FIRST CHOICE HEALTH PLAN

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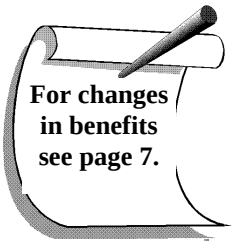
2001

A Health Maintenance Organization

Serving: The greater Puget Sound area



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

Enrollment codes for this Plan:

5G1 Self Only
5G2 Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
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FEHB
Federal Employees
Health Benefits Program

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Introduction

First Choice Health Plan
601 Union Street, Suite 1100
Seattle, WA 98101-4072

This brochure describes the benefits of First Choice Health Plan under our contract (CS 2809) 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 pages 55 and 56. 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 First Choice Health Plan.

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 providers, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

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

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

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

How we pay providers

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

The Plan's provider directory lists primary care providers (family practitioners, pediatricians, and internists) with their locations and phone numbers, and notes whether or not the provider is accepting new patients. Directories are updated twice a year and are available at the time of enrollment or upon request by calling the Member Services Department at 1-800-783-7312. You can also find out if your provider participates with this Plan by calling this number, or visiting our website at www.fchn.com. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients.

Important Note: When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one provider, hospital, or other provider cannot be guaranteed.

If you enroll, you will be asked to let the Plan know which primary care doctor(s) you've selected for you and each member of your family by sending a selection form to the Plan. If you need help choosing a doctor, call the Plan. Members may change their doctor selection by notifying the Plan. Changes take effect the first day of the month following 15 days notice.

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

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Explanation of compliance and licensing requirements
- Years in existence
- Profit status

If you want more information about us, call 1-800-783-7312, or write to 601 Union Street, Suite 1100, Seattle, WA 98101-4072. You may also contact us by fax at 1-888-206-3092 or visit our website at www.fchn.com.

Service Area

To enroll with us, you must live or work in our service area. This is where our providers practice. Our service area is: King, Lewis, Pierce, Snohomish, and Thurston counties in Washington State.

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 service.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employer 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 higher patient cost sharing on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many health care organizations have turned their attention this past year to improving health care 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 the Member Services Department at 1-800-783-7312, **or** checking our website *http://www.fchn.com*. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your health care, 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 nonpostal premium will increase by 31.4% for Self Only or 40.2% for Self and Family.
- We have reduced our service area and no longer cover Mason and Grays Harbor counties.
- Our prescription drug benefits will be administered through a 3-tier managed drug formulary. You will pay a $5 generic, $10 preferred brand, and $25 non-preferred brand copayment for prescription drugs at retail pharmacies. You will pay a $10 generic, $20 preferred brand, and $50 non-preferred brand copayment for a 90 day supply of maintenance prescription drugs through the mail order pharmacy.

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 60 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-783-7312 or visit our website at www.fchn.com.

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 at www.fchn.com or you may call 1-800-783-7312.

- **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 at www.fchn.com, or you may call 1-800-783-7312.

What you must do

It depends on the type of care you need. First, you and each family member must choose a primary care provider. This decision is important since your primary care physician provides or arranges for most of your health care.

The Plan's provider directory lists primary care providers (family practitioners, pediatricians, and internists) with their locations and phone numbers, and notes whether or not the provider is accepting new patients. Directories are updated twice a year and are available at the time of enrollment or upon request by calling the Member Services Department at 1-800-783-7312. You can also find out if your provider participates with this Plan by calling this number. Call the provider to verify that he or she currently participates with the Plan.

- **Primary care**

Your primary care provider can be a family practitioner, internist or pediatrician. Your primary care provider will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care providers or if your primary care provider leaves the Plan, call us. We will help you select a new one.

• Specialty care

Your primary care provider will refer you to a specialist for needed care. Women may self-refer to Plan providers who specialize in the treatment of women's health care.

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 provider will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care provider will use our criteria when creating your treatment plan (the provider may have to get an authorization or approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care provider. Your primary care provider 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 provider, 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 at 1-800-783-7312 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 provider 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 1-800-783-7312. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

Circumstances beyond our control

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

Services requiring our prior approval

Your primary care provider has authority to refer you for most services. For certain services, however, your provider 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 the referral process.

Your provider must obtain approval for services such as:

- Physical Therapy
- Acupuncture
- Massage Therapy
- Inpatient Hospitalizations
- Outpatient Surgery
- Mental Health and Substance Abuse

Please contact Member Services to find out if the services require authorization.

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 provider you pay a copayment of $10 per office visit.

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

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

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

Your out-of-pocket maximum for coinsurance and copayments

after your coinsurance and copayments total $1,500 per person or $4,500 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your out-of–pocket maximum, and you must continue to pay copayments for these services:

- Prescription drugs

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

Section 5. Benefits -- OVERVIEW

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

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain more information about our benefits contact us at 1-800-783-7312 or our website at www.fchn.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 providers must provide or arrange your care.
- We have no calendar-year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office	$10 per office visit
Professional services of providers • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Office medical consultations • Second surgical opinion	$10 per visit
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	You pay
Routine screenings, such as: • Blood lead level – One annually • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including ••Fecal occult blood test ••Sigmoidoscopy, screening – every five years starting at age 50 • Prostate Specific Antigen (PSA test) – one annually for men age 40 and older • Routine pap test	Nothing
Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	Nothing
Not covered: Travel immunizations	*All charges*
Preventive care, children	**You pay**
Childhood immunizations recommended by the American Academy of Pediatrics	$10 per office visit

Preventive care, children *(Continued)*	**You pay**
• 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 • Sonograms to determine fetal size or age. Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 29 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	Nothing
Not covered: • *Sonograms to determine sex* • *Home births*	*All charges*
Family planning	**You pay**
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	$10 per office visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling	*All charges*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: ••intravaginal insemination (IVI) ••intracervical insemination (ICI) ••intrauterine insemination (IUI)	*$10 per office visit*
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* ••*in vitro fertilization* ••*embryo transfer and GIFT* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm*	*All charges*

Allergy care	You pay
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 26. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Growth hormone therapy (GHT) covered under Prescription drug benefits as a prior authorization drug. See page 36.	$10 per visit
• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	Nothing

Rehabilitative therapies	You pay
Physical therapy, occupational therapy, and speech therapy. • 60 visits per condition for the services of each of the following: ••qualified physical therapists ••speech therapists ••occupational therapists Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or speech due to illness or injury. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 36 sessions.	$10 per visit
Not covered: • *long-term rehabilitative therapy* • *exercise programs* • *Phase III cardiac rehabilitation*	*All charges*

Hearing services (testing, treatment, and supplies)	You pay
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (One routine hearing exam per year.)	Nothing
Not covered: • *Hearing aids, testing and examinations for them*	*All charges*

Vision services (testing, treatment, and supplies)	You pay
Routine Examination (every 12 months)	$10 per office visit
Vision Hardware (Lenses and Frames only/1 pair of eye glasses) Note: Discount given if purchased within 12 months of exam	All charges after 20% discount
Contact Lenses • The provider must be a Vision Service Plan (VSP) participating provider to be covered. • No referral is necessary from the member's primary care provider for vision care. • Discounts only offered through the VSP Participating Provider who last provided the eye examination.	All charges after 15% discount
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	$10 per office visit
Not covered: • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Measurement, fitting, and adjustment of contact lenses, and purchase of contact lenses or eyeglasses*	*All charges*
Foot care	**You pay**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*

Orthopedic and prosthetic devices	You pay
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5 (c) for payment information. See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	20% of Plan allowance
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* • *implants including, but not limited to, penile prosthetics*	*All charges*

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, including repair and adjustment of durable medical equipment prescribed by your Plan physician such as oxygen and dialysis equipment. Under this benefit we also cover: • Continuous Positive Airway Pressure (CPAP) • Crutches • Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape. Benedict's solution or equivalent, glucose monitors and acetone test tablets. We do cover insulin pumps on a review basis (requires medical director approval). • Standard manual wheelchairs • Standard manual hospital beds • Oxygen and equipment for administering oxygen • Walkers Pre-authorization is required for all durable medical equipment and supplies. All durable medical equipment and supplies must be obtained through a Plan provider.	20% of Plan allowance
Not covered: • *Personal comfort items such as whirlpool baths, air conditioners, lumbar rolls* • *Supplies or equipment primarily for use during sports or recreational activities* • *Hearing aids and their fitting* • *Equipment, such as, but not limited to, handrails, ramps, shower chairs, and car lifts*	*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	$10 per visit
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family* • *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship, or giving oral medication*	*All charges*

Alternative treatments	You pay
• Acupuncture – Services by referral for treatment and management of pain	$10 per office visit
• Chiropractic – Coverage includes diagnosis and treatment of musculoskeletal disorders (bone, muscle and spinal subluxations) as well as diagnostic radiology and durable medical equipment, such as, cervical collars or lumbar braces, when prescribed by a Participating provider.	
• Massage Therapy - Treatment is for trauma or injury and when massage is expected to produce sustainable functional improvement in a 60-day period. If treatment is not furnished by your primary care provider, a referral is required. Treatment must be provided by a participating massage therapist. Massage therapy is not covered for recreational, sedative, or palliative reasons, or maintenance therapy.	$10 per office visit; $250 annual maximum per member

• Naturopathic Care –The services of a naturopathic physician are covered for the treatment of a covered illness, injury or condition. These services include, but are not limited to the following:
  • Common diagnostic procedures consistent with accepted naturopathic practice
  • Homeopathy
  • Manual manipulation
  • Minor office procedures
  • Radiology services (when ordered by the naturopath)
	$10 per office visit; $500 annual maximum per member

Alternative Treatments continued on next page

Alternative treatments – *(Continued)*	**You pay**
Not covered: • *Botanical and herbal medicines* • *Hair analysis* • *Prescription drugs or medications, except vitamin B-12 intramuscular injections for the treatment of Vitamin B-12 deficiency* • *Vitamins and food supplements* • *Aromatherapy* • *Hypnotherapy* • *Biofeedback*	*All charges*
Educational classes and programs	**You pay**
Coverage is limited to: • Smoking Cessation – Services for smoking cessation are covered in full when participating in an approved FCHP smoking cessation program. • Diabetes self-management	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 providers 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.).
- Certain services require a referral in order to be covered. When your care is coordinated through your primary care provider, s/he is responsible for obtaining the necessary approval. If your care is not coordinated through your primary care provider **and** is not approved by this Plan, and is for a service that requires a referral, you are responsible for the entire cost of the services received.

IMPORTANT

Benefit Description	You pay
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 • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information	Nothing

Surgical procedures continued on next page.

Surgical procedures *(Continued)*	**You pay**
• 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 prostheses (devices) according to where the procedure is done. For example, we pay hospital benefits for pacemaker and surgery benefits for insertion of the pacemaker.	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 toe • 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: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*All charges*

Oral and maxillofacial surgery	You pay
Oral surgical procedures limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures	Nothing
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Dental work is excluded even for TMJ.* • *Orthognathic*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogenic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Transplants are covered when approved by the Medical Director. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan. Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing

Organ/tissue transplants – *Continued on next page*

Organ/tissue transplants *(Continued)*	**You pay**
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**You pay**
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- 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., providers, etc.) are covered in Section 5(a) or (b).
- Certain services require a referral in order to be covered. When your care is coordinated through your primary care physician, she/he is responsible for obtaining the necessary approval. If your care is not coordinated through your primary care physician **and** is not approved by this Plan, and is for a service that requires a referral, you are responsible for the entire cost of the services received.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing

Inpatient hospital - continued on next page.

Inpatient hospital *(Continued)*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood, blood products and their administration • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	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 • Blood, blood products, and their administration • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing

Extended care benefits/skilled nursing care facility benefits	You pay
Extended care benefit: The Plan provides a comprehensive range of benefits with no dollar limit for up to 90 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 provider and approved by the Plan. **All necessary services are covered**, including: • Bed, board, and general nursing care. • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	Nothing
Hospice care	**You pay**
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility limited to a maximum of 10 days inpatient per calendar year and one period of continuous home care for up to five days not to exceed four hours per day and 120 hours of respite care during each three-month period of hospice care to include any days of extended care already used. Services include inpatient and outpatient care, and family counseling. These services are provided under the direction of a Plan provider 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**
• Professional ambulance service when medically appropriate	20% of Plan allowance

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 an emergency:

In the case of a life-threatening emergency, whether at home or away from home, you should seek the most immediate care available. When you receive emergency care, or if you are admitted to a hospital on an emergency basis, call your primary care physician within twenty-four (24) hours of the emergency situation, or as soon as you are reasonably able to do so. All follow-up care must be provided or authorized by your primary care physician. If you are admitted to a non-Plan facility, your primary care provider may arrange for your transfer to a Plan facility as soon as your condition permits. There is no cost for a transfer to a Plan facility when ordered by your primary care provider.

In all cases, any follow-up care rendered by a non-Plan provider must be authorized. If you do not obtain a referral, your benefits will be substantially reduced or denied.

Urgent Care: Urgently Needed Services means covered services provided when you are temporarily absent from the Plan service area (or under unusual and extraordinary circumstances, if you are in the service area but Plan providers or facilities are temporarily unavailable or inaccessible) when such services are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition. Examples of urgent conditions include: sprains, strains, urinary tract infections, minor allergic reactions, cuts and lacerations, fever, vomiting, and diarrhea.

Emergencies within our service area: If an urgent, but non-life threatening, situation occurs, contact your primary care physician. Your primary care physician, or a covering Plan physician, is required to be available by telephone twenty-four (24) hours a day, 7 days a week, and may give you treatment advice over the phone, or may direct you to an urgent care center or a hospital emergency room.

Emergencies outside our service area: If an urgent, but non-life threatening, situation occurs while you are traveling or visiting outside the service area, seek care immediately. Please contact your primary care physician as soon as possible after seeking care.

Please note: All follow-up care must be provided by or authorized by your primary care physician.

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

Section 5 (d). Emergency services/accidents (Continued)

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center	$10 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services. Note: Copay waived if admitted within 24 hours	$50 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	$10 per visit
• Emergency care as an outpatient at or inpatient at a hospital, including doctors' services Note: Copay waived if admitted within 24 hours	$50 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	**You pay**
Professional ambulance service, including air ambulance, when medically appropriate. If you are admitted to a non-Plan facility, your primary care provider may arrange for your transfer to a Plan facility as soon as your condition permits. There is no cost for a transfer to a Plan facility when ordered by your primary care provider. See 5(c) for non-emergency service	20% of Plan allowance

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 and are payable only when we determine they are clinically appropriate to treat your condition.
- 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 Continued on Next Page

Mental health and substance abuse benefits *(Continued)*	**You Pay**
Preauthorization:	To be eligible to receive these benefits you must follow you treatment plan and all the following authorization processes: All mental health and chemical dependency care is coordinated through special care managers. If you need mental health or chemical dependency treatment, please refer to your ID card or Provider Directory for the phone number. Care managers are available 24 hours a day, 7 days a week.
Special transitional benefit	If a mental health or substance abuse professional provider is treating you under our Plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following condition: • If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause. If this condition applies to you, we will allow you reasonable time to transfer your care to a network 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. The transitional period will last for up to 90 days from the date you receive notice of the change. You may receive this notice prior to January 1, 2001, and the 90-day period begins with receipt of the notice.
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 licensed plan provider must write the prescription.
- **Where you can obtain them.** All prescriptions must be dispensed through a Participating Pharmacy or by mail. You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication. To obtain mail order information call Member Services at 1-800-783-7312.
- **We use a formulary.** The 3-Tier formulary is a managed formulary, where most prescription drugs are reimbursed, whether on formulary or not. However, some benefit restrictions may apply for some types of products. For example, over-the-counter (OTC) products, with the exception of insulin and diabetes monitoring products, are excluded from the pharmacy benefit.
- **These are dispensing limitations.** You may get up to a 30-day supply in a retail pharmacy. You may get up to a 90-day supply via mail order.

  NOTE: The copay for generic $5, preferred brand $10, and non-preferred brand $25. When a generic substitution is permissible (i.e., a generic drug is available and the doctor does not require the use of a name brand drug), but you request the name brand drug, you pay the price difference between the generic and the name brand drug, including the copay, per prescription unit or refill.
- **When you have to file a claim.** There are some drugs that require prior authorization, while other drugs may have quantity limitations. These lists are subject to change. To find out if your drug requires prior authorization or has a quantity limitation call Member Services at 1-800-783-7312.

Section 5(f) Prescription Drug Benefits continued on next page

Section 5 (f). Prescription drug benefits (Continued)

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:	
RETAIL PHARMACY BENEFIT – up to 30-day supply	
Tier 1: Generic Drugs	$5 Copay
Tier 2: Preferred Brand Name Drugs	$10 Copay
Tier 3: Non-Preferred Brand Name Drugs	$25 Copay
MAIL ORDER PHARMACY BENEFIT – up to 90-day supply	
Tier 1: Generic Drugs	
Tier 2: Preferred Brand Name Drugs	$10 Copay
Tier 3: Non-Preferred Brand Name Drugs	$20 Copay
	$50 Copay
NOTE: The copay for generic $5, preferred brand $10, and non-preferred brand $25. When a generic substitution is permissible (i.e., a generic drug is available and the prescribing doctor does not require the use of a name brand drug), but you request the name brand drug, you pay the price difference between the generic and the name brand drug, inclusive of copay, per prescription unit or refill.	
Covered Drugs: • Compound medications in which at least one ingredient is a legend drug • Diabetic supplies, including disposable needles/syringes, blood testing agents (e.g. Chemstrips, AccuCheck, One Touch) and lancets • Insulin and disposable needles/syringes. Needles/syringes must be dispensed in quantities corresponding to the amount of insulin prescribed and at the same time in order to be included under the same copayment with the insulin • Prescription drugs, including fluoride supplements (oral tablets or drops only) and prenatal vitamins • PKU formulas (e.g. Lofenalac, Phenex-2, Phenyl-Free, PKU2, PKU3). • Retin-A for individuals through the age of 25 • Any other drug which, under applicable state law, may only be dispensed by means of a written prescription from a physician or other lawful prescriber, and which is (i) to treat the condition of the patient and (ii) not otherwise limited or excluded • Drugs for sexual dysfunction • Contraceptive drugs and devices	

Section 5(f) Prescription Drug Benefits continued on next page

Section 5 (f). Prescription drug benefits (Continued)

Benefit Description	You pay
Not Covered medications and supplies	
Not Covered: • *Anabolic steroids, unless specifically preauthorized by the member's Primary Care Provider* • *Any drug used for the purpose of weight loss i.e. Anorectics, dietary supplements, except PKU formulas* • *Infertility medications (e.g. Clomid, Metrodin, Pergonal, Profasi)* • *Lost, stolen or replacement prescriptions* • *Over-the-counter (OTC) products* • *Products and drugs used for cosmetic purposes* • *Smoking deterrent medications and smoking cessation aids, unless prescribed while participating in an approved FCHP smoking cessation program.*	*All charges*

Section 5 (g). 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. For the purpose of this coverage, a "sound natural tooth" is a tooth that is (i) free of active or chronic clinical decay, (ii) contains at least fifty percent (50%) bony structure, (iii) is functional in the arch, and (iv) has not been excessively weakened by multiple dental procedures. The need for these services must result from an accidental injury. After the initial examination, preauthorization by us for further services is required. All services related to the repair must be completed within six (6) months of the date of the accident. Any services received after six (6) months have elapsed, or after you become disenrolled from this Plan, regardless of whether six (6) months have elapsed or not, are not covered. Damage due to biting or chewing is not covered.	**Nothing**

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 provider determines it is medically necessary to prevent, diagnose, or treat your illness disease, injury, or condition and we agree, as discussed under *What Services Require Our Referral Process Prior Approval* on page 10.**

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

Medical, hospital and drug benefits

In most cases, providers and facilities file claims for you. Providers 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 1-800-783-7312.

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 the following:

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

Submit your claims to: 601 Union Street, Suite 1100, Seattle, WA 98101

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to: First Choice Health, Attn: Appeals Coordinator, 601 Union Street, Suite 1100 Seattle, WA 98101; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim such as providers' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, D.C. 20044-0436.

Section 8 The Disputed Claims Process continued on next page

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 providers' 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 1-800-783-7312 and we will expedite our review, or

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

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

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 managed care plan 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.

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan PCP, or precertified as required.

We will not waive any of our copayments or coinsurance.

(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 1-888-206-3092 or visit our website at www.fchn.com.

We do not waive any out-of-pocket costs when Medicare is the primary payer.

•Medicare managed care plan

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

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare **managed care** plan and also remain enrolled in our FEHB Plan. We will still provide benefits when your Medicare managed care plan is primary, but we will not waive any of our copayments, or coinsurance.

Suspended FEHB coverage and a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare managed careplan. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care plan service area.

• Enrollment in Medicare Part B

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

TRICARE

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

Workers' Compensation

We do not cover services that:

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

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

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

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness 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 11.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 11.

Covered services

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

Custodial care

Care that is rendered primarily for the purpose of helping you perform activities of daily living or meet your personal needs, and can be provided safely and reasonably by persons who do not have professional training skills. Much of the care provided in nursing homes to people with chronic, long-term illnesses or disabilities is considered to be custodial care. For example, custodial care includes help in walking, getting in or out of bed, bathing, dressing, eating, and taking medicine. First Choice Health Plan does not pay for custodial care when that is the only care needed. Even if you are in a participating hospital or skilled nursing facility, First Choice Health Plan does not cover your stay if you only need custodial care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. First Choice Health Plan does not have a deductible.

Experimental or investigational services

Items and procedures determined by First Choice Health Plan not to be generally accepted by the medical community or determined by First Choice Health Plan to be experimental and investigational under First Choice Health Plan guidelines. **Experimental and Investigational Services are not covered under First Choice Health Plan.**

Medical necessity

A determination made by First Choice Health Plan that a service or procedure is (1) consistent with the symptoms, diagnosis, and treatment of a patient's condition, (2) meets the appropriate standards of good medical practice, and (3) is not provided solely for the convenience of the patient, the patient's family or the provider.

Plan allowance

Means the maximum amount paid by the Plan for a Medically Necessary Covered Service. Generally this is an amount agreed to contractually by the Plan and Network Providers. The maximum amount paid by this plan for service from non-network providers and for out-of-area providers is based on usual, customary and reasonable (UCR) charges for the services rendered.

Definition of terms of terms continued on next page

	The Plan allowance for providers who do not have agreements with us shall be determined based on the Usual, Customary and Reasonable amount or an amount designed by an independent entity for the applicable geographical region. The Usual, Customary and Reasonable amounts are those charges that fall within the usual range of charges for the same service or supply in a geographical area.
Us/We	Us and we refers to First Choice Health Plan.
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
- 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.

Note: 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.

Section 11 FEHB facts continued on next page

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 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 TCC.

• Spouse equity coverage

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

•TCC

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for 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 1-800-783-7312 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 try 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 the First Choice 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.....	$10 per office visit	13
Services provided by a hospital:		28
• Inpatient.....	*Nothing*	
• Outpatient.....	*Nothing*	29
Emergency benefits:		31
• In-area and out-of-area		
- In doctor's office and urgent care center	$10 per visit	
- In hospital	$50 per visit	
Mental health and substance abuse treatment	Regular cost sharing	33
Prescription drugs: • Retail Pharmacy Benefit Tier 1 – Generic Tier 2 – Preferred Tier 3 – Non-Preferred • Mail Order Pharmacy Benefit Tier 1 – Generic Tier 2 – Preferred Tier 3 – Non-Preferred	 $5 Copay $10 Copay $25 Copay $10 Copay $20 Copay $50 Copay	35
Dental Care.....	No Benefit	38
• Accidental Injury	Nothing	

Summary of benefits continued on next page

Summary of benefits for the First Choice Health Plan – 2001 *(Continued)*

Vision Care: Routine Exam ..... Lenses & frames ..... Professional services related to contact lenses	$10 Copay 20% discount 15% discount	19
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $1,500/Self Only or $4,500/Self and family enrollment per calendar year This copay maximum does not include prescription drugs.	11

2001 Rate Information for
First Choice Health Plan

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
Greater Seattle area							
Self Only	5G1	$86.59	$32.47	$187.61	$70.35	$102.22	$16.84
Self and Family	5G2	$195.82	$113.72	$424.28	$246.39	$231.17	$78.37