Premera HealthPlus

http://www.premera.com

2001

A Health Maintenance Organization

Serving: Most of Washington State and parts of Idaho

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

This Plan has full accreditation from the NCQA. See the 2001 Guide for more information on NCQA.

Enrollment codes for this Plan:

8F1 Self Only
8F2 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management
Retirement and Insurance Service
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Federal Employees
Health Benefits Program

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Introduction

Premera HealthPlus
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Mountlake Terrace, WA 98043-2124

This brochure describes the benefits of Premera HealthPlus under our contract (CS2850) 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.

A person enrolled in this Plan is 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 6. 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 Premera HealthPlus.

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 and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

How we pay providers

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

Who provides my health care?

Premera HealthPlus is a mixed-model HMO with an extensive network of participating primary care physicians, specialty care providers, and health care facilities. Most primary care physicians are part of a group practice. These group practices have arrangements with specialists, laboratories, hospitals, and other providers. When you need specialty services, your primary care physician will usually refer you to a provider who is affiliated with his or her group practice. Keep this in mind when choosing a primary care physician.

The most important decision you will make as a Premera HealthPlus member is the selection of a primary care physician. Your primary care physician will coordinate your care under this plan, and will obtain any necessary authorizations for specialty care or hospitalizations. Always look to your primary care physician as your first source for information on your health care.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, which 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.

- Premera HealthPlus is a state-certified health maintenance organization (HMO). In April 2000 we received three-year, Excellent Accreditation from the National Committee for Quality Assurance, an independent, nonprofit organization which evaluates managed care plans.
- Premera HealthPlus has operated in Washington State since 1981.
- We are a nonprofit health maintenance organization licensed in Washington State.

If you want more information about us, call 800/527-6675 or write to Premera HealthPlus, PO Box 2113, Seattle, WA 98111-2113. You may also contact us by fax at 425/670-5922 or visit our website at www.premera.com.

Service Area

To enroll with us, you must live in our service area. This is where our providers practice. Our service area includes the following areas: In Washington, all zip codes in the following counties: Adams, Asotin, Benton, Chelan, Clallam, Columbia, Cowlitz, Douglas, Ferry, Franklin, Garfield, Grant, Grays Harbor, Island, Jefferson, King, Kitsap, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, San Juan, Skagit, Skamania, Snohomish, Spokane, Stevens, Thurston, Walla Walla, Whatcom, Whitman, and Yakima.

In Idaho, all zip codes in Kootenai and Latah counties, and the indicated zip codes in the following counties: Benewah: 83824, 83851, 83861, 83870; Bonner: 83804, 83809, 83813, 83821-22, 83825, 83840-41, 83848, 83852, 83856, 83860, 83862, 83864-65; Nez Perce: 83501, 83524, 83540-41, 83551; Shoshone: 83839, 83850, 83868.

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. Follow-up care must be approved by the Plan, or be received from Plan providers.

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. Premera HealthPlus participates in *Blues*CONNECT, a nationwide network of HMOs. In many cases you and your family members can receive care from a participating HMO on the same basis as from your plan at home. Contact us for more information on *Blues*CONNECT. 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 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 and activities by calling our Member Services Department at 800/527-6675 or checking our website at www.premera.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 28.8% for Self Only or 40.2% for Self and Family.
- **Prescription Drug Benefits** You pay a $10 copay for generic drugs, a $20 copay for preferred brand name drugs and a $30 copay for non-preferred brand name drugs when purchased from a participating pharmacy. You can obtain up to a 100-day supply of mail order drugs with a $20 copay for generic drugs, a $30 copay for preferred brand name drugs, or a $40 copay for non-preferred brand name drugs.
- **Service Area** We have expanded our service area to include: all zip codes in these Washington counties: Chelan, Cowlitz, Ferry, Grays Harbor, Jefferson, Klickitat, Pacific, Pend Oreille, Skagit, Stevens, and Whatcom; and selected zip codes in Benewah County in Idaho. See page 5 for details

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 obtain 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 800/527-6675.

Where you get covered care

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

· **Plan providers**

Plan providers are physicians and other health care professionals 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 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. This decision is important since your primary care physician provides or arranges for most of your health care. Each member must choose a primary care physician. If desired, each family member may choose a different physician. You will receive a provider directory upon enrollment, or you may request one by calling Member Services at 800/527-6675. If you are interested in having a provider in the directory as your primary care physician, call them to verify they are still participating with Premera HealthPlus and are accepting new patients.

· **Primary care**

Your primary care physician can be a family practitioner, internal medicine specialist, pediatrician, general practitioner, or an advanced registered nurse practitioner (ARNP). 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.

You may begin to visit your new primary care physician as of the first of the month after we approve your request.

· **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, you may see certain participating Premera HealthPlus providers without a referral.

You can self refer to Plan providers **only** for the following services:

- Routine eye exam (to prescribe corrective lenses): one each calendar year.
- Chiropractic care (up to 20 visits each calendar year).
- Smoking cessation programs
- Community wellness classes and programs

Additionally, female members may self-refer for women's health care services, including gynecological care, reproductive health services, and obstetrical care. All services must be from Plan providers.

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. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause; or
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
  - reduce our service area and you enroll in another FEHB Plan,

  you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

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

· **Hospital care**

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

Hospital care (continued)

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800/527-6675. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process "pre-approval of coverage." Your physician must obtain pre-approval of coverage for the following services: inpatient facility admissions, home health or hospice care, organ and bone marrow transplants, surgical treatment of morbid obesity and human growth hormone therapy.

In some instances, the medical director at your primary care physician's clinic must also approve the referral. Your primary care physician will work directly with us or your clinic's medical director whenever pre-approval of coverage is required.

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 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 $100 per admission.
· **Deductible**	We do not have a deductible.
· **Coinsurance**	Coinsurance is the percentage of our negotiated fee that you must pay for your care. Certain benefits require you to pay coinsurance. Example: In our Plan, you pay 50% of our allowance for infertility services.
Your out-of-pocket maximum for copayments and coinsurance	We do not have an out-of-pocket maximum.

Section 5. Benefits OVERVIEW

(See page 6 for how our benefits changed this year and page 47 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 800/527-6675 or at our website at www.premera.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.
- 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 • In an urgent care center • At home • Office medical consultations • Second surgical opinions	$10 per visit
Professional services of physicians: • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child in the hospital	Nothing
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing. Services provided in a physician's office require a $10 office visit copay.

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 • Prostate Specific Antigen (PSA test) – one annually for men age 40 and older • Routine pap test • Sigmoidoscopy, screening–every five years starting at age 50.	Nothing. Services provided in a physician's office require a $10 office visit copay.
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 • When recommended by your primary care physician or women's health care provider	Nothing. Services provided in a physician's office require a $10 office visit copay.
Not covered: Physical exams and immunizations 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
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• 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. • Well-child care charges for routine examinations, immunizations and care (through age 22)	$10 per 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. Benefits for newborn care are provided automatically for 21 days after the date of birth when the mother is receiving maternity benefits. Coverage beyond the 21 day period is provided 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: Routine sonograms to determine fetal age, size or sex	*All charges*
Family planning	
• Voluntary sterilization • Injectable contraceptive drugs • Intrauterine devices (IUDs)	$10 per visit
• Surgically implanted contraceptives, such as Norplant. Limited to one device plus insertion and removal every five years.	$100
Not covered: reversal of voluntary surgical sterilization.	*All charges*
Infertility services	
Diagnosis and treatment of infertility, such as: • Artificial insemination: ••*intravaginal insemination (IVI)* ••*intracervical insemination (ICI)* ••*intrauterine insemination (IUI)*	50% of charges

Infertility services continued on next page.

Infertility services *(Continued)*	**You pay**
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* ••*in vitro fertilization* ••*embryo transfer and GIFT* • *Services and supplies related to excluded ART procedures* • *Fertility Drugs (oral and injectable)* • *Cost of donor sperm*	*All charges*
Allergy care	
Testing and treatment Allergy injection	$10 per visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 22. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Biofeedback (up to 10 visits per calendar year) • Office consultations and services from participating naturopathic physicians, acupuncturists, and dieticians	$10 per visit
• Growth hormone therapy (GHT) We will only cover GHT when treatment is pre-approved for coverage. Your primary care physician will request this for you. We will ask the physician to submit information that establishes that the GHT is medically necessary.	20% of charges

Rehabilitative therapies	You pay
Physical therapy, occupational therapy and speech therapy -- • Up to 2 consecutive months per condition for: •• qualified physical therapists •• speech therapists •• occupational therapists •• massage 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 functional speech due to illness or injury. •• cardiac rehabilitation following heart transplant, bypass surgery, myocardial infarction, or when referred by primary care physician • Up to 30 inpatient days and 60 outpatient visits per calendar year for neurodevelopmental therapy for children age six and under. Services must be to improve neurodevelopmental functioning that is not occurring at a normal rate.	$10 per visit
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Hearing services (testing, treatment, and supplies)	
• Routine hearing testing for adults age 18 and older when referred by primary care physician, limited to one exam every 24 consecutive months. • For children through age 17 (see *Preventive care, children*)	$10 per visit
Not covered: • *All other hearing testing* • *Hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	
• Eyeglasses or contact lenses following intraocular surgery (such as for cataracts)	Nothing
• Annual eye refractions for all members. Primary care physician referral not required, but you must use a plan vision care provider.	$10 per visit

Vision services continued on next page.

Vision services *(Continued)*	**You pay**
Not covered: • *Eyeglasses or contact lenses except after intraocular surgery* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	
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 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	
Benefits for orthopedic and non-implanted prosthetic devices are limited to $1,000 per member per calendar year. This limit also includes durable medical equipment; see benefit below. Covered items include: • Artificial limbs and eyes; stump hose • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome; • Orthopedic corrective shoes and orthotics • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy are not included in the $1,000 maximum. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy are not included in the $1000 maximum. 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
Not covered: • *Heel pads and heel cups* • *Lumbosacral supports*	*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. Benefits are limited to $1000 per Member per Calendar Year. This benefit maximum includes covered items described in the Orthopedic and Prosthetic Devices benefit described above. Under this benefit, we also cover: • hospital beds; • wheelchairs; • crutches; • walkers; • blood glucose monitors; and • insulin pumps.	Nothing
Not covered: • *Personal convenience items* • *Non-medical equipment such as air filters, air conditioners, or exercise equipment*	*All charges*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide • Services include oxygen therapy, intravenous therapy and medications	Nothing
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	
• Acupuncture – by a doctor of medicine or osteopathy or plan acupuncturist for: anesthesia, pain relief, or treatment of other covered condition when referred by your primary care physician. • Chiropractic services from plan chiropractors (D.C.) when referred by your primary care physician. You may self-refer for up to 20 visits per calendar year from plan chiropractors. • Naturopathic services from plan naturopathic physician (N.D.) when referred by your primary care physician.	$10 per visit
Not covered: • *Hair analysis, naturopathic/homeopathic remedies, medicines or devices*	*All charges*

Educational classes and programs	You pay
Coverage is limited to: • Smoking Cessation – Up to $250 for one smoking cessation program per member per calendar year. Referral from the primary care physician is not required, but you must use a plan-designated program. Call member services for a list of designated programs. Coverage for smoking cessation drugs is provided under the Prescription Drug benefit. See page 29. • Diabetes self-management • Other educational classes or programs for an existing illness, injury or conditions when referred by the primary care physician.	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 precertication information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

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) • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information.	Nothing. Services in a physician's office require the office visit copayment See Section (5a).
• 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.	50% of charges
• Voluntary sterilization • Norplant and intrauterine 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 a pacemaker and Surgery benefits for insertion of the pacemaker.	Nothing. Services in a physician's office require the office visit copayment See Section (5a).
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. Services in a physician's office require the office visit copayment See Section (5a).
• 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. Services in a physician's office require the office visit copayment See Section (5a).
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures	Nothing. Services in a physician's office require the office visit copayment See Section (5a).
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 care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.*	*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 Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing.
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled Nursing Facility • Ambulatory surgical center	Nothing
• 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 NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$100 copay per admission up to a $300 copay maximum under a Self only enrollment or a $500 copay maximum under a Self and Family enrollment.
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.	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 • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Extended care benefits/skilled nursing care facility benefits	
Extended Care/Skilled nursing facility (SNF): Up to 120 days per calendar year	$100 copay per admission up to a $300 copay maximum under a Self only enrollment or a $500 copay maximum under a Self and Family enrollment.
Not covered: custodial care	*All charges*
Hospice care	
Up to six months of care when referred by primary care physician. Benefits can be extended an additional six months when medically necessary. Hospice care benefits include: • Inpatient hospice facility care of up to 10 days • Home visits • Respite care of up to 120 hours in a three-month period	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate. Includes ground and air ambulance	$25 per trip

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: If you have a medical emergency, call 911 or seek care immediately.

If you have a medical emergency, you can go to any provider's office, urgent care center, or hospital emergency room without a referral from your primary care physician.

If you are admitted as a hospital inpatient directly from the emergency room (or within 24 hours) the emergency room copayment is waived.

If you are admitted to a non-plan hospital in an emergency, we may require you to transfer to a Plan hospital once your condition has stabilized. We will pay the costs of that transfer. If you refuse to transfer, all further costs related to that inpatient stay will be your responsibility.

Emergencies within our service area: Call 911 or seek care immediately. You may receive care in any provider's office, hospital emergency room, or urgent care center.

Emergencies outside our service area: Same as for emergencies within our service area. If you are hospitalized outside the service area, please call us as soon as you are medically able to do so.

Note: All follow up care (such as suture removal, dressing changes, etc.) must be provided or referred by the primary care physician.

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 at a hospital, including doctors' services	$50 per visit (waived if admitted)
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 a hospital, including doctors' services	$50 per visit (waived if admitted)
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*	*All charges*
Ambulance	
Professional ambulance service when medically appropriate. Includes ground and air ambulance. See 5(c) for non-emergency service.	$25 per trip

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.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per visit
• Diagnostic tests	Nothing. If you receive these services during an office visit, you pay a $10 office visit copay.
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$100 copay per inpatient admission up to $300 copay maximum under a Self only enrollment, or $500 under Self and family enrollment.

Mental health and substance abuse benefits –Continued on next page

Mental health and substance abuse benefits *(Continued)*	
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. These include:

- Getting a referral from your primary care physician for mental health services. If you need inpatient care, your primary care physician will obtain the necessary authorizations from us.
- Contacting our Substance Abuse Coordinator. The Coordinator will assess your situation, and refer you to a Plan treatment facility for care. You do not need a referral form your primary care physician. The Substance Abuse Coordinator can be reached by calling 800/333-1687.

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 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 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.
- Certain drugs may require prior approval for benefits beyond an initial course of treatment in accordance with established pharmacy practice standards .
- 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 provider licensed by state law to prescribe drugs must write the prescription.
- **Where you can obtain them**. You may fill the prescription at a Plan retail pharmacy, or through our Prescriptions-By-Mail program.
- **We use a formulary.** This is a list of preferred brand name drugs we recommend doctors and other practitioners prescribe when a generic drug is not available. This list is evaluated and updated periodically by a group of community doctors and pharmacists who review current medical and scientific literature. If your physician prescribes a drug that is not on the preferred brand name list, you pay the nonpreferred brand name copayment.
- **These are the dispensing limitations**:

  Participating Retail Pharmacy: Up to a 100 day supply. You pay a separate copayment for each 34 days supply dispensed.

  Prescriptions-By-Mail program: Up a 100 day supply. You pay a single copayment for the entire supply.

  Dispensed amounts for certain drugs may be limited based on medical necessity, or to amounts appropriate for a usual course of treatment. In making this determination, we take into consideration the recommendations of the manufacturer, the circumstances of the individual case, U.S. Food and Drug Administration Guidelines, and standard reference compendia.

  Generic Drugs When available and allowed by prescription, generic drugs are dispensed in place of brand name drugs. In the event a generic is not manufactured, the brand name copayment will apply. If you request a brand name drug when a generic equivalent is available and allowed by prescription, you will pay the difference in price between the brand name drug and the generic equivalent, in addition to the brand name copayment.

  Refills: Refills are provided only when you have used three-fourths (75%) of the current supply.

  When you have to file a claim. Plan retail pharmacies and our Prescriptions-By-Mail program will submit claims for you. If you ever need to submit a claim yourself, simply fill out a prescription drug claim form, and send it along with the itemized receipt to the address shown on the claim form.

  If you need claim forms, call Member Services at 800/527-6675.

Prescription drug benefits begin on the next page.

Description	You pay
Covered medications and supplies:	
We cover the following medications and supplies when prescribed by a legal prescriber and obtained from a Plan retail pharmacy or through our Prescriptions-By- Mail program: • Drugs and medicines that by Federal law of the United States requires a physician's prescription for their purchase. • Compounded drugs in which at least one ingredient by Federal law of the United States requires a physician's prescription • Injectable drugs such as insulin • Insulin needles, syringes, and injection aids • Prescriptive oral agents for controlling blood sugar • Disposable diabetic testing strips and lancets • Oral contraceptives, diaphragms, and cervical caps • Glucagon and allergy emergency kits • Vitamins which by law require a prescription • Prescription smoking cessation drugs, up to $250 per member per calendar year • Drugs to treat sexual dysfunction. These drugs are subject to dose limits. Contact us for dose limits. Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic. • 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 800/527-6675. Prescriptions-By-Mail: You can save time and money by filling your prescriptions through our Prescriptions-By-Mail program. This benefit is available only for prescriptions filled through our participating mail order pharmacy.	***Retail Pharmacy (up to 34-day supply)*** $10 copay for generic drugs $20 copay for preferred brand name drugs $30 copay for non-preferred brand name drugs ***Prescriptions-By-Mail Program (up to 100-day supply)*** $20 copay for generic drugs $30 copay for preferred brand name drugs $40 copay for non-preferred brand name drugs
Not covered: • *Fertility drugs* • *Drugs to enhance athletic performances* • *Nonprescription medications* • *Drugs and supplies for cosmetic purposes* • *Drugs for obesity treatment or weight control* • *Prescriptions or refills in excess of the quantity specified by the prescribe, or that are dispensed after one year from the date the prescription was written*	*All charges*

Section 5 (g). Special Features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. Alternative benefits are subject to our ongoing review. By approving an alternative benefit, we cannot guarantee you will get it in the future. The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call HealthNurse at 800/841-8343 and talk with a registered nurse who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired	You may contact our Member Services Department via TTY/TDD: 425/670-4557 (Seattle area) 800/842-5432 (Toll free statewide)
Reciprocity benefit	Benefits for away-from-home care are available through *Blues*CONNECT, our national network of affiliated HMOs. When you are outside our service area, call *Blues*CONNECT to be referred to a participating HMO. By using *Blues*CONNECT providers, all you have to pay are your normal copayments. The *Blues*CONNECT provider will bill us directly. To reach *Blues*CONNECT for away-from-home care, call 800/446-6872.
High risk pregnancies	BestBeginnings provides mothers-to-be with quick and easy access throughout their pregnancy to a nurse trained in obstetrics. The BestBeginnings nurse can help answer questions about pregnancy, prenatal care and delivery and provide mothers-to-be with other helpful information to assist them in making healthy choices during their pregnancy. BestBeginnings is available by calling 888/733-6399.
Community Wellness Benefit	The Community Wellness Benefit allows you to participate in classes and programs which promote positive health and lifestyle choices. Examples of these programs are home safety, parenting, and first aid. This benefit provides up to $250 per Calendar Year for approved programs. A referral from your primary care physician is not required, but programs or classes must be from Premera HealthPlus providers. Please call us for a list of these programs.

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.
- Your primary care physician must 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. Services must be received within 12 months of the date of the accidental injury. Benefits are not provided for injuries due to biting or chewing.	Nothing.

Dental benefits

We have no other dental benefits.

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

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

Health Club Memberships Selected health and fitness clubs in Washington State offer a discounted membership rate or other special offers to Premera HealthPlus members. You can call Member Services at 800/527-6675 and ask for a list of participating clubs.

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 physician determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree as discussed under *What Services Require Our Prior Approval* on page 9.**

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 800/527-6675.

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

- Covered member's name and ID number;
- Name and address of 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: Premera HealthPlus, P.O. Box 2113, Seattle, WA 98111-2113

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, (a) Send your request to us at: Premera HealthPlus, ATT: Appeals Coordinator, PO Box 2113, Seattle, WA 98111-2113; and (b) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (c) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (b) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (c) Write to you and maintain our denial – go to step 4; or (d) 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. 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.

Disputed claims process continued on next page.

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 800-527-6675 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. 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-State 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 primary care physician and preapproved for coverage when 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,	✓	
b) Or 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, a) And are an annuitant,	✓	
b) Or are an active employee		✓

When you receive services from plan providers, they will submit claims for you. Otherwise, follow the procedure listed in "Filing a claim for covered services" on page 35.

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 800/527-6675.

We waive some costs when you have Medicare -- When Medicare is the primary payer, we will waive some out-of-pocket costs, as follows: In this case we do not waive any out-of-pocket costs.

· **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, 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 plan provider and referral requirements.

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 care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care plan 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 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

If we pay claims on your behalf for injury or illness for which another party is liable, we may be entitled to be repaid for those payments out of any recovery from that liable party. This may also be true if motor vehicle or personal injury insurance exists. The liable party is also known as the "third party," because it is a party other than you or us. "Subrogation" means we may collect directly from that third party for claims we have paid on your behalf. Because we have paid for your illness or injuries, we may be entitled to recover for those expenses.

To the fullest extent permitted by law, we are entitled to the proceeds of a recovery from a third party, up to the amount of benefits paid by us. To do this, we may decide to hire our own attorney or be represented by your attorney. If we choose to be represented by your attorney, we will pay, on a contingent basis, a reasonable portion of the attorney fees necessary to assert our right of recovery. This portion will usually not be more than 20 percent of the amount we seek to recover. We will not pay for any legal costs incurred on your behalf. You will not be required to pay any portion of the legal costs incurred on our behalf.

Before you accept any settlement with a third party, you must notify us in writing of any terms or conditions offered in a settlement. You must also notify the third party of our interest in the settlement. You must cooperate with us in recovering amounts we paid. If you hire an attorney or other agent to represent you, you must require your attorney or agent to reimburse us directly from any settlement.

To the maximum extent permitted by law, we are "subrogated" to your rights against any third party who is responsible for the condition. This means that we have the right to sue the third party in your name. It also means we have a security interest in and lien upon any recovery to the extent of the amount of benefits paid by us and for our expenses in obtaining a recovery. We may also seek recovery directly from the third party.

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 10
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See page 10.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Non-medical care which is provided for assistance with every day activities of living. Examples are assistance with feeding, bathing, dressing, or supervision of taking medicine.
Experimental or investigational services	Services, supplies, or drugs which are not considered an appropriate type or standard of care based on current, generally-accepted medical and scientific literature, and the Blue Cross Blue Shield Technical Evaluation Center (TEC).
Medical necessity	Appropriate treatment for a medical condition as indicated in authoritative medical or scientific literature. Medically necessary treatment must be consistent with the diagnosis, cost effective, and is essential to the diagnosis or treatment of an illness or injury.
Us/We	"Us" and "we" refer to Premera HealthPlus.
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

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 800/527-6675 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 are 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 Premera HealthPlus - 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 the front of 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 office visit copay	12
Services provided by a hospital: ▪ Inpatient …… ▪ Outpatient ……	$100 copay per admission Nothing	23
Emergency Benefits: • In-area …… • Out-of-area ……	$50 per emergency room visit $10 per urgent care center visit Same as in-area	26 26
Mental health and substance abuse treatment ……..	Regular cost sharing	27
Prescription Drugs • Generic drugs ……... • Brand name preferred drugs …… • Non-preferred drugs ……	$10 copay $20 copay $30 copay	29
Dental Care - accidental injury……..	Nothing	32
Vision Care-annual eye refraction……..	$10 copay	16
Special features: ▪ HealthNurse (24 hour nurse line) ▪ BestBeginnings (pregnancy help and advice) ▪ Community Wellness Benefit (coverage for wellness and health classes)		31
Protection against catastrophic costs (your out-of-pocket maximum) ……..	We do not have an out-of-pocket maximum.	10

2001 Rate Information for Premera HealthPlus

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 Services Nurses and Tool & Die employees (See RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIC) 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
Self Only	8F1	$86.59	$32.09	$187.61	$69.53	$102.22	$16.46
Self and Family	8F2	$195.82	$90.98	$424.28	$197.12	$231.17	$55.63