share**	**Gov't Share**	**Your Share**	**USPS Share**	**Your Share**

Fill in Location Here

Self Only	**MN1**	**$56.45**	**$18.81**	**$122.30**	**$40.76**	**$66.79**	**$8.47**
Self and Family	**MN2**	**$148.24**	**$49.41**	**$321.18**	**$107.06**	**$175.41**	**$22.24**