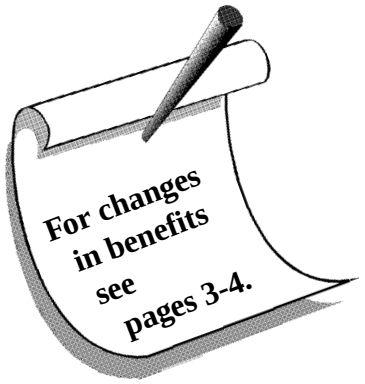
Group Health Cooperative of Puget Sound

2000

A Health Maintenance Organization



Serving: Most of Washington State and Northern Idaho
Enrollment in this Plan is limited; see page 5 for requirements.

Western Washington
Enrollment code:
541 Self only
542 Self and family

Eastern & Central Washington and Northern Idaho
Enrollment codes:
VR1 Self only
VR2 Self and family

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

Special Notice: This Plan has eliminated a portion of its Service Area for 2000. If you are enrolled in this Plan and live or work in one of the following areas, you must select another plan during Open Season to continue to receive full benefits: the **Washington** counties of Adams, Chelan, Clallam, Douglas, Ferry, Grant, Klickitat, Lincoln, Okanogan, Pend Oreille, and Stevens, and the **Idaho** counties of Benewah, Bonner, and Shoshone. If you live or work in one of these areas, and do not select another FEHB Plan, you must travel to a county in the Service Area, and be seen by a Plan provider, in order to receive full Plan benefits.

Visit the OPM website at http://www.opm.gov/insure
and
our Plan's website for Western Washington at http://www.ghc.org
and
our Plan's website for Eastern & Central Washington and Northern Idaho at http://www.ghnw.org

Authorized for distribution by the:

United States Office of Personnel Management
Retirement and Insurance Service

Federal Employees Health Benefits Program

RI 73-012

Table of Contents

Introduction

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

This brochure describes the benefits you can receive from Group Health Cooperative under its contract (CS 1043) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on pages 3-4. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to Group Health Cooperative or GHC as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not re-written the Benefits section of this brochure. You will find new benefits language next year.

How to use this brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. **Health Maintenance Organizations (HMO)**. This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.
2. **How we change for 2000.** If you are a current member and want to see how we have changed, read this section.
3. **How to get benefits.** Make sure you read this section; it tells you how to get services and how we operate.
4. **What to do if we deny your claim or request for service.** This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.
5. **Benefits.** Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.
6. **General exclusions – Things we don't cover.** Look here to see benefits that we will not provide.
7. **Limitations – Rules that affect your benefits.** This section describes limits that can affect your benefits.
8. **FEHB FACTS.** Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organizations

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventative care such as routine office visits, physical exams, well-baby care and immunizations, as well as treatment for illness and injury.

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay copayments and coinsurance listed in this brochure. When you receive emergency services you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How we change for 2000

Program-wide changes

- To keep your premium as low as possible OPM has set a minimum copay of $10 for all primary care office visits.
- This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.
- If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program (See Section 3., How to get benefits, for more information).
- You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.
- If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

- Your share of the non-postal premium for Enrollment Code 54 will increase by 12.5% for Self Only and by 11.5% for Self and Family, and for Enrollment Code VR it will increase by 3.7% for Self Only and by 4.8% for Self and Family.
- The Plan's copay for a Primary Care Physician office visit has increased from $5 to $10. This increase applies to visits for short-term rehabilitative therapy; diagnosis and treatment of infertility; chiropractic services; podiatric services; naturopathic services; acupuncture services; cardiac rehabilitation; and routine eye examinations and refractions (See pages 9, 10, and 11).
- The Plan now covers durable medical equipment, such as wheelchairs and hospital beds, subject to a member copay of 20% of charges. Previously, there was no coverage for durable medical equipment (See page 11).
- The Plan now covers prosthetic devices, such as artificial limbs, subject to a member copay of 20% of charges. Previously, there was no coverage for prosthetic devices, such as artificial limbs (See page 11).
- The Plan now provides coverage for orthopedic appliances, such as braces, subject to a member copay of 20% of charges. Previously orthopedic appliances were subject to a member copay of 50% of charges (See page 11).
- Oxygen and oxygen equipment for home use is now a part of the durable medical equipment benefit and as such, subject to a member copay of 20% of charges. Previously oxygen and oxygen equipment for home use was covered at 100% (See page 11).

Section 2. How we change for 2000 *continued...*

- Ostomy supplies necessary for the removal of bodily secretions or waste through an artificial opening is now part of the prosthetic device benefit and as such, subject to a member copay of 20% of charges. Previously ostomy supplies were covered at 100% (See page 11).
- External breast protheses, post-mastectomy bras, and their replacements are now a part of the prosthetic devices benefit and as such, subject to a member copay of 20% of charges. Previously external breast prostheses were limited to one every two years, and post-mastectomy bras were limited to two (2) every six (6) months, and were subject to a member copay of 50% of charges (See page 11).
- Nasal CPAP devices are now a part of the durable medical equipment benefit and as such, subject to a member copay of 20% of charges. Previously, nasal CPAP devices were subject to a member copay of 50% of charges (See page 11).
- The Plan now covers insulin pumps and diabetic monitoring equipment as a part of the durable medical equipment benefit and as such, subject to a member copay of 20% of charges. Previously, insulin pumps and diabetic monitoring equipment were covered under the Prescription Drug Benefit, and subject to the $7 copay (See page 15).
- The hospice care benefit can provide coverage for drugs, biologicals, medical appliances and supplies that are used primarily for the relief of pain and symptom management. Previously, these items were not listed in the hospice care benefit (See page 12).
- Chiropractic coverage excludes services not listed in the Plan's protocol including, but not limited to, supportive care provided primarily to maintain the level of correction already achieved; care given primarily for the convenience of the member; care given on a non-acute, asymptomatic basis; or charges for office visits other than the initial evaluation. Previously, the brochure did not list these chiropractic exclusions (See page 11).
- The out-of-pocket maximum or catastrophic limit for services provided or arranged by the Plan for a Self Only enrollment will increase from $750 to $1,000, and for a Self and Family enrollment the increase will be from $1,500 to $2,000 (See page 5).
- The member's 20% copay for covered inpatient mental health care now applies to the increase in the out-of-pocket maximum or catastrophic limit of $1,000 for a Self Only enrollment and $2,000 for a Self and Family enrollment. Previously, the member's 20% copay applied to the $750 out-of-pocket maximum or catastrophic limit for a Self Only enrollment and $1,500 for a Self and Family enrollment (See page 14).
- The Plan has eliminated a portion of its Service Area for 2000. If you are enrolled in this Plan and live or work in one of the following areas, you must select another plan during Open Season to continue to receive full benefits: the **Washington** counties of Adams, Chelan, Clallam, Douglas, Ferry, Grant, Klickitat, Lincoln, Okanogan, Pend Oreille, and Stevens, and the **Idaho** counties of Benewah, Bonner, and Shoshone. If you live or work in one of these areas, and do not select another FEHB Plan, you must travel to a county in the Service Area, and be seen by a Plan provider, in order to receive full Plan benefits (See front cover and page 5).

Section 3. How to get benefits

What is this Plan's service area?

To enroll with us, you must live or work in our service area. This is where our providers practice. Our service area is:

In Western Washington

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

In Central and Eastern Washington

Spokane county and those counties surrounding Spokane within a 70-mile radius of downtown Spokane: Benton, Columbia, Franklin, Kittitas, Walla Walla, Whitman and Yakima.

In Northern Idaho

The counties of Kootenai and Latah.

You may also enroll with us if you live or work in the following places:

In Washington

The counties of Grays Harbor and Jefferson.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency services as described on pages 12 and 13, or those services covered under Benefits Available Away From home described on page 17. 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 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 temporarily reside outside the service area of this Plan may have access to care with Plans that have Reciprocity Agreements with this Plan**.** The Plans are as follows: Kaiser Permanente Plans; the American Association of Health Plans (AAHP); and Alliance of Community Health Plans (ACHP). 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 888/901-4636.

How much do I pay for services?

You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services, except for emergency care.

After you pay $1,000 in copayments or coinsurance for one family member, or $2,000 for two or more family members, you do not have to make any further payments for certain services for the rest of the year. This is called a catastrophic limit. However, copayments or coinsurance for: Infertility treatment services; devices, equipment and supplies; dental care; the $100 non-Plan emergency care deductible; the 20% coinsurance for ambulance services; or the outpatient mental health care copayment do not count toward these limits and you must continue to make these payments.

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

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

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

Section 3. How to get benefits *continued...*

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

What do I do if my primary care physician leaves the Plan?

Call us. We will help you select a new one.

What do I do if I need to go into the hospital?

Talk to your Plan physician. If you need to be hospitalized, your primary care physician or specialist will make the necessary hospital arrangements and supervise your care.

What do I do if I'm in the hospital when I join this Plan?

First, call our customer service department at 888/901-4636. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching 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 became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

How do I get specialty care?

Your primary care physician will arrange your referral to a specialist.

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.

What do I do if I am seeing a specialist when I enroll?

Your primary care physician will decide what treatment you need. If they decide 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. For Whatcom and Skagit Division or Central and Eastern Washington and Northern Idaho members only; if the doctor who originally referred you to this specialist is now your Plan primary care doctor, you need only call to explain that you are now a Plan member and ask that you be referred for your next appointment.

What do I do if my 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.

Section 3. How to get benefits *continued...*

But, what if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

How do you authorize medical services?

Your physician must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice.

How do you decide if a service is experimental or investigational?

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.

Section 4. What to do if we deny your claim or request for service

If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing,
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Arrange for a health care provider to give you the service; or
4. Ask for more information

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious or life threatening condition and you haven't responded to my request for service?

Call us at 888/901-4636 and we will expedite our review.

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's Health Benefits Contracts Division 3 at 202/606-0755 between 8 a.m. and 5 p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Section 4. What to do if we deny your claim or request for service *continued...*

Are there other time limits? You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.
2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM? Your request must be complete, or OPM will return it to you. You must send the following information:

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

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

Who can make the request? Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

Where should I mail my disputed claim to OPM? Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, P.O. Box 436, Washington, D.C. 20044.

What if OPM upholds the Plan's denial? OPM's decision is final. There are no other administrative appeals. If OPM agrees with our 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 or supplies.

What laws apply if I file a lawsuit? 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 made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. Benefits

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; **you pay** a $10 office visit copay, but no additional copay for laboratory tests and X-rays. Within the service area, house calls will be provided if, in the judgment of the Plan doctor, such care is necessary and appropriate; you pay nothing for a doctor's house call and nothing for home visits by nurses and health aides.

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

- Preventive care, including periodic check-ups according to well care schedule and well-baby care (**copay is waived**)
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters (**copay is waived**)
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and post-natal care by a Plan doctor. Copays are waived for maternity care. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization (therapeutic and nontherapeutic procedures) and family planning counseling services
- Diagnosis and treatment of diseases of the eye
- Blood derivatives and the administration of blood
- Allergy testing and treatment, including testing and treatment materials
- The insertion of internal prosthetic devices, such as pacemakers, artifical joints, intraocular lenses, cochlear implants, and penile implants; excluded from coverage are the costs of a penile implanted device, and artificial or mechanical hearts
- Cornea, heart, heart/lung, kidney, liver, lung (single or double) and pancreas/kidney transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan, and are limited to procurement center fees, travel costs for a surgical team, excision fees, and matching tests. Transportation and living expenses are excluded.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy

Section 5. Benefits *continued...*

- Surgical treatment of morbid obesity
- Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you
- Routine nutritional counseling
- Total parenteral nutritional therapy and supplies necessary for its administration; **you pay** nothing
- Enteral nutritional therapy when necessary due to malabsorption, including equipment and supplies; **you pay** 20% of charges for enteral nutrition therapy and nothing for equipment and supplies. Over the counter formulas are excluded.
- Dietary formula for the treatment of Phenylketonuria (PKU)
- Routine circumcision
- Diabetic training and education

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. Treatment of temporomandibular joint (TMJ) pain dysfunction syndrome is covered; **you pay** 50% of charges. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in the treatment of TMJ pain dysfunction syndrome.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery. A patient and her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance. Following mastectomy, internal breast prostheses are covered; **you pay** nothing.

Short-term rehabilitative therapy (physical, occupational, speech and massage) is provided on an inpatient and outpatient basis to restore function following illness, injury or surgery. Coverage is limited to two months per condition per calendar year for combined inpatient services and 60 visits per condition per calendar year for combined outpatient services. **You pay** a $10 copay per outpatient session. Services are limited to those necessary to restore or improve functional abilities when impairment exists due to injury or illness, and those for which significant improvement can be expected within two months as a consequence of intervention by therapy services. Subject to the above limits, services for the restoration and improvement of function for neurodevelopmentally disabled children age six (6) and under are covered, including maintenance in cases where significant deterioration of the child's condition would result without such services.

Diagnosis and treatment of infertility is covered. For nonexperimental infertility services that are limited to general diagnostic services, **you pay** a $10 copay per outpatient visit. For specific diagnostic services, medical and surgical treatment, including the following types of artificial insemination; intravaginal insemination (IVI), intracervical insemination (ICI), and intrauterine insemination (IUI), **you pay** 50% of charges. Donor expenses for infertility treatment, including donor sperm are not covered. Fertility drugs are not covered. Other assisted reproductive technology (ART) procedures, such as in vitro fertilization and embryo transfer, are not covered.

Section 5. Benefits *continued...*

Chiropractic services (without a referral) for manipulative therapy of the spine and extremities are covered when provided by Plan providers. The medical necessity for manipulative therapy must meet Plan protocol. Excluded from coverage are services not listed in the Plan's protocol including, but not limited to, supportive care provided primarily to maintain the level of correction already achieved; care given primarily for the convenience of the member; care given on a non-acute, asymptomatic basis; or charges for office visits other than the initial evaluation. **You pay** a $10 copay per visit.

Podiatric services which meet Plan protocol and are authorized in advance by the member's primary care doctor; excluded is treatment of flat feet or other misalignments of the feet; removal of corns and calluses; and hygienic foot care, except in the presence of a non-related medical condition affecting the lower limbs. **You pay** a $10 copay per visit.

Naturopathic services which meet Plan protocol and are authorized in advance by the member's primary care doctor; excluded are botanical/herbal medicines, vitamins, and food supplements. **You pay** a $10 copay per visit.

Acupuncture services which meet Plan protocol and are authorized in advance by the member's primary care doctor; excluded are botanical and herbal medicines. **You pay** a $10 copay per visit.

Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, when provided at a Plan facility; **you pay** a $10 copay per visit.

Durable medical equipment, such as hospital beds, wheelchairs, walkers, crutches, canes, oxygen and oxygen equipment for home use, nasal CPAP device, glucose monitors, and external insulin pumps, as well as medically necessary replacement of supplies are covered, subject to the rental price (or purchase price, if the cost of purchase is less than the anticipated total rental charges as determined solely by the Plan); **you pay** 20% of charges. Replacement of devices, equipment and supplies due to loss, breakage or damage is excluded.

Prosthetic devices, such as artificial limbs; ostomy supplies necessary for the removal of bodily secretions or waste through an artificial opening; external breast prostheses following a mastectomy and post-mastectomy bras; as well as medically necessary replacement of devices are covered; **you pay** 20% of charges. Replacement of devices, equipment and supplies due to loss, breakage or damage is excluded.

Orthopedic appliances, such as braces are covered; occlusal splints (including fittings) are the only devices covered for treatment of temporomandibular joint (TMJ) dysfunction; therapeutic shoe inserts are covered only for severe diabetic foot disease; as well as medically necessary replacement of appliances are covered; **you pay** 20% of charges. Corrective shoes and over the counter custom shoe inserts and their fittings are excluded, as are replacement of devices, equipment and supplies due to loss, breakage or damage.

What is not covered

- Physicial examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of therapeutic or nontherapeutic sterility
- Surgery primarily for cosmetic purposes
- Homemaker services
- Hearing Aids
- Transplants not listed as covered
- Long-term rehabilitative therapy
- Foot orthotics
- The cost of blood
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperopia), and astigmatism (blurring)

Hospital/Extended Care Benefits

What is covered

Hospital care

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

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

Extended care

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

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

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or a hospice facility. Services could include inpatient and outpatient care, drugs, biologicals, medical appliances and supplies that are used primarily for the relief of pain and symptom management**,** and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance service

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

Limited benefits

Inpatient dental procedures

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

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 14 for nonmedical substance abuse benefits.

What is not covered

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

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Emergency Benefits

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 the Plan may determine are medical emergencies-what they all have in common is the need for quick action.

Emergency Benefits *continued...*

Emergencies within the service area

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

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 888/457-9516, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full. If you have questions about acute illness other than emergencies, you should call your primary care doctor.

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

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

Plan pays…

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

You pay…

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

Emergencies outside the service area

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

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

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

Plan pays…

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

You pay…

Same as within the service area

What is covered

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

What is not covered

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

Filing claims for non-Plan providers

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

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 7.

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered

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

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

Outpatient care

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

Inpatient care

Up to 30 days of hospitalization each calendar year; **you pay** 20% of charges for the first 30 days-all charges thereafter. The member's 20% copay applies to the out-of-pocket maximum of $1,000 per Self Only enrollment or $2,000 per Self and Family enrollment.

What is not covered

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

Substance abuse

What is covered

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

Outpatient care

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

Inpatient care

Covered under Mental conditions benefit.

What is not covered

- Treatment that is not authorized by a Plan doctor

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. **You pay** a $7 copay 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).

You pay a $7 copay per prescription unit or refill for generic drugs or for name brand drugs when generic substitution is not permissible. When generic substitution is permissible (i.e., a generic drug is available and the prescribing doctor does not require the use of a name brand drug), but you request the name brand drug, you pay the price difference between the generic and name brand drug as well as the $7 copay per prescription unit or refill.

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

Covered medications and accessories include:

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

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

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, subject to the $7 pharmacy copay.
- Sexual dysfunction drugs are subject to a 50% copay and dosage limits set by the Plan. Contact the Plan for details.

What is not covered

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

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Other Benefits

Dental care

IMPORTANT: The following is a summary of the Plan's dental benefits. Please call the Plan's Member Services Department at 206/448-4140 or 800/542-6312 for more information on additional exclusions and limitations.

What is covered

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

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

- Prophylaxis (cleaning 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

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

- 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

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

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

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Other Benefits *continued...*

What is not covered

- Other dental services not shown as covered

Vision care

What is covered

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

- Routine eye examinations and refractions, including eyeglass lens prescription, limited to once every 12 months, except when medically necessary. **You pay** a $10 copay per visit.
- When dispensed through Plan facilities, one contact lens per diseased eye, including exam and fitting, for members following cataract surgery performed by a Plan doctor, in lieu of an intraocular lens. Replacement of covered contact lenses will be provided only when needed due to change in the member's medical condition and will be replaced only one time within any 12 month period.

What is not covered

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

Benefits available away from home

If you are traveling, and are outside the Plan's 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, and 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, PO Box 34585, Seattle, WA 98124-1585.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Non-FEHB Benefits Available to Plan Members

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

Group Health Cooperative Resource Line

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

• **Seniors:** The Resource Line specializes in information for seniors, including listings on home care, transportation and other resources in your community. In addition, pamphlets are available on coping with stress and depression, routine foot care, medication tips, and sleeping better.

• **Health promotion:** The Group Health Resource Line has pamphlets to help you learn how to reduce fat in your diet, manage stress, and keep track of your medications. Call and ask for the Fats of Life packet, Managing Everyday Stress workbook, or the Medication Record wallet card.

Group Health Cooperative Health Promotion Programs

• **The Free and Clear Program:** Group Health's tobacco cessation program is offered as an individual phone-based program or as a group program with classes. Free & Clear is a medically proven program shown to double your chances of successful quitting. Participants receive a Free & Clear kit with program and support materials. Individual program participants receive five phone calls from a tobacco cessation specialist. Group participants attend eight classes taught by a qualified instructor. Call the Center for Health Promotion today for more information, to register for the Free & Clear program, or to request a program brochure, 206/287-2527 or 1-800/462-5327 outside the Seattle dialing area.

• **Advance Directive Program:** Public programs are available throughout the area to educate people about Living Wills, Durable Power of Attorney for Healthcare and other advance directives. Group Health and Senior Rights Assistance schedule volunteers who work individually with people to explain how to use these documents. For more information or to request a copy of advance directives, call the Group Health Resource Line.

• **Senior Caucus:** All Group Health enrollees who are seniors are invited to chapter meetings for interesting programs on health promotion topics such as: self-care, exercise, humor and chronic conditions. To receive a mailed announcement of the location, time and topic of the chapter nearest you, call the Group Health Resource Line.

Medicare+Choice prepaid plan enrollment - This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 19, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare+Choice prepaid plan when one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those **without** Medicare Part A may join this Medicare+Choice prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. **Before** you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare+Choice prepaid plan. Contact us at 206/901-4600 or toll free at 1-888/901-4600 for information on the Medicare+Choice prepaid plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 206/901-4600 or toll free at 1-888/901-4600 for information on the benefits available under the Medicare HMO.

Benefits on this page are not part of the FEHB contract

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 or condition.**

We do not cover the following:

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

Section 7. Limitations – Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800/638-6833. For information on the Medicare+Choice plan offered by this Plan, see page 18.

Other group insurance coverage

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Section 7. Limitations – Rules that affect your benefits *continued...*

Circumstances beyond our control

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. We will cover the cost of treatment that exceeds the amount you received in the settlement. If you do not seek damages, you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

TRICARE

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

Workers' compensation

We do not cover services that:

- You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide;
- 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 the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

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

Section 8. FEHB FACTS

You have a right to information about your HMO.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. 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 website (www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call 888/901-4636, or write to Group Health Cooperative at PO Box 34590, Seattle WA, 98124-1590. You may also contact us by fax at 206/901-4612, or visit our website at http://www.ghc.org or http://www.ghnw.org, or by e-mail at info@ghc.org.

Where do I get information about enrolling in the FEHB Program?

Your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans and other materials you need to make an informed decision about:

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

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.

Section 8. FEHB FACTS *continued...*

When are my benefits and premiums effective?

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

What happens when I 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, which is described later in this section.

What types of coverage are available for my family and me?

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 or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get 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 you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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.

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

Are my medical and claims records 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.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

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

When you lose benefits

What happens if my enrollment in this Plan 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 former spouse coverage or Temporary Continuation of Coverage.

Section 8. FEHB FACTS *continued...*

What is former spouse 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 more information about your coverage choices.

What is TCC?

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 TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct.

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

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an 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.

Section 8. FEHB FACTS *continued...*

If you leave Federal service, your employing office will notify you if individual coverage is available. 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.

How can I get a Certificate of Group Health Plan Coverage?

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

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

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 206/448-4140 or 800/542-6312 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Summary of Benefits for Group Health Cooperative - 2000

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.**

Benefits		Plan pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** nothing	**12**
	Extended care	All necessary services, for up to 30 days. **You pay** nothing	**12**
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. **You pay** 20% of charges	**14**
	Substance abuse	Covered under Mental conditions	**14**
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; laboratory tests and X-rays; complete maternity care. **You pay** a $10 copay per office visit; nothing per house call by a doctor; nothing for preventive care, including well-baby care, periodic check-ups and routine immunizations; and nothing for maternity care	**9**
	Home health care	All necessary visits by nurses and health aides. **You pay** nothing	**10**
	Mental conditions	All necessary outpatient visits per year. **You pay** nothing for visits 1-20; a $15.70 copay thereafter	**14**
	Substance abuse	All necessary visits. **You pay** nothing	**14**
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $100 deductible for each emergency visit to a non-Plan facility, a $50 copay at a Plan facility and any charges for services that are not covered by this Plan	**12-13**
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** a $7 copay per prescription unit or refill	**15**
Dental care		Preventive dental care; wide range of restorative and other services. Comprehensive range of services. **You pay** a $50 annual deductible per member ($150 per family), variable copays for most care, and any charges beyond the Plan payment	**16-17**
Vision care		Routine eye exam and refractions for eyeglasses. **You pay** a $10 copay per outpatient visit	**17**
Out-of-pocket maximum		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $1,000 per Self Only or $2,000 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include charges for: infertility treatment services; devices, equipment and supplies; dental care; the $100 non-Plan emergency care deductible; the 20% coinsurance for ambulance services; and the outpatient mental health care copayment	**5**

2000 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 most career U.S. Postal Service employees. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee but not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees," RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Western Washington									
Self Only	541	$78.83	$28.50	$170.80	$61.75	$93.06	$14.27	$93.26	$14.07
Self and Family	542	$175.97	$66.19	$381.27	$143.41	$207.74	$34.42	$201.02	$41.14
Eastern & Central Washington and Northern Idaho									
Self Only	VR1	$78.83	$30.33	$170.80	$65.71	$93.06	$16.10	$93.26	$15.90
Self and Family	VR2	$175.97	$105.23	$381.27	$228.00	$207.74	$73.46	$201.02	$80.18