Group Health Cooperative of Puget Sound 2002

Western Washington http://www.ghc.org
Eastern & Central Washington and North Idaho http://www.ghnw.org

A Health Maintenance Organization

Serving: Most of Washington State and Northern Idaho

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.

Commercial and Medicare Plans

This plan has excellent accreditation from the NCQA. See the 2002 Guide for more information on NCQA.

Western Washington
Enrollment codes for this Plan:
541 Self Only
542 Self and Family

Eastern & Central Washington and Northern Idaho
Enrollment codes for this Plan:
VR1 Self Only
VR2 Self and Family

Authorized for distribution by the:
UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

FEHB
Federal Employees Health Benefits Program

RI 73-012

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Introduction

Group Health Cooperative of Puget Sound
521 Wall Street
Seattle WA 98121

This brochure describes the benefits provided by Group Health Cooperative of Puget Sound under our contract (CS 1043) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

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

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 8. The amount you pay is shown on the back cover of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means Group Health Cooperative of Puget Sound.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, DC 20415-3650.

Inspector General Advisory

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 888/901-4636 and explain the situation.
- If we do not resolve the issue, call or write to:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
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 any one who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific 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 covered services from Plan providers, you generally 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 if a provider leaves our Plan. We cannot guarantee that any one provider, 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.

Who provides my health care?

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

For Central and Eastern Washington and Northern Idaho and Whatcom Division members only: All participating providers are practitioners who provide routine care within their private office settings in the community.

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

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You can also find out about Care Management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you.

If you would like more information about us, call 1-888/901-4636, or write to Group Health Cooperative, Customer Service, P.O. Box 34590, Seattle WA 98124-1590. You may also contact us by fax at 1-206/901-4612 or visit our website at http://www.ghc.org for Western Washington and http://www.ghnw.org for Eastern and Central Washington and Northern Idaho. You may get information about us, our networks, providers and facilities.

Service Area

To enroll in this Plan, you must live or work in our Service Area. Group Health Cooperative providers practice in the following areas. Our service area is:

Western Washington (entire counties):

- Island
- King
- Kitsap
- Lewis
- Mason
- Pierce
- San Juan
- Skagit
- Snohomish
- Thurston
- Whatcom

In Grays Harbor County, the following cities, by Zip Code:

- Elma (98541)
- Malone (98559)
- McCleary (98557)
- Oakville (98568)
- Porter (98573)

In Jefferson County, the following cities, by Zip Code:

- Brinnon (98320)
- Chimacum (98325)
- Gardner (98334)
- Hadlock (98339)
- Nordland (98358)
- Port Ludlow (98365)
- Port Townsend (98368)
- Quilcene (98376)

(which are east of a line drawn southward from Port Angeles)

Central and Eastern Washington (entire counties):

- Benton
- Columbia
- Franklin
- Kittitas
- Spokane
- Walla Walla
- Whitman
- Yakima

(locations within a 70 mile radius of downtown Spokane)

Northern Idaho (entire counties):

- Kootenai
- Latah

If you receive care outside our service area, we will pay only for emergency services as described on pages 28 and 29, or those services covered under "Travel Benefit" described on page 34. We will not pay for any other health care services.

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 service area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Plan members who are temporarily outside the service area of this Plan have access to care with Kaiser Permanente Plans. If you need services when out of the area, and are in the service area of a Kaiser Permanente Plan, you may obtain care from any Kaiser Permanente Provider, medical office, or medical center. If you plan to travel and wish to obtain more information about the benefits available to you, please call Customer Service at 1-888/901-4636.

Section 2. How we change for 2002

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- We simplified the criteria for coverage of speech therapy benefits. We will now provide speech therapy in all situations where it is determined to be medically necessary. Section 5(a)

Changes to this Plan

- Your share of the non-Postal premium for Enrollment Code 54 will increase by 11.8% for Self Only and 11.8% for Self and Family, and for Enrollment Code VR it will decrease by 9.3% for Self Only and decrease by 25.5% for Self and Family.
- For all emergency visits at a Plan hospital or Plan designated facility you now pay $75 and at a non-designated facility you pay $125. Previously, you paid $50 at a Plan hospital or Plan designated facility and at a non-plan designated facility you paid $100. (see pages 28-29)
- For prescription drugs prescribed by your Plan doctor and obtained at a Plan pharmacy you will now have a $10 copayment for generic drugs and $20 copayment for brand name drugs. Previously, your pharmacy copayment was $10. Section 5 (f)
- We now cover certain intestinal transplants. Section 5(b)
- We no longer limit total blood cholesterol tests to certain age groups. Section 5(a)
- We changed the address for sending disputed claims to OPM. Section 8

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, please call our Customer Service at 1-888/901-4636.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance, 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 list Plan providers in our provider directories, which we update periodically. You may call Customer Service at 1-888/901-4636.

- **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 our provider directories. The list is also on our websites.

What you must do to get covered care

You and each family member should choose a primary care physician. This decision is important, since your primary care physician provides or arranges for most of your health care. There are several ways to select a physician; you may contact Customer Service 1-888/901-4636 or your chosen plan facility for assistance.

- **Primary care**

Your primary care physician (such as a family practitioner or pediatrician), will arrange for 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 Customer Service at 1-888/901-4636 or contact your chosen plan facility. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see a woman's health care specialist or a mental health provider without a referral. A woman may see a participating General or Family Practitioner, Physician's Assistant, Gynecologist, Certified Nurse Midwife, Doctor of Osteopathy, Obstetrician or Advanced Registered Nurse Practitioner who provide women's health care services directly, without a referral from her primary care provider, for medically appropriate maternity care, reproductive health services, preventive care and general examination, gynecological care and

medically appropriate follow-up visits for the above services. If the chosen provider diagnoses a condition that requires a referral to other specialists or hospitalization, you or your chosen provider must obtain preauthorization and care coordination in accordance with applicable Plan requirements.

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 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 our Customer Service Department at 1-888/901-4636 or, if we drop out of the Program, contact your new plan.

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our Customer Service department immediately at 1-888/901-4636. 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 "prior approval." Your physician must obtain "prior approval" for the following services: Hospitalization, Specialty Care and orders for Durable Medical Equipment. Upon obtaining "prior approval," all of the above are subject to the applicable copays or coinsurance.

Section 4. Your costs for covered services

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

• Copayments

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

Example: When you see your primary care physician you pay a copayment of $10 per office visit. When you are admitted to the hospital you pay $100 per day up to a $300 maximum per person per year.

• Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. Our Plan's deductible is an amount you pay for emergency care received at non-Plan facilities.

NOTE: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

• Coinsurance

Coinsurance is the percentage of our allowed charges for specific benefits that you must pay for your care.

Example: In our Plan, you pay 50% of our allowed charges for infertility services, 20% of our allowed charges for durable medical equipment; devices, equipment and supplies and ambulance services; and varying amounts for dental care.

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

After your copayments, coinsurance, and deductibles total $1,000 per person or $2,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments, coinsurance, and deductibles for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments, coinsurance, and deductibles for these services:

- Infertility services
- Medical devices, equipment and supplies
- Dental care
- $125 non-Plan emergency care deductible
- Ambulance services

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

Section 5. Benefits — OVERVIEW

(See page 8 for how our benefits changed this year and page 54 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 subsection. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-888/901-4636 or at our website at www.ghc.org for Western Washington or www.ghnw.org for Eastern Washington.

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 provider's office	$10 per office visit
Professional services of physicians • In an urgent care center • Office medical consultations • Second surgical opinion	$10 per visit
At home	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
Preventive care, adult	
Routine screenings according to the Plan's well adult schedule, such as but not limited to: • Total Blood Cholesterol – once every five years • Colorectal Cancer Screening, including – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50	Nothing Nothing

Preventive care, Adult - continued on next page

Preventive care, adult *(continued)*	**You Pay**
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	Nothing
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 one to two years according to risk	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, or travel.	*All charges*
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 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
• Well-child care charges for routine examinations, immunizations, immunization updates and care according to the Plan's well child schedule (under age 22) • Examinations, such as: – Eye exams to determine the need for vision correction once every 12 months – Ear exams to determine the need for hearing correction	Nothing $10 per visit
Maternity care	
Complete maternity (obstertrical) care, such as: • Prenatal care • Delivery • Postnatal care **Note:** Here are some things to keep in mind: • You do not need to have "prior approval" for your normal delivery; see below 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 including circumcision 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).	Copays are waived for prenatal and postnatal care

Family planning	You pay
A broad range of voluntary family planning services, limited to: • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Intrauterine devices (IUDs)-insertion • Injectable contraceptive drugs (such as Depo Provera) • Diaphragms-fitting **NOTE:** We cover oral contraceptives under the prescription drug benefits (Section 5(f)	$10 per office visit
Not covered: reversal of voluntary or involuntary surgical sterilization.	*All charges*
Infertility services	
Nonexperimental infertility services limited to general diagnostic services Specific diagnosis and treatment of infertility, such as: • Artificial insemination: – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI)	$10 per office visit 50% of all charges
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* – *in vitro fertilization* – *embryo transfer, gamete GIFT and zygote ZIFT* – *zygote transfer* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility Drugs*	*All charges*
Allergy care	
Testing and treatment Allergy injection	$10 per office visit Nothing
Allergy serum	Nothing
Not covered: any testing or treatment that does not meet Plan protocols	*All charges*

Treatment therapies	You pay
• Chemotherapy and radiation therapy	$10 per visit
Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under "Organ/Tissue Transplants" on page 24.	
• Respiratory and inhalation therapy	
• Dialysis – Hemodialysis and peritoneal dialysis	
• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	Nothing when administered at home
• Growth hormone therapy (GHT)	Covered under prescription drug benefit
• Dietary formula for the treatment of Phenylketonuria (PKU)	Nothing
• Enteral nutritional therapy when necessary due to malabsorption, including equipment and supplies	20% of charges for enteral nutritional therapy. Equipment and supplies are covered under Durable medical equipment (DME)
• Total parenteral nutritional therapy and supplies necessary for its administration	Nothing for formula. Equipment and supplies are covered under Durable medical equipment (DME)
• Routine nutritional counseling	$10 per visit
Not covered: over the counter formulas	*All charges*
Physical and occupational therapies	
Physical therapy, occupational therapy, and speech therapy are subject to a combined limit of sixty (60) visits per condition per calendar year. Speech therapy benefit is described in the next section. The following physical and occupational therapy benefits are covered:	10 per outpatient visit Nothing when provided on an inpatient basis (See Section 5(c) for Hospital charges)
• qualified physical therapists; and	
• qualified occupational therapists	
Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.	
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction when provided at a Plan facility	
Not covered:	*All charges*
• *long-term rehabilitative therapy*	
• *exercise programs*	

Speech therapy	You pay
Speech therapy, physical therapy and occupational therapy are subject to a combined limit of sixty (60) visits per condition per calendar year. The physical and occupational therapy benefits are described under "Physical and Occupational therapies". Speech therapy is covered: • Qualified speech therapists	$10 per outpatient visit Nothing when provided on an inpatient basis (see Section (c) for Hospital charges)
Hearing services (testing, treatment, and supplies)	
• Hearing testing to determine hearing loss	$10 per office visit
Not covered: • *hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	
• When dispensed through a Plan facility one contact lens per diseased eye following cataract surgery provided by a Plan doctor in lieu of an intraocular lens. Replacement will be provided only when needed due to change in your medical condition and will be replaced only one time within any 12 month period.	$10 per visit
• Eye exam to determine the need for vision correction • Annual eye exams or refractions **Note:** See "Preventive care, children," for eye exams for children.	$10 per office visit
Not covered: • *Eyeglasses* • *Contact lenses and related supplies including examinations and fittings for them, except as provided above* • *Eye exercises and orthoptics* • *Evaluations and surgical procedures to correct refractions which are not related to eye pathology including complications*	*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 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 • Ostomy supplies necessary for the removal of bodily secretions or waste through an artificial opening • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, intraocular lenses, and surgically implanted breast implant following mastectomy. **Note:** We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See Section 5(b) for coverage of the surgery to insert the device. • Occlusal splints (including fittings) for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Therapeutic shoe inserts for severe diabetic foot disease • Braces, such as back, knee, and leg braces, but not dental braces	20% of charges
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* • *cost of artificial or mechanical heart* • *cost of penile implanted device* • *Orthopedic and prosthetic replacements provided except when medically necessary* • *Replacement of devices, equipment and supplies due to loss, breakage or damage*	*All charges*
Durable medical equipment (DME)	
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician. Under this benefit, we cover: • hospital beds; • standard wheelchairs; • crutches; • walkers; • canes; • oxygen and oxygen equipment for home use; • nasal CPAP device • blood glucose monitors; • external insulin pumps; and • medically necessary replacement of supplies.	20% of charges

Durable medical equipment (DME) - continued on next page

Durable medical equipment (DME) *(continued)*	**You Pay**
Not covered: • *Motorized wheelchairs except when approved by the medical director as medically necessary* • *Replacement of devices, equipment and supplies due to loss, breakage or damage* • *Equipment not listed as covered in our DME formulary*	*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 per visit by provider 20% for oxygen therapy $10 copay per prescription for generic oral medications and $20 copay per prescription for brand name oral medications
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*
Manipulative therapy services	
Manipulative therapy services – for manipulation of the spine and extremities when treatment is received from a Plan provider and meets Plan protocols.	$10 copay per visit
Not covered: • *maintenance therapy* • *care given on a non-acute asymptomatic basis* • *services provided for the convenience of the member*	*All charges*

Alternative treatments	You Pay
Acupuncture – for pain relief for such conditions as chronic arthritis; chronic myofascial pain and chronic headaches when authorized in advance by your Plan provider and treatment meets Plan protocols.	$10 per visit
Naturopathic services-for treatment of conditions such as chronic arthritis; chronic fatigue syndrome and fibromyalgia when authorized in advance by your Plan provider and treatment meets Plan protocols.	$10 per visit
Not covered: • *maintenance therapy* • *vitamins* • *food supplements* • *care given on a non-acute asymptomatic basis* • *services provided for the convenience of the member* • *hypnotherapy* • *biofeedback* • *botanical and herbal medicines*	*All charges*
Educational classes and programs	
Coverage is limited to: • Tobacco Cessation – Participation in the Plan's "Free and Clear (tobacco cessation) Program" is required in order to receive coverage for one course of nicotine replacement or other approved pharmacy product therapy per year. • Diabetes self-management	Nothing for the Program; (See Section 5(f) for pharmacy charges for nicotine replacement therapy) $10 copay

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.).
- YOUR PLAN DOCTOR MUST GET "PRIOR APPROVAL" OF SOME SURGICAL PROCEDURES. Please refer to the "prior approval" information shown in Section 3 to be sure which services require "prior approval" and identify which surgeries require "prior approval".

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity — a condition for which an individual's Body Mass Index (BMI) must be 40 or greater, and when all other medical criteria is met including the requirement that eligible members must be age 20 or over. • Insertion of internal prosthetic devices. See 5(a) — "Orthopedic and prosthetic devices" for device coverage information. • Voluntary sterilization • Treatment of burns • Routine circumcision **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.	$10 per visit for outpatient care Nothing when provided on an inpatient basis (See Section 5(c) for hospital charges)
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care* • *Cost of a penile implanted device* • *Cost of an artificial or mechanical heart* • *Weight loss programs*	*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. • 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; – compression garments to treat lymphedema (see Durable Medical Equipment) – 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.	$10 per visit for outpatient care. Nothing, when provided on an inpatient basis (See Section 5(c) for hospital charges) See above
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 or cleft palate; • Removal of stones from salivary ducts; • Excision of malignancies; • Excision of non-dental cysts and incision of non-dental abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$10 per visit
Not covered: • *Oral implants including preparation for implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Surgical correction of malocclusion done solely to improve appearance*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single or Double • 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. • Intestinal transplants (small intestine) and small intestine with the liver or small intestine with multiple organs such as, the liver, stomach and pancreas. **Note:** We cover related medical and hospital expenses of the donor when we cover the recipient. These expenses are limited to procurement center fees, travel costs for a surgical team, excision fees, and matching tests.	$10 per visit for outpatient care Nothing when provided on inpatient basis (See Section 5(c) for Hospital charges)
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* • *Transportation and living expenses*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Skilled nursing facility	Nothing
Professional services provided in – • Hospital outpatient department • Ambulatory surgical center • Provider's office	$10 per visit

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 • Semiprivate room accommodations; • special care units such as intensive care or cardiac units • 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.	A $100 inpatient copayment per day for 3 days; maximum of $300 per person per calendar year
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 derivatives • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services	Nothing except the $100 inpatient copayment per day for 3 days; maximum of $300 per person per calendar year
• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	According to the benefit of the specific item you take home, i.e., hospital bed, pharmacy items, etc.
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Non-covered facilities, such as nursing home, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Blood* • *Private nursing care*	*All charges*

Outpatient hospital or ambulatory surgical center	You pay
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines administered at the facility • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood derivatives • 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.	Outpatient surgery is subject to the $10 outpatient copayment.
Not covered: blood	*All charges*
Rehabilitative therapies	
Physical therapy, occupational therapy, speech therapy - Two months per condition per calendar year for the services of each of the following in a certified rehabilitation facility: • qualified physical therapists • qualified speech therapists; and • qualified occupational therapists	Nothing after the $100 inpatient copayment per day for three days; maximum of $300 per person per calendar year.
Not covered: Long-term rehabilitative therapy	*All charges*
Extended care benefits/skilled nursing care facility benefits	
Skilled nursing facility (SNF) benefit: When full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and authorized by the Plan you will receive up to 30 days per calendar year.	Nothing
Not covered: • *custodial care;* • *rest cures;* • *domiciliary or convalescent care* • *personal comfort items, such as telephone and television*	*All charges*

Hospice care	You pay
Supportive and palliative care for a terminally ill member is covered in the home or a hospice facility. Services could include: • inpatient and outpatient care • drugs • biologicals • medical appliances and supplies that are used primarily for the relief of pain and symptom management • family counseling These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
• Ground and air ambulance transportation to a Plan facility, Plan designated facility, or non-Plan designated facility, when medically appropriate and ordered or authorized by a Plan doctor.	20% of charges

Section 5 (d). Emergency services/accidents

IMPORTANT

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

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

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Remember, it is your responsibility to notify the Plan.

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 24 hours by calling the Plan notification line at 1-888/457-9516, unless it was not reasonably possible to do so. If you are hospitalized in a non-Plan facility and a Plan doctor believes that better care can be provided in a Plan hospital, you will be transferred when medically feasible with ambulance charges covered in full. If you have questions about acute illnesses other than emergencies, you should call your primary care physician.

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

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

If you are admitted to an in-Plan hospital or designated facility directly from the emergency room, we will waive the in-Plan copayment.

Emergencies outside our service area: Benefits are available for medically necessary health service that is immediately required because of injury or unforeseen illness.

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

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

Benefit Description	You pay
Emergency within our service area	
• Emergency or urgent care at a Plan doctor's office • Emergency or urgent care at a Plan urgent care center • Emergency Room, Plan or Plan designated emergency department • Emergency care at a non-plan facility, including doctors' services	$10 copay $10 copay $75 copay $125 deductible per member per visit
Not covered: Elective care or non-emergency care	*All charges except at Plan doctor's office or Plan urgent care center*
Emergency outside our service area	
• Emergency care or urgent at a doctor's office • Emergency care or urgent at an urgent care center • Emergency care at a hospital, including doctors' services	$125 deductible per member per visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	
Professional ambulance service which include both ground and air ambulance transportation when medically appropriate and approved by the Plan. See Section 5(c) for non-emergency service.	20% of charges
Not covered: Cabulance	*All charges.*

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

IMPORTANT

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:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are provided only when we determine they are clinically appropriate to treat your condition.
- Plan doctor 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
Mental health and substance abuse benefits	
We will cover all diagnostic and treatment services for the treatment of mental health and substance abuse conditions that are clinically necessary and recommended by the member's primary physician and approved by the Plan Medical Director or designee.	Cost sharing and limitations for benefits that we cover (for example, visit/day limits, copayments, and out-of-pocket maximums) for mental health and substance abuse are based on the cost sharing and limits for similar benefits under our Plan medical, hospital, prescription drug, diagnostic testing, and surgical benefits.
Examples of mental health inpatient and outpatient treatment can include: • Diagnosis evaluation • Diagnostic tests • Consultation services • Psychiatric treatment (individual, family and group therapy) by providers such as psychiatrists, psychologists, or clinical social workers • Hospitalization (including professional services) • Services in approved alternative care settings such as partial hospitalization • Medication management visits	For example: • The same $10 copayment that applies when you visit a specialist for a physical illness or disease applies to a visit to a mental health or substance abuse provider for a therapy session. • The same generic $10 or brand name $20 copayment for a prescription drug to treat a mental health or substance abuse condition as you would for a prescription to treat a physical illness or disease. • The same $100 inpatient copayment per day for 3 days; maximum of $300 per person per calendar year as you would for a physical illness or disease.
Examples of substance abuse inpatient and outpatient treatment can include: • Diagnosis, treatment and counseling for alcoholism and drug addiction • Diagnostic tests • Detoxification • Hospitalization (including inpatient professional services) • Medication management visits • Alcohol and drug education • Services in approved alternative care settings such as intensive outpatient treatment	A $25 copayment per day for partial hospitalization; no day limit A $10 copayment for each office visit Nothing for diagnostic tests

Mental health and substance abuse benefits - continued on next page

Mental health and substance abuse benefits *(Continued)*	**You Pay**
Not covered by the Plan: The same exclusions that apply to other benefits apply to these mental health and substance abuse benefits. *Examples of mental health inpatient and outpatient treatment that the Plan excludes are:* • *Psychiatric evaluation or therapy that is court ordered as a condition of parole or probation unless determined by a Plan provider to be necessary and appropriate* • *Psychological testing that is not medically necessary* • *Services that are custodial in nature* • *Assessment and treatment services that are primarily vocational and academic in nature (i.e., educational testing)* • *Services provided under a Federal, state, or local government program* • *Services rendered or billed by a school or a member of its staff* • *Continued services if you do not substantially follow your treatment plan* • *Treatment not authorized by a Plan provider, provided by the Plan, or specifically contracted for by the Plan* ***Note:*** *OPM will base its review of disputes about treatment plans on the treatment plans clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

Section 5 (f). Prescription drug benefits

IMPORTANT

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

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

IMPORTANT

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

- **Who can write your prescription.** A Plan physician or referral doctor must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy.
- **We use a formulary.** Prescriptions written by Plan physicians are dispensed in accordance with the Plan's drug formulary. A drug formulary is a list of preferred pharmaceutical products that our pharmacists and physicians, have developed to assure that you receive quality prescription drugs at a reasonable price. Non-formulary drugs will be covered only if based on medical necessity and if prescribed by a plan doctor. For information about specific formulary drugs, please call Customer Service at 1-888/901-4636.

  A generic equivalent to a brand name drug will be dispensed if it is available. If your physician believes that a name brand product is medically necessary, or if there is no generic equivalent available, your physician may prescribe a name brand drug. You pay a higher copay when a brand name drug is prescribed.
- **These are the dispensing limitations.** Prescription drugs prescribed by Plan doctors and filled at Plan pharmacies will be dispensed for up to a 30-day supply. You will be required to pay a copay for each 30-day supply. If your prescription is written for more than a 30-day supply, such as a 90 day supply, you are responsible for three copays, one for each 30-day supply.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which a manufacturer advertises and sells that drug. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. Generic drugs cost you and your plan less money than a name-brand drug.

Prescription drug benefits begin on the next page.

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: • Drugs (including injectibles) for which a prescription is required by Federal law • Insulin • Diabetic supplies, including needles, syringes, lancets, urine and blood glucose testing reagents; a copay charge applies per item per each 30-day supply • Oral, injectable, and implanted contraceptive drugs and devices • Compound dermatological preparations • Disposable needles and syringes for the administration of covered prescribed medications • Allergy serum Intravenous fluids and medication for home use are covered under (Section 5(a) – "Treatment Therapies"	A $10 copay for generic drugs and a $20 copay for brand name drugs, per prescription unit or refill for up to a 30-day supply or 100-unit supply, whichever is less; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin). Non-formulary drugs will be covered subject to the applicable copay when prescribed by a Plan doctor. A $200 copay for the contraceptive implant Norplant Nothing for Allergy serum
Limited benefits: • Drugs to aid in tobacco cessation. Participation in the Plan's Free and Clear Program is required in order to receive coverage for one course of nicotine replacement therapy per calendar year. • Sexual dysfunction drugs; dosage limits set by the Plan. Contact Customer Service at 1-888/901-4636 for details.	$10 copay for generic drugs or a $20 copay for brand name drugs per 30-day supply 50% copayment
Not covered: • *Drugs available without a prescription or for which there is a nonprescription equivalent available* • *Drugs obtained at a non-Plan pharmacy; except when due to an out of area emergency* • *Vitamins and nutritional substances, including dietary formulas and special diets, except for the treatment of phenylketonuria (PKU); total parenteral; and enteral nutrition therapy* • *Oral nutritional supplements* • *Medical supplies such as dressings, antiseptics, etc* • *Experimental drugs, devices and biological products* • *Drugs for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Replacement of lost or stolen drugs, medicines or devices.*	*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.
Consulting Nurse Service	For urgent care information and after hours care between 5:30 PM and 8:30 AM call toll-free 1-800/297-6877 for Western WA or 1-800/497-2210 for Eastern WA and Idaho.
Services for deaf and hearing impaired	Members who are hearing or speech-impaired may use the following number to access a Group Health Facility, staff member, or Group Health provider. Seattle Area 1-877/901-4678 Spokane Area 1-800/833-6388
Reciprocity benefit	Plan members who temporarily reside or are traveling outside the service area of this Plan may have access to care with Kaiser Permanente Plans. If you need services when out of the area, and are in the service area of a Kaiser Permanente Plan, you may obtain care from any Kaiser Permanente provider, medical office, or medical center. If you plan to travel and wish to obtain more information about the benefits available to you, please call our Customer Service Center at 1-888/901-4636
Travel benefit	If you are traveling, and are outside the Plans' service area by more than 100 miles, certain health services, i.e., follow-up care and continuing care, are covered. You pay a $25 copay per follow-up or continuing care visit, up to a maximum Plan copayment of $1,200 per person per calendar year. You must pay the provider at the time you receive the services. If the services are covered under this benefit, you will be reimbursed the reasonable charges for the care, up to a maximum of $1,200 per person per calendar year, and the $25 copay per visit will be deducted from the payment you receive from the Plan. Submit a claim to the Plan for the services on a HCFA Form 1500, with necessary supporting documentation, i.e., itemized bills and receipts, along with an explanation of the services, and the identification information from your ID card. Send the claims to Group Health Cooperative, Claims Administration, P.O. Box 34585, Seattle, WA 98124-1585.

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.
- We cover hospitalization for dental procedures only when a non-dental 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.
- The following is a summary of the Plan's dental benefits. Please call the Plan's member Services Department at 1-206/522-2300 or 1-800/554-1907 or you may visit our website at www.deltadentalwa.com for more information on additional exclusions and limitations.
- You are not required to receive your care from specified dental providers.
- Benefits are provided only for services included in the list of covered dental services and no charges will be paid in excess of the reasonable and customary charge. No dental benefit will be paid for any dental service or supply which is incomplete or temporary.

IMPORTANT

The Dental program will pay a percentage of the reasonable and customary charge for dental services listed below and will reimburse any dentist, dental hygienist (under the supervision of a dentist), or denturist, that you select. You pay an annual deductible of $50 per member and $150 per family per year up to $1,000 maximum benefit per member per year as well as any amounts over Plan payment. You are not required to receive your care from specified dental providers.

Important: Benefits are provided only for services included in the list of covered dental services and no charge will be paid in excess of the reasonable and customary charge. No dental benefit will be paid for any dental service or supply which is incomplete or temporary.

Dental Benefits	
Service	**You Pay**
Preventive Care • Prophylaxis (cleaning and polishing of teeth) not more than once in any five month period • Routine oral examinations, except for orthodontics • Fluoride treatment for children under age 16 • Dental X-rays, except for orthodontics • Bacteriologic cultures and biopsies of tissue • Emergency palliative treatment for relief of dental pain • Space maintainers, except for orthodontics	Nothing after the deductible

Dental Benefits *(continued)*	**You Pay**
Basic Dental Care • Endodontic treatment as follows: root canal therapy, pulpotomy, apicoectomy, and retrograde fillings • Simple extractions • Oral surgery • Basic periodontal services, limited to occlusal adjustment when performed with a covered root scaling • Study models • Crown build-up on non-vital teeth • Pin retention of fillings • Fillings (restorations) using amalgam, silicate, acrylic synthetic porcelain and composite fill materials to restore teeth broken down by decay or injury; on posterior teeth, an allowance will only be made for an amalgam filling • Recementing inlays, onlays, and crowns • Recementing bridges • Repairs to full and partial dentures and bridges • General anesthetics and analgesics • Injectable antibiotics	50% of reasonable and customary charges after the deductible
Major dental care • Major periodontal treatment of the gums and supporting structure of the teeth • Bridges and dentures • Crowns and gold restorations • Replacement of damaged appliances	70% of reasonable and customary charges after the deductible
Not covered: Other dental services not shown as covered.	*All charges*

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.

Vision Hardware (See Centers)

Federal employees and their dependents are eligible for a 10% vision hardware discount at Group Health Cooperative "See Centers." The discount applies to the cost of one or more pairs of prescription eyeglasses or one pair of contact lenses per year if these items are purchased through a See Center. Fitting and evaluation fees are not included in the discount.

Take Care Stores

"Take Care" stores sell self-care and wellness products such as back support cushions, blood pressure monitors, and allergy-control bedding. There are four Take Care Stores (located at Group Health Capitol Hill, Group Health Northgate Medical Center, Group Health Eastside Hospital, and Group Health Olympia Medical Center), or you can order directly online from the Take Care website (www.take-care.com).

Hear Centers

Our "Hear Centers" offer a full range of the latest hearing aid technology from the world's leading manufacturers, as well as custom noise plugs, swim molds, assistive listening devices, other accessories and batteries. There are four Hear Centers (located in Redmond, Seattle, Tacoma, and Olympia).

Smoking Cessation

Group Health continues to pave the way in smoking cessation benefits with our nationally recognized "Free & Clear" program. Any currently enrolled Group Health member may participate in the "Free & Clear" program. Participants pay extra for any pharmaceuticals used. To learn more, call Free & Clear at 1-800-462-5327.

Complementary Choices Network

Many alternative care services that are not part of your FEHB benefit are available to you as a Group Health member on a discounted, fee-for-service basis. You may choose any provider in our Complementary Choices network without a referral, and receive a 20% discount on the provider's fee. For more information, call Customer Service at 1-888-901-4636.

Weight Management Program

Group Health's Weight Management program offers a total lifestyle plan. It teaches positive behaviors that promote health, and helps improve overall well-being through weight management. For more information, call 206-527-6920 in Seattle or 1-888-874-7783 toll free.

My Group Health

My Group Health is an online health center available to all members. My Group Health provides access to valuable health risk assessment tools, doctor profiles and selection, medical center locations and programs, and 22,000 pages of reliable health care information. Visit My Group Health at www.ghc.org.

SilverSneakers (FOR WESTERN WASHINGTON MEMBERS ONLY)

As a member of the FEHB Medicare Managed Care Plan, your member ID card entitles you to participate in our popular SilverSneakers program. With over twenty health and fitness facilities to choose from throughout the Puget Sound area, you choose what you want to do: relax in a sauna, improve your posture and flexibility in a Silver Sneakers class, or tone your body with weight training, circuit training, or aerobics.

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under *What Services Require Our Prior Approval*** on page 11.

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;
- Procedures, 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;
- Procedures, services, drugs, or supplies related to sex transformations; or
- Procedures, 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 fill 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 1-888/901-4636.

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

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

Submit your claims to: Group Health Cooperative, Claims Administration, P.O. Box 34585, Seattle WA 98124-1585

Prescription drugs

Outpatient drugs and medicines obtained at non-Plan pharmacies are not covered; except when due to an out of area emergency.

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 us at: Group Health Cooperative, Appeals Department, P.O. Box 34593, Seattle WA 98124; 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 3, 1900 E. Street, NW, Washington, D.C. 20415-3630.

Send OPM the following information:

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

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

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

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

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

OPM's review of disputes about Group Health Cooperative's treatment plans will be based on the treatment plan's clinical appropriateness. OPM will generally not order the Plan to provide one clinically appropriate treatment plan rather than another.

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

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-888/901-4636 and we will expedite our review; or

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division 3 at 1-202/606-0755 between 8 a.m. and 5 p.m. eastern standard time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a family member are 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, after the primary plan pays, we will apply benefits as described in this brochure to any balances left owing.

• What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities, under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare 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 (Part A or Part B)

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

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

We will not waive any of our copayments, coinsurance, and deductibles.

(Primary payer chart begins on next page.)

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

Primary Payer Chart		
A. When either you — or your covered spouse — are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when…		
a) The position is excluded from FEHB, or	✓	
b) 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, and		
a) are an annuitant, or	✓	
b) an active employee, or		✓
c) a former spouse of an annuitant, or	✓	
d) a former spouse of an active employee		✓

Please note, if your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

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

- 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 1-888/901-4636.

• Medicare managed care plan

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

If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. When you elect to become part of our Medicare managed care plan, we will waive your outpatient copayment and your hospital emergency room copayment. We will also waive all coinsurances and deductibles. You are responsible for your outpatient drug copayment.

This Plan and another plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage 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 reenroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care plan's service area.

• If you do not enroll in Medicare Part A or Part B

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medcare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE

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

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care, up to the benefit limits of this plan. 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 our Customer Service at 1-888/901-4636 for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Coinsurance

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

Copayment

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

Covered services

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

Custodial care

Care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training, such as assistance in mobility, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by the Medicare managed care plan, or Medicare, unless provided in conjunction with skilled nursing care and/or skilled rehabilitation services.

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. See page 12.

Experimental or investigational services

The Plan makes its determination of experimental or investigational treatment, including medical and surgical services, drugs, devices and biological products upon review of evidence provided by evaluations of national medical associations, consensus panels, and/or other technological evaluations, including the scientific quality of such supporting evidence and rationale. The information it reviews comes from the U.S. Food and Drug Administration, and from scientific evidence in published medical literature, as well as in published peer-reviewed medical literature.

Group health coverage

Coverage offered by your employer

Medical necessity

Medical services or hospital services which are determined by the Plan Medical Director or designee to be:

a) Rendered for the treatment or diagnosis of an injury or illness; and

b) Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and

c) Not furnished primarily for the convenience of the Member, the attending physician, or other Provider of service.

Whether there is "sufficient scientific evidence" shall be determined by the Plan based on the following: peer-reviewed medical literature; publications, reports, evaluations, and regulations issued by state and federal government agencies; Medicare local carriers, and intermediaries; and such other authoritative medical sources as deemed necessary by the Plan.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: the charges are consistent with those normally charged by the provider or organization for the same services or supplies; and the charges are within the general range of charges made by other providers in the same geographical area for the same services or supplies.

Us/We

Us and we refer to Group Heath Cooperative of Puget Sound

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, 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, when your child under age 22 marries or turns 22.

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

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

Your medical and claims records are confidential

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

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

When you retire

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

When you lose benefits

• When FEHB coverage ends

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

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

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

• Spouse equity coverage

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

• Temporary continuation of coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

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

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

• Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI *79-27,* Temporary Continuation of Coverage TCC under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later In 2002!

- Many FEHB enrollees think their health plan and/or Medicare covers long-term care. Unfortunately, they are *WRONG!*
- How are YOU planning to pay for the future custodial or chronic care you may need? Consider buying long term care.

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

What is long term care (LTC) insurance?

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

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

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

Is long term care expensive?

- Yes. A year in a nursing home can exceed $50,000 and only three 8- hour shifts a week can exceed $20,000 a year, that's before inflation!
- LTC can easily exhaust your savings but LTC insurance can protect it.

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

- Not FEHB. Look under *"Not covered"* in sections 5(a) and 5(c) of your FEHB brochure. Custodial care, assisted living, or continuing home health care for activities of daily living are not covered. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care after a hospitalization with a 100 day limit.
- Medicaid covers LTC for those who meet their state's guidelines, but restricts covered services and where they can be received. LTC insurance can provide choices of care and preserve your independence.

When will I get more information?

- Employees will get more information from their agencies during the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

A toll-free telephone number will begin in mid-2002. You can learn more about the program now at www.opm.gov/insure/ltc.

Index

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

NOTES

Summary of Benefits for Group Health Cooperative of Puget Sound-2002

- **Do not rely on this chart alone**. All benefits are provided in full unless indicated and are subject to the definitions, limitations and exclusions in this brochure. On this page we summarized 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 providers, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care or specialist	14-21
Services provided by a hospital:		
• Inpatient	$100 per day for 3 days; maximum of $300 per person per calendar year	25
• Outpatient	$10 per visit	26
Emergency benefits:		
• In-area	$75 copay	28-29
• Out-of-area	$125 deductible	28-29
Mental health and substance abuse treatment	Regular cost sharing	30-31
Prescription drugs Up to a 30-day supply per prescription unit or refill	$10 copay for generic prescription / $20 copay for brand name prescription	32-33
Dental Care • See Dental Schedule for complete coverage	$50 deductible per member ($150 per family), variable copays for most care, and any charges beyond the Plan payment	35-36
Vision Care • Routine eye exam and refractions for eyeglasses	$10 copay per outpatient visit	18
Special features: Flexible benefits options; Consulting Nurse service; Services for deaf and hearing impaired; Reciprocity benefit; and Travel benefit		34
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $1,000/Self Only or $2,000/Self and Family enrollment per year Some costs do not count toward this protection	12

NOTES

2002 Rate Information for Group Health Cooperative of Puget Sound

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, 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 who are not career postal employees. 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
Western Washington							
High Option Self only	541	$96.71	$32.24	$209.54	$69.85	$114.44	$14.51
High Option Self and Family	542	$218.23	$72.74	$472.83	$157.61	$258.24	$32.73
Eastern and Central Washington and Northern Idaho							
High Option Self only	VR1	$89.45	$29.82	$193.82	$64.60	$105.85	$13.42
High Option Self and Family	VR2	$223.41	$83.21	$484.06	$180.28	$263.75	$42.87