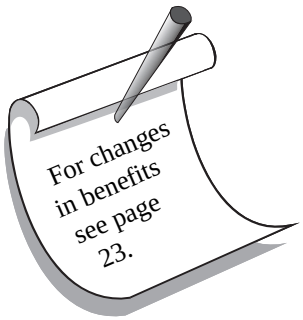
Group Health Northwest 1998

A Health Maintenance Organization



Serving: Most of Eastern and Central Washington and North Idaho counties.

You must live in the service area to enroll in this Plan.

Enrollment code:
VR1 Self Only
VR2 Self and Family

Service area: Services from Plan providers are available only in the following area:

In Washington:

Spokane county and those counties surrounding Spokane county within a 70 mile radius of downtown Spokane; Benton, Chelan, Columbia, Douglas, Franklin, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Stevens, Walla Walla, Whitman and Yakima and partially served counties listed on page 9.

In Idaho:

Benewah, Bonner, Kootenai, Latah and Shoshone counties

Visit the Plan's Web site at: http://www.ghnw.org

Authorized for distribution by the:

United States Office of Personnel Management

Federal Employees Health Benefits Program

RI 73 - 96

Group Health Northwest

Group Health Northwest, an affiliate of Group Health Cooperative of Puget Sound, 5615 West Sunset Highway, Spokane, Washington 99204, has entered into a contract (CS 1920) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called Group Health Northwest, Group Health, or the Plan.

This brochure is based on text included in the contract between OPM and this Plan and is intended to be a complete statement of benefits available to FEHB members. A person enrolled in the Plan is entitled to the benefits stated in this brochure. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1998, and are shown on page 23 of this brochure.

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Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital or pharmacy, charged your plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation - sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at 509/838-9100 or 1-800/497-2210 and explain the situation.
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, D.C. 20415

The inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

General Information

Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confidential and will be used only: 1) by the Plan and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education.

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. **As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor except in the case of emergency as described on page 15.** If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See “If you are hospitalized” on page 4.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB.

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about: when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The **benefits** in this brochure are effective on January 1 for those already enrolled in this Plan; if you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new **rates** are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers, except for emergency benefits.
- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Plan promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.
- Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

- You may also remain enrolled in this Plan when you join a Medicare prepaid plan.
- Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. See page 20 for information on the Medicare prepaid plan offered by this Plan.
- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she generally will be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date and coverage may not exceed the 18 or 36 month period noted above.

Notification and election requirements

Separating employees — Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

Children — You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.

Former spouses — You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices are available — or chosen — when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Facts about this Plan

This Plan is a comprehensive medical plan, sometimes called a health maintenance organization (HMO). When you enroll in an HMO, you are joining an organized system of health care that arranges in advance with specific doctors, hospitals and other providers to give care to members and pays them directly for their services. Benefits are available **only** from Plan providers except during a medical emergency. **Members are required to select a personal doctor from among participating Plan primary care doctors.** Services of a specialty care doctor can only be received by referral from the selected primary care doctor. There are no claim forms when Plan doctors are used.

Your decision to join an HMO should be based on your preference for the plan's benefits and delivery system, not because a particular provider is in the plan's network. You cannot change plans because a provider leaves the HMO.

Because the Plan provides or arranges your care and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan emphasizes preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness.

Who provides care to Plan members?

Group Health Northwest is a Mixed Model Prepayment (MMP) plan. Care is provided by primary care doctors practicing in group practices or individually; specialty care and hospitalization are provided locally.

In the Spokane area Group Health Northwest provides care at medical centers and at designated community physicians offices. There are approximately 35 staff family practice doctors with Group Health Northwest, 33 physicians at Rockwood Clinic and 29 local, community physicians to choose from for your primary care.

In the Coeur d'Alene, Kellogg, Post Falls and Sandpoint, Idaho area there are four Group Health Northwest Family Practice doctors and 22 local, community Family Practice doctors to choose from for your primary care.

In the Colville area Group Health Northwest members choose a primary care doctor from 12 local community primary care doctors.

In Adams, Benton, Columbia, Franklin, Klickitat, Yakima, Walla Walla and Kittitas Counties, Group Health Northwest members may choose a primary care doctor from a network of over 160 local, community primary care doctors.

In Whitman and Latah Counties, Group Health Northwest members choose a primary care doctor from 21 local, community primary care doctors.

In Chelan, Douglas, Grant, and Okanogan Counties, Group Health Northwest members choose a primary care doctor from over 100 local, community primary care doctors.

Role of a primary care doctor

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 you have been referred by your primary care doctor, with the following exceptions: preventive women's health care services and other selected women's health care services and pre-natal care are available, on a self-referral basis, to designated Plan providers. Pre-natal care may be provided by an M.D. or licensed midwife.

Choosing your doctor

The Plan's provider directory lists primary care doctors (family practitioners, pediatricians and internists), with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated twice a year and are available at the time of enrollment or upon request by calling the Membership Services Department at Spokane, 509/838-9100; Colville and Northeastern Washington 1-800/497-2210; Whitman and Latah Counties 1-800/497-2210; Kootenai and Bonner Counties 208/664-5174 or 1-800/497-2210; Benton, Franklin, Adams, Columbia and Walla Walla Counties 509/783-3484 or 1-800/458-5450; Kittitas, Klickitat and Yakima Counties 509/248-8315 or 1-800/274-2140; Chelan, Douglas, Grant and Okanogan Counties 509/884-7127 or 1-800/884-7127; and Benewah and Shoshone Counties 1-800/497-2210; you can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new

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

If you enroll, and if you choose to receive care in the Tri-Cities, Sandpoint, Post Falls, Colville, Cle Elum, Yakima, Walla Walla, Dayton, Drosser, Ellensburg, Kellogg, Goldendale, Othello, Wenatchee, Ephrata, Chelan, Moses Lake, Okanogan, Omak, Davenport, Odessa or Pullman and Moscow areas, you will be asked to complete a primary care doctor selection form and send it directly to the Plan, indicating the name of the primary care doctor(s) selected for you and each member of your family. All members choosing to receive care in Spokane County or Coeur d'Alene, will be asked to complete a provider selection form, indicating your choice of Medical Center or physician. You may call your Group Health Northwest Medical Center or call your Group Health Northwest Administrative office in Coeur d'Alene, Tri-Cities, Yakima or Wenatchee for assistance in selecting a primary care doctor in your area. Members in the Pullman-Moscow areas, call Group Health at 1-800/497-2210. You may change your center or doctor by notifying the Plan at any time. Physician changes can be made prior to the first of any month. The change will be effective the first day of the upcoming month.

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

Referrals for specialty care

Except in a medical emergency or when a primary care doctor has designated another doctor to see his or her patients, you must receive a written referral from your primary care doctor before seeing any other doctor or obtaining special services. Referral to a participating specialist is given at the primary care doctor's discretion; if non-Plan specialists or consultants are required, the primary care doctor will arrange appropriate referrals.

When you receive a written referral from your primary care doctor, you must return to the primary care doctor after the consultation unless your doctor authorizes additional visits. All follow-up care must be provided or authorized by the primary care doctor. Do not go to the specialist for a second visit unless your primary care doctor has arranged for, and the Plan has issued an authorization for, the referral in advance.

For new members

If you are already under the care of a specialist who is a Plan participant, you must still obtain a referral from a Plan primary care doctor for the care to be covered by the Plan. 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.

If you are selecting a new primary care doctor and want to continue with this specialist, you must schedule an appointment so that the primary care doctor can decide whether to treat the condition directly or refer you back to the specialist.

Hospital care

If you require hospitalization, your primary care doctor or authorized specialist will make the necessary arrangements and continue to supervise your care.

Out-of-pocket maximum

Copayments are required for a few benefits. However, copayments will not be required for the remainder of the calendar year after your out-of-pocket expenses for services provided or arranged by the Plan reach $2,600 per member per calendar year. This copayment maximum does not include charges for prescription drugs.

You should maintain accurate records of the copayments made, as it is your responsibility to determine when the copayment maximum is reached. You are assured a predictable maximum in out-of-pocket costs for covered health and medical needs. Copayments are due when service is rendered, except for emergency care.

Deductible carryover

If you changed to this Plan during **open season** from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible will be covered by your old plan if they are for care you got in January **before** the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Facts about this Plan *continued*

Submit claims promptly

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. The Plan will not pay benefits for claims submitted later than December 31 of the calendar year following the year in which the expense was incurred unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Other considerations

Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you will be able to accept treatment or procedures that may be recommended by Plan providers.

The Plan's service area

The service area for this Plan, where Plan providers and facilities are located, is described on the front cover of this brochure and on this page.

The service area for this Plan includes the following areas:

In Washington: Spokane county and those counties surrounding Spokane county within a 70-mile radius of downtown Spokane; Benton, Chelan, Columbia, Douglas, Franklin, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Stevens, Walla Walla, Whitman and Yakima. Zip codes for those partially served counties around Spokane are as follows: Adams – 99169, 99327, 99332, 99344; Ferry – 99107, 99138, 99146; and Pend Oreille – 99119, 99139, 99152-3, 99156, 99180.

In Idaho: Benewah, Bonner, Kootenai, Latah and Shoshone counties.

Reciprocal Agreements with Group Health Cooperative of Puget Sound and Kaiser Permanente: Plan members who temporarily reside outside the service area of this Plan but within the Puget Sound area of Washington or Vancouver or Portland areas may receive care at Group Health Cooperative of Puget Sound facilities and Kaiser Permanente. This applies also to students and enrolled dependents who, due to divorce or legal separation, do not reside with the enrollee, but live in the Puget Sound area or Vancouver, WA or Portland, Oregon areas. You will want to notify your "home" plan if this applies to you.

If you or a covered family member move outside the service area, you may enroll in another approved plan. It is not necessary to wait until you move or for the open season to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan.** This brochure is based on text included in the contract between OPM and this Plan and is intended to be a complete statement of benefits available to FEHB members. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control.

Circumstances beyond Plan control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Plan and complete all necessary documents and authorizations requested by the Plan.

General Limitations *continued*

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, benefits will be coordinated with Medicare according to Medicare's determination of which coverage is primary. Generally, you do not need to take any action after informing the Plan of your or your family member's eligibility for Medicare. Your Plan will provide you with further instructions if a Medicare claim needs to be filed.

Group health insurance and automobile insurance

This coordination of benefits (double coverage) provision applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Plan.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan.

One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of a prepaid plan, special limitations on your CHAMPUS coverage apply; your primary care provider must authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities, and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. If you need more information about subrogation, the Plan will provide you with its subrogation procedures.

General Exclusions

All benefits are subject to the limitations and exclusions in this brochure. **Although a specific service may be listed as a benefit, it will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose or treat your illness or condition.** The following are excluded:

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see Emergency Benefits);
- Expenses incurred while not covered by this Plan;
- Services furnished or billed by a provider or facility barred from the FEHB Program;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Procedures, treatments, drugs or devices that are experimental or investigational;
- Procedures, services, drugs and supplies related to sex transformations; and
- 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.

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 $5 office visit copay, except for preventive care, pre-natal and post-partum office visits, 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** a $5 copay 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 well-baby care and periodic check-ups; pre-natal and post-partum office visits by an M.D. or licensed midwife (**you pay** nothing)
- 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
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal 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. Inpatient stays will be extended if medically necessary. 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 and family planning services; **you pay** a $150 copay per female sterilization and a $50 copay per male sterilization
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints

- Cornea, heart, heart/lung, kidney, liver, lung (single and double) and pancreas 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. Treatment for breast cancer, multiple myeloma and epithelial ovarian cancer will be subject to approval by the Plan's Medical Director. Transplants are covered when approved by the Medical Director. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.
- 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
- 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
- Blood derivatives
- Ostomy supplies
- Oxygen and oxygen equipment for home use
- Nutritional counseling for diabetes (provided by Plan doctors)

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. 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 temporomandibular joint (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. Internal breast prostheses required incidental to surgery will be provided.

Short-term rehabilitative therapy (physical, speech, occupational and massage) is provided on an inpatient basis for 60 consecutive days per episode and on an outpatient basis for 30 visits per episode if significant improvement can be expected within two months; **you pay** nothing in the hospital; **you pay** $5 per outpatient session. Therapy for neuro-developmentally disabled children is covered for children under age 6, up to 30 visits per calendar year. **You pay** nothing in the hospital; a $5 copay per visit for outpatient therapy. Massage therapy is covered for up to a maximum of 6 visits, when referred by Plan providers; **you pay** a $5 copay per visit. Additional visits are subject to review by the Office of the Medical Director.

Chiropractic services are covered for up to 10 visits per member per calendar year upon referral for conditions for which improvement is anticipated in a short, generally predictable period of time. **You pay** a $5 copay per visit. Additional visits are subject to review of the Office of the Medical Director.

Orthopedic devices are covered for temporary use during short term treatment for up to six months when the devices assist in the restoration or improvement of physical functioning. **You pay** nothing. **You pay** 40% of charges for nontemporary devices necessary for physical functioning when approved by the Plan. Corrective shoes and arch supports are not covered.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Prosthetic devices are covered when necessary for physical functioning, such as artificial limbs; one approved external breast prosthesis per calendar year is covered. **You pay** nothing.

Diagnosis and treatment of infertility is covered; **you pay** a $5 copay per visit for routine evaluation and counseling. **You pay** 50% of charges for extended diagnosis and treatment of infertility. The following types of **artificial insemination** are covered: intrauterine insemination (IUI) and intracervical insemination (ICI). **You pay** 50% of charges. **Fertility drugs** are covered; **you pay** 50% of charges. Cost of donor sperm is not covered. **Other assisted reproductive technology (ART) procedures,** such as in vitro fertilization and embryo transfer, are not covered. Also, infertility treatment is not covered if member has undergone voluntary surgical sterilization.

Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided at a designated Plan facility for up to 2 months per episode; **you pay** nothing in the hospital; a $5 copay per visit for outpatient therapy.

Biofeedback therapy is covered for incontinence (urinary and fecal) for up to 10 visits per member per calendar year, upon referral by a Plan provider. **You pay** a $5 copay per visit.
Acupuncture therapy is covered for up to a maximum of 5 visits for initial referral when referred by Plan providers; **you pay** a $5 copay per visit. Additional visits are subject to review by the Office of the Medical Director. No coverage is provided when used for weight loss or smoking cessation.

Naturopathy therapy is covered for up to a maximum of 3 visits for initial referral when referred by Plan providers; **you pay** a $5 copay per visit. Additional visits are subject to review by the Office of the Medical Director.

What is not covered

- Physical 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 voluntary, surgically-induced sterility
- Plastic surgery primarily for cosmetic purposes
- Transplants not listed as covered
- Blood not replaced by the member
- Hearing aids
- Homemaker services
- Durable medical equipment, such as wheelchairs, except while in the hospital or during a rehabilitation period
- Long-term rehabilitative therapy; long-term inhalation therapy
- Foot orthotics

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
- Outpatient surgery in a Plan hospital or doctor's office

Extended care

The Plan provides a comprehensive range of benefits with no dollar or day 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 include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor; **you pay** nothing.

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons 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 16 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 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 and urgent conditions that the Plan may determine are medical emergencies — what they all have in common is the need for quick action.

Emergencies within the service area

If you are in an emergency situation, please call your Medical Center or your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours. 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 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If 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.

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...

50% of the actual charges up to a maximum of a $50 copay per hospital emergency room visit provided at Group Health Northwest designated hospitals for covered emergency services. At non-designated hospitals in the area, **you pay** 50% of the actual charges up to a $200 maximum copay. If the emergency results in admission to a hospital, the copay 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 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

Plan pays...

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

You pay...

50% of the actual charges up to a maximum of a $50 copay per hospital emergency room visit or urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the copay is waived.

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 service approved by the Plan

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
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area

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 21.

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute and chronic psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)
- Biofeedback therapy

Outpatient care

Up to 20 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year; **you pay** a $10 copay per group session or a $20 copay per individual session -— all charges thereafter.

Inpatient care

Up to 30 days of hospitalization each calendar year; **you pay** a $50 copay per admission for for the first 30 days — all charges thereafter.

What is not covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment
- 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
- Outpatient mental health care in excess of 20 visits per member per calendar year

Substance abuse

What is covered

This 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 visits to Plan mental health providers for follow-up care and counseling are covered, as well as inpatient services necessary for diagnosis and treatment. The following benefits are provided for drug treatment or alcoholism treatment **up to a $5,000 maximum benefit per member each 24 months, with a lifetime maximum of $10,000. This Plan's maximum is based on combined inpatient and outpatient benefits.**

Outpatient care

All necessary visits to Plan providers for treatment; **you pay** a $5 copay per individual or group visit up to Plan maximum benefit — all charges thereafter.

Inpatient care

Rehabilitation in a substance abuse rehabilitation (intermediate care) program in an alcohol or drug rehabilitation center approved by the Plan; **you pay** nothing for charges up to Plan maximum benefit — all charges thereafter. **You pay** nothing for detoxification.

What is not covered

- Treatment that is not authorized by a Plan doctor

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 $5 copay per prescription unit or refill for up to a 30-day supply; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin).

You pay a $5 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 $5 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 for which a prescription is required by Federal law
- Oral contraceptive drugs; contraceptive diaphragms
- Injectable contraceptive drugs, such as Depo Provera; **you pay** $12 per injection
- Intrauterine devices (IUDs); **you pay** a $50 copay. Medically necessary removal is covered subject to the $5 office visit copay.
- Norplant contraceptive device, for members who meet Plan medical requirements; **you pay** a $48 copay. After five (5) years the member will pay an office visit copayment for the removal procedure. Removal of Norplant prior to 5 years, for non-medical reasons, including pregnancy planning, the member must pay the current and customary charge for removal.
- Fertility drugs; **you pay** 50% of charges
- Insulin; a copay charge applies to each vial
- Diabetic supplies, including insulin syringes, needles, glucose and acetone test tablets and test tape, Benedict's solution or equivalent, and acetone test tablets
- Disposable needles and syringes needed to inject covered prescribed medication
- Vitamins when prescribed for pre-natal care
- Dietary formula for PKU (phenylketonuria)
- Smoking cessation drugs and medications, including nicotine patches, if Plan requirements are met

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

What is not covered

- Drugs available without a prescription or for which there is a non-prescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Medical supplies such as dressings and antiseptics
- Contraceptive devices (except diaphragms, IUDs, Depo Provera and Norplant)
- Nutritional substances that can be purchased without a prescription
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance

Other Benefits

Dental care

IMPORTANT: The following is a summary of the Plan's dental benefits. Please call the Plan's Marketing Department at 509/838-9100 or 1-800/497-2210 (Spokane & Moscow-Pullman areas) 509/783-3484 or 1-800/458-5450 (Tri Cities); 509/248-8315 or 1-800/274-2140 (Yakima); 509/884-7127 or 1-800/884-7127 (Wenatchee) 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 or dental hygienist (under the supervision of a dentist) or denturist that you select. The Plan has contracts with most dentists. These contracts make your program easy to use. YOU ARE NOT REQUIRED TO RECEIVE YOUR CARE FROM A MEMBER DENTIST. You may receive your care from any licensed provider. Call 1-800/497-2210 ext. 7186 for a Member Dentist Directory. The Plan pays up to $1,000 in benefits per member per calendar year for covered dental expenses. **You pay** an annual $50 deductible and all charges per year over the Plan maximum of $1,000 per member per year for covered dental expenses. 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 & customary charge; **you pay** nothing:

- Prophylaxis (cleaning, scaling, and polishing of teeth) not more often than once in any five month period.
- Routine oral examinations of the mouth and teeth, not more often than once in any five month period.
- Fluoride treatment for children under age 16, not more often than once in any five month period.
- Dental X-rays as follows:
    1. Full mouth X-rays or panoramic X-rays, not more often than once in any three year period.
    2. Bitewing X-rays, not more often than once in any five month period.
    3. Periapical X-rays.
    4. Occlusal X-rays, not more often than once in any two year period.
- Bacteriologic cultures and examination of oral tissue excised for biopsy.
- Emergency palliative treatment primarily for relief of dental pain, not cure.
- Space maintainers designed to preserve the space between teeth caused by the premature loss of a primary tooth. This does not include space maintainers used in orthodontics to create a space between teeth.

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

- Endodontic treatment as follows: Root canal therapy, pulpotomy, apicoectomy, and retrograde filling.
- Simple extraction.
- Oral surgery, including customary postoperative treatment furnished in connection with oral surgery, as follows:
    1. Surgical extraction of one or more teeth, including impacted teeth.
    2. Extraction of the tooth root.
    3. Alveolectomy, alveoplasty, and frenectomy.
    4. Excision of pericoronal gingiva, exostosis, or hyperplastic tissue, and excision of oral tissue for biopsy.
    5. Reimplantation of a natural tooth or transplantation of a natural tooth.
    6. Excision of a tumor or cyst and incision and drainage of an abscess or cyst.

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- Basic periodontal services, limited to:
  1. Periodontal prophylaxis, not more often than once in any two and one-half month period.
  2. Root scaling and root planing, not more often than once per quadrant of the mouth in any five month period.
  3. Occlusal adjustment when performed with a covered periodontal surgery.
- Study models, not more often than once in any three year period.
- Crown build-up on non-vital teeth.
- Pin retention of fillings.
- Fillings (restorations) using amalgam, silicate, acrylic, synthetic porcelain, and composite filling materials to restore teeth broken down by decay or injury.
- Recementing inlays, recementing onlays, and recementing crowns.
- Recementing bridges.
- Repairs to full and partial dentures and bridges, not more often than once in any two year period and for an amount not greater than 20% of the cost of replacement.
- General anesthetics and analgesics, including intravenous sedation, when administered in connection with a covered oral surgery.
- Antibiotic injections administered by the treating dentist.

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 diagnosis and treatment of diseases of the eye, annual eye refractions (to provide a written lens prescription for eyeglasses) may be obtained from Plan providers. **You pay** a $5 copay per visit.

- $35 allowance provided not more often than once every 24 months (from actual date of service), to use for prescription eyeglass lenses, frames, contact lenses, contact lens examination, related services, fittings, and follow-up visits

What is not covered

- Replacements for any lenses provided during a 24 month period
- Eye exercises
- Costs in excess of the $35 allowance for prescription eyeglass lenses, frames, contact lenses, contact lens examination, related services, fittings, and follow-up visits
- Refractive surgery

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.

Fitness program

All Group Health Northwest Members who live in the Spokane, North Idaho areas can join one of the five Sta-Fit Athletic Club facilities at a substantial discount. This offer is currently available for Members located in the Spokane and Coeur d'Alene areas only. Please call (509) 838-9100 or (208) 664-5174 and we will send a descriptive flyer, or simply visit the Sta-Fit facility nearest you for details.

All Group Health Northwest members who live in Colfax, Washington can join Peak Fitness at a discounted rate.

Health education

A variety of classes such as Smoking Cessation, Stress Management, Nutrition and Weight Management are offered for nominal fees to Group Health Members. Call your local Group Health office for a brochure.

Evening Consulting Nurse Service

All plan members can reach our evening consulting nurses after office hours by calling 509-324-6464 in Spokane, or toll free at 1-800-826-3620. The nurse can advise you how to get through a long night if you are ill, whether to wake your doctor with a call, or go directly to the emergency room.

Medicare prepaid plan enrollment

This Plan offers Medicare recipients who reside in Spokane County, Washington or Kootenai County, Idaho the opportunity to enroll in the Plan through Medicare. As indicated on page 4, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare 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 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 prepaid plan. Contact us at 509/459-9100 or 1-800/497-2210 for information on the Medicare 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 509/459-9100 or 1-800/497-2210.

Benefits on this page are not part of the FEHB contract

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Member Services Office in Spokane at 509/838-9100 or 1-800/497-2210 or 509/459-1084 (for the hearing impaired - TDD) or in Coeur d'Alene at 208/664-5174; Tri-Cities at 509/783-3484 or 1-800/458-5450; Yakima at 509/248-8315 or 1-800/274-2140; and Wenatchee at 509/884-7127 or 1-800/884-7127 for information, or you may write to the Plan at P.O. Box 204, Spokane, WA 99210-0204 or 3311 W. Clearwater, Suite 1010, Kennewick, WA 99336, or 2010 W. Lincoln Avenue, Yakima, WA 98902, or 200 Valley Mall Parkway #200, East Wenatchee, WA 98802.

Disputed claims review

Plan reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing and within six months of the date of the denial, to reconsider its denial before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided.

Within 30 days after receipt of your request for reconsideration, the Plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If the Plan asks a provider for information it will send you a copy of this request at the same time. The Plan has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Plan will base its decision on the information it has on hand.

OPM review

If the Plan affirms its denial, you have the right to request a review by OPM to determine whether the Plan's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (if the Plan failed to respond, provide instead (a) the date of your request to the Plan or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim, such as doctors' letters, operative reports, bills, medical records, and explanation of benefit (EOB) forms; and
- Your daytime phone number.

Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, P.O. Box 436, Washington, DC 20044.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement — If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Plan to determine if the Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan in support of OPM's decision on the disputed claim.

How Group Health Northwest Changes January 1998

Do not rely on this page; it is not an official statement of benefits.

Program-wide changes

- This year the Office of Personnel Management (OPM) instituted minimum benefit levels in all plans for normal delivery (48 hours of inpatient care), caesarean sections (96 hours of inpatient care) and mastectomies (48 hours of inpatient care). See pages 11 and 12 for this Plan's benefits.
- The mammogram screening schedule is shown on page 11.
- OPM also requires each prepaid plan to list the specific artificial insemination procedures that it covers. See page 13 for this Plan's benefits.

Changes to this Plan

- The prescription drug copay has increased from $4 to $5 per prescription unit or refill. See page 17.
- Short term rehabilitative therapy is now covered on an inpatient or outpatient basis for up to 60 visits per condition subject to no copay in the hospital and a $5 copay per outpatient session. See page 12.
- Ostomy supplies are covered. See page 12.
- Oxygen and oxygen equipment for home use is covered. See page 12.
- Nutritional counseling for diabetes that is provided by Plan doctors is covered. See page 12.
- Dietary formula for PKU (phenylketonuria) is covered subject to the $5 prescription drug copay per prescription unit or refill. See page 17.

Summary of Benefits for Group Health Northwest - 1998

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	14
	Extended care	All necessary services, no dollar or day limit. **You pay** nothing	14
	Mental conditions	Diagnosis and treatment of acute and chronic psychiatric conditions for up to 30 days of inpatient care per year. **You pay** a $50 copay per admission	16
	Substance abuse	Drug treatment and alcoholism covered up to $5,000 per member per 24 months; lifetime maximum of $10,000; **you pay** nothing up to Plan maximums	16
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** a $5 copay per office visit; copays are waived for maternity care and preventive care; $5 per house call by a doctor	11, 12, 13
	Home health care	All necessary visits by nurses and health aides. **You pay** nothing	11, 12
	Mental conditions	Up to 20 outpatient visits per year. **You pay** a $10 copay per group session or a $20 copay per individual session	16
	Substance abuse	Drug treatment and alcoholism covered up to $5,000 per member per 24 months; lifetime maximum of $10,000 (combined inpatient and outpatient benefits); **you pay** a $5 copay per covered individual or group outpatient session	16
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** a 50% copay of actual charges up to a maximum of a $50 copay at designated hospitals for each emergency room visit and any charges for services that are not covered by this Plan	15
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** a $5 copay per prescription unit or refill.	17
Dental care		**You pay** a $50 annual deductible. Preventive dental care; **you pay** nothing for reasonable and customary charges; basic restorative services; **you pay** 50% of the reasonable and customary charges. **You pay** all charges above the reasonable and customary charges.	18, 19
Vision care		One refraction annually. **You pay** a $5 copay per refraction. There is a $35 allowance for eyeglasses or contact lenses (including the fitting and examination for contact lenses) or frames once every 24 months (from the actual date of service)	19
Out-of-pocket maximum		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $2,600 per member per calendar year, covered benefits will be provided at 100%. This copay maximum does not include charges for: prescription drugs	8