Group Health Cooperative

www.ghc.org/fehb

Customer Service 1-888-901-4636

2015

A Health Maintenance Organization (high and standard option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details.

Serving: Most of Washington State and Northern Idaho

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 13 for requirements.

Enrollment codes for this Plan:

- **541 High Option Self Only**
- **542 High Option Self and Family**
- **544 Standard Option Self Only**
- **545 Standard Option Self and Family**

IMPORTANT

- Rates: Back Cover
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- Summary of benefits: Page 77

Group Health Standard Option Plan

Group Health High Option Plan

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-012

Important Notice from Group Health Cooperative About

Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the Group Health Cooperative's Plan prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and Group Health Cooperative will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1 % per month for each month you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may also have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY: 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048).

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Introduction

This brochure describes the benefits provided by Group Health Cooperative under our contract (CS 1043) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 1-888-901-4636 or through our website: www.ghc.org. The address for Group Health Cooperative's administrative office is:

Group Health Cooperative
320 Westlake North, Suite 100
Seattle, WA 98109-5233

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2015, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2015, and changes are summarized on page 15. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples,

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

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your health care providers, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 1-888-901-4636 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR GO TO: www.opm.gov/org

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.

- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines, and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.

- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.

- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Never Events

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen. These conditions and errors are called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use Group Health Cooperative preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value, your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - 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
  - What happens when your enrollment ends
  - When the next Open Season for enrollment begins

  We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

  Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

  If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

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

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren (including children of same sex domestic partners in certain states) are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your children.

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;

- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.
- As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or Plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2015 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2014 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

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

- **Upon divorce**

  If you are divorced from a Federal employee, or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's website, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides.

- **Temporary Continuation of Coverage (TCC)**

  If you leave Federal service, tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

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

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

  Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.healthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHBP coverage.

- **Finding replacement coverage**

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

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

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

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

  In lieu of offering a non-FEHB plan for conversion purposes, we will assist you, as we would assist you in obtaining a plan conversion policy, in obtaining health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace. For Assistance in finding coverage, please contact us at 1-888-901-4636 or visit our website at www.ghc.org.

- **Health Insurance Marketplace** If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of our most recent provider directory. We give you a choice of enrollment in a High Option or a Standard Option Plan.

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

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

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

General features of our High and Standard Options

On our High Option Plan, when you receive covered services, you will be responsible for a copayment or a coinsurance unless the service is covered in full. This Plan also covers dental care. See Section 5 for Plan specifics.

Our Standard Option Plan is an annual deductible plan. Most services are subject to the annual deductible, coinsurance, and copayments. There is no dental coverage on this Plan.

How we pay providers

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

Who provides my health care?

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

In some of the Group Health Cooperative Service areas, participating providers are practitioners who provide routine care within their private office settings in the community.

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

Your Rights

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

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

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

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

Western Washington (entire counties):

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

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

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

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

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

Central and Eastern Washington (entire counties):

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

Northern Idaho (entire counties):

- Kootenai
- Latah

If you receive care outside the service area described above, we will pay for covered services described under the "Travel Benefit" page 57 or for emergency services as described on page 47. We will not pay for any other health care services.

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

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

Section 2. Changes for 2015

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

Program Wide Changes

Changes to this Plan

- We now classify most drugs into one of five tier categories. Tier 4 covers preferred specialty drugs; you pay 25% coinsurance up to $200 per 30-day supply. Tier 5 coveres non-preferred specialty drugs; you pay 50% coinsurance up to $500 per 30-day supply.
- We now cover unlimited acupuncture treatments when used to treat substance use disorders.
- We now cover autologous pancreas islet cell transplants.
- We have added copayments to certain services when you have this Plan and a Group Health Medicare Advantage plan. See page 68.

Changes to High Option only:

- Your share of the non-Postal premium will decrease for Self Only or decrease for Self and Family. See page 80.
- Your share of the Postal premium will increase for Self Only or increase for Self and Family. See page 80.

Changes to Standard Option only:

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. See page 80.
- Your share of the Postal premium will increase for Self Only or increase for Self and Family. See page 80.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, please call our Customer Service at 1-888-901-4636 or write to us at Group Health Cooperative, Customer Service, P.O. Box 34590, Seattle WA 98124-1590. You may also request replacement cards through our website, www.ghc.org

Where you get covered care

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

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. You may call Customer Service at 1-888-901-4636. The list is also on our website.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directories. The list is also on our website.

What you must do to get covered care

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

- **Primary care**

Your primary care physician (such as family practitioner or pediatrician) will arrange for most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call Customer Service at 1-888-901-4636 or contact your chosen Plan facility. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care, but you may also self-refer to many specialists at Group Health Cooperative facilities. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. However, you may see a woman's health care specialist or a mental health provider without a referral. A woman may see a participating General or Family Practitioner, Physician's Assistant, Gynecologist, Certified Nurse Midwife, Doctor of Osteopathy, Obstetrician or Advanced Registered Nurse Practitioner who provide women's health care services directly, without a referral from her primary care provider, for medically appropriate maternity care, reproductive health services, preventive care and general examination, gynecological care, and medically appropriate follow-up visits for the above services. If the chosen provider diagnoses a condition that requires a referral to other specialists or hospitalization, you or your chosen provider must obtain preauthorization and care coordination in accordance with applicable Plan requirements.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- Your primary care physician will create your treatment plan. The physician may have to get an authorization or approval beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan;
  - reduce our Service Area and you enroll in another FEHB plan;

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact our Customer Service Department at 1-888-901-4636 or, if we drop out of the Program, contact your new plan.

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

- **Hospital care**

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

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Customer Service department immediately at 1-888-901-4636. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM 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.

You need prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other Services.*

- **Inpatient hospital admissions**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other Services**

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

- Specialty care
- Surgical treatment of morbid obesity
- Non-emergency ambulance
- Durable Medical Equipment

How to request Precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 1-888-901-4636 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possess an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) to end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow-up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-888-901-4636. You may also call OPM's Health Insurance 3 at (202) 606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 1-888-901-4636. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

Concurrent care claims

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the Precertification rules when using non-Plan facilities

We will not cover any care you receive from a non-Plan facility without following the Precertification rules.

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification on an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

  Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

  1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
  2. Ask you or your provider for more information.

     You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

     If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
  3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

  In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written request for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

  After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in section 8 of this brochure.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care:

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g. deductible, coinsurance and copayments) for the covered care you receive.
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: When you see your primary care physician, you pay a copayment of $25 per office visit if you are on the High Option Plan. On the Standard Option Plan you pay a copayment of $25 for primary care services and $35 for a specialist per office visit. Example: When you are admitted to the hospital, you pay $350 per person per hospitalization under the High Option Plan; under the Standard Option Plan you pay $500 per person per hospitalization after the annual deductible is met.
Deductible	A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. The calendar year deductible is $350 per person under the Standard Option. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $700 under the Standard Option. There is no calendar year deductible for the High Option Plan. Note: If you change plans during Open Season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.
Coinsurance	We have different coinsurance percentages for some benefits, and in those cases, we specify the percentage that you must pay. For example, there is a 50% coinsurance for certain types of infertility services. Durable medical equipment and ambulance services are other services that require you to pay a coinsurance.
Your catastrophic protection out-of-pocket maximum	**For High Option:** After your copayments, coinsurance and deductibles total $3,000 for self only or $6,000 per family enrollment in any calendar year for the High Option Plan, you do not have to pay any more for covered services. Be sure to keep accurate records of your copayments, coinsurance and deductibles since you are responsible for informing us when you reach the maximum. **For Standard Option:** After your copayments, coinsurance and deductibles total $5,000 for self only or $5,000 per family enrollment in any calendar year for the Standard Option Plan, you do not have to pay any more for covered services. Be sure to keep accurate records of your copayments, coinsurance and deductibles since you are responsible for informing us when you reach the maximum.
When Government facilities bill us	Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services or supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

High and Standard Option Benefits

See page 15 for how our benefits changed this year. Page 77 and page 78 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. High and Standard Option Benefits Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 1-888-901-4636 or on our website at www.ghc.org/fehb.

Each option offers unique features.

- **High Option**

The High Option Plan covers most outpatient services subject to a copayment. Select services are covered subject either to a copayment or to a coinsurance and some services are covered in full. This Plan also covers dental care. See Section 5 for Plan specifics.

- **Standard Option**

The Standard Option Plan is an annual deductible plan, with most services covered subject to the annual deductible and a copayment. See Section 5 for Plan specifics. Dental care is not covered on this Plan.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Under Standard Option –The calendar year deductible is $350 per person ($700 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when they do not apply.
- Under High Option –We have no calendar year deductible or Plan coinsurance. Most outpatient services are subject to a copayment.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.

Benefit Description	You pay After the calendar year deductible…	
Note: The Standard Option calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians • In provider's office	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
At home	Nothing	Nothing
Professional services of physicians • In an urgent care center • Office medical consultation • Second surgical opinion	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing	Nothing after deductible

Benefit Description	You pay After the calendar year deductible…	
Preventive care, adult	**High Option**	**Standard Option**
Routine physical according to the Plan's well adult schedule, which includes: Routine screenings, such as: • Total blood cholesterol - once every five years • Colorectal cancer screening, including - Fecal occult blood test - Sigmoidoscopy screening – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older Well woman care; including, but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence.	Nothing	Nothing (No deductible)
Routine mammogram - covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing	Nothing (No deductible)
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	Nothing	Nothing (No deductible)
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Preventive care, children	**High Option**	**Standard Option**
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction once every 12 months - Hearing exams through age 17 to determine the need for hearing correction • Childhood immunizations recommended by the American Academy of Pediatrics Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	Nothing	Nothing (No deductible)
Maternity care	**High Option**	**Standard Option**
Routine maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to have "prior approval" for your normal delivery; see below for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care, including circumcision, of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	Nothing for routine prenatal and postpartum care Non-routine care: $25 copayment per office visit	Nothing for routine prenatal and postpartum care Non-routine care: $25 copayment for primary care services or $35 copayment for specialty care services per office visit
Breastfeeding support, supplies and counseling for each birth	Nothing	Nothing

Benefit Description	You pay After the calendar year deductible…	
Family planning	**High Option**	**Standard Option**
Contraceptive counseling	Nothing	Nothing (No deductible)
A range of voluntary family planning services, limited to: • Voluntary sterilization - vasectomy (See Surgical procedures Section 5(b))	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
• Voluntary sterilization - tubal ligation (See Surgical procedures Section 5(b) • Intrauterine devices (IUDs) - insertion • Injectable contraceptive drugs • Diaphragms - fittings • Oral contraceptives • Implantable contraceptives	Nothing	Nothing (No deductible)
Not covered: Reversal of voluntary or involuntary surgical sterilization	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
• Nonexperimental infertility services limited to general diagnostic services.	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
• Specific diagnosis and treatment of infertility, such as artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI)	50% of all charges	50% of all charges (No deductible)
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization* - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Allergy care	**High Option**	**Standard Option**
• Testing and treatment	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
• Allergy injections • Allergy Serum	Nothing	Nothing
Not covered: any testing or treatment that does not meet Plan protocols	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 39. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
• Intravenous (IV)/Infusion Therapy - Home IV and antibiotic therapy	Nothing when administered at home	Nothing when administered at home
• Growth hormone therapy (GHT)	Covered under prescription drug benefit	Covered under prescription drug benefit
• Dietary formula for the treatment of Phenylketonuria (PKU)	Nothing	Nothing
• Enteral nutritional therapy when necessary due to malabsorption, including equipment and supplies	20% of charges for enteral nutritional therapy. Equipment and supplies are covered under Durable medical equipment (DME)	20% of charges for enteral nutritional therapy. Equipment and supplies are covered under Durable medical equipment (DME) (No deductible)
• Total parenteral nutritional therapy and supplies necessary for its administration	Nothing for formula. Equipment and supplies are covered under Durable medical equipment (DME)	Nothing for formula. Equipment and supplies are covered under Durable medical equipment (DME)
• Routine nutritional counseling	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
Not covered: over the counter formulas	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Physical and occupational therapies	**High Option**	**Standard Option**
The following therapies are covered for rehabilitative or habilitative care. Physical therapy, occupational therapy, massage therapy and speech therapy are subject to a combined limit of 60 visits per condition per calendar year. Speech therapy benefit is described in the next section. The following physical and occupational therapy benefits are covered: • Qualified physical therapists • Qualified occupational therapists • Qualified massage therapists • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction when provided at a Plan facility	$25 copayment per office visit See Section 5(c) for Hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit See Section 5(c) for Hospital charges
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
Speech therapy, physical therapy and occupation therapy are subject to a combined limit of 60 visits per condition per calendar year. The physical and occupational therapy benefits are described under "Physical and Occupational therapies." Speech therapy is covered: • Qualified speech therapists	$25 copayment per office visit See Section 5(c) for Hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit See Section 5(c) for Hospital charges
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
Hearing testing to determine hearing loss. Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children* • Implanted hearing-related devices, such as bone anchor hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *orthopedic and prosthetic devices*	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
Not covered: Hearing aids, testing and examinations for them	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• When dispensed through a Plan facility contact lenses are covered when medically necessary for eye pathology, including following cataract surgery. Replacement lenses for eye pathology, including following cataract surgery will be provided only when needed due to change in your medical condition and will be replaced only one time within any 12 month period. • Eye exam to determine the need for vision correction • Annual eye exams or refractions Note: See *Preventive care, children* for eye exams for children.	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
Not covered: • *Eyeglasses* • *Contacts lenses and related supplies including examinations and fittings for them, except as provided above* • *Eye exercises and orthoptics* • *Evaluations and surgical procedures to correct refractions which are not related to eye pathology including complications*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Ostomy supplies necessary for the removal of bodily secretions or waste through an artificial opening • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, auditory osseointegrated implants/bone anchored health assistance (BAHA), intraocular lenses, and surgically implanted breast implant following mastectomy Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See Section 5(b) for coverage of the surgery to insert the device. • Occlusal splints (including fittings) for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Therapeutic shoe inserts for severe diabetic foot disease • Braces, such as back, knee, and leg braces, but not dental braces	20% of all charges	20% of all charges (No deductible)
Not covered: • *orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *cost of artificial or mechanical hearts* • *cost of penile implanted device* • *orthopedic and prosthetic replacements provided except when medically necessary* • *replacement of devices, equipment and supplies due to loss, breakage or damage*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Durable medical equipment (DME)	**High Option**	**Standard Option**
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician. Under this benefit, we cover: • hospital beds • standard wheelchairs • crutches • walkers • speech generating devices • canes • oxygen and oxygen equipment for home use • nasal CPAP device • blood glucose monitors • external insulin pumps • medically necessary replacement of supplies	20% of our allowance	20% of our allowance (No deductible)
Not covered: • *Motorized wheelchairs except when approved by the medical director as medically necessary* • *Replacement of devices, equipment and supplies due to loss, breakage or damage*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), physical therapist, occupational therapist or speech therapist. Home health services require the skill of one of the listed providers based on the complexity of the service and the condition of the patient. • Services may include oxygen therapy, intravenous therapy or services provided by a Social Worker, licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide, when provided in connection with the skilled services described above	Nothing 20% for oxygen therapy	$25 copayment per visit 20% for oxygen therapy
Not covered: • *Nursing care requested by, or for the convenience of the patient or the patient's family* • *Home care primarily for personal assistance, custodial care or maintenance care that is not diagnostic, therapeutic, or rehabilitative*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Chiropractic	**High Option**	**Standard Option**
Manipulative therapy services— for manipulation of the spine and extremities when treatment is received from a Plan provider and meets Plan protocols up to a maximum of 20 visits per Member per calendar year	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
Not covered: • *Maintenance therapy* • *Care given on a non-acute asymptomatic basis* • *Services provided for the convenience of the member*	*All charges*	*All charges*
Alternative treatments	**High Option**	**Standard Option**
Acupuncture services – Self referral to a Plan provider for up to 8 visits per medical diagnosis per calendar year. Additional visits must meet Plan protocols and be authorized in advance by your Plan. • anesthesia • pain relief • substance abuse - unlimited	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
Naturopathic services – Self referral to a Plan provider for up to 3 visits per medical diagnosis per calendar year. Additional visits must meet Plan protocols and be authorized in advance by your Plan.	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
Not covered: • *Maintenance therapy* • *Vitamins* • *Food supplements* • *Care given on a non-acute asymptomatic basics* • *Services provided for the convenience of the member* • *Hypnotherapy* • *Biofeedback* • *Botanical and herbal medicines*	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
Coverage is provided for: • Tobacco cessation - Participation in an individual or group program, including educational materials and approved pharmacy products, provided you are actively participating in a Group Health Cooperative -designated tobacco cessation program.	Nothing	Nothing (No deductible)

Educational classes and programs - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Educational classes and programs (cont.)	**High Option**	**Standard Option**
• Diabetes self-management	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Under Standard Option –The calendar year deductible is $350 per person ($700 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when they do not apply.
- Under High Option –We have no calendar year deductible or Plan coinsurance. Most outpatient services are subject to a copayment.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.
- The services listed below are for charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

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

Benefit Description	You pay After the calendar year deductible…	
Note: The Standard Option calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) Surgical treatment of morbid obesity (bariatric surgery), subject to the following criteria: • You must be at least 20 years of age • Your BMI (Body Mass Index) must be 40 or greater (or between 35 and 39, with medical record documentation of one or more complicating medical conditions) • You must have failed all non-surgical methods of weight loss	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• You must enroll in the required prepaid weight management program • Your medical record must show the absence of medical contraindications for the procedure **Note:** You will need to meet the above qualifications before your Plan provider will refer you to our bariatric surgery program. This program may refer you to other Plan providers to determine if you meet the additional criteria necessary for bariatric surgery, including nutritional, psychological, medical and social readiness for surgery. Final approval for surgical treatment will be required from the Group Health clinical review physician. • Insertion of internal prosthetic devices. See Section 5(a) – "Orthopedic and prosthetic devices" for device coverage information. **Note:** Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns • Circumcision	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care* • *Cost of penile implanted device* • *Cost of an artificial or mechanical heart* • *Weight loss programs* • *Adjustable gastric banding, Laparoscopic or Open* • *Bilio-pancreatic bypass* • *Distal gastric bypass* • *Duodenal Switch* • *Mini-gastric bypass*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance; and - the condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedemas - compression garments to treat lymphedemas (see Durable Medical Equipment) - breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip or cleft palate • Removal of stones from salivary ducts • Excision of malignancies • Excision of non-dental cysts and incision of non-dental abscesses when done as independent procedures; and	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Oral and maxillofacial surgery (cont.)	**High Option**	**Standard Option**
• Other surgical procedures that do not involve the teeth or their supporting structures • TMJ related services (non-dental)	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges
Not covered: • *Oral implants including preparation for implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Surgical correction of malocclusion done solely to improve appearance*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney/Pancreas • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. • **Autologous tandem transplants** for - AL Amyloidosis	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit.	$25 copayment for primary care services or $35 copayment for specialty care services per office visit

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Muliple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplant for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed)	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Amyloidosis - Breast cancer - Epithelial ovarian cancer - Neuroblastoma - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges
Mini-transplants performed in a clinical trial setting (non myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Tandem transplants for covered transplants: Subject to medical necessity.	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols for: • National Transplant Program (NTP) • Autologous Transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Childhood rhabdomyosarcoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Aggressive non-Hodgkin's lymphomas (Mantel Cell lymphoma, adult T-cell leukemia/ lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. Group Health Cooperative contracts with transplant centers who deal directly with a National Organ Transplant Clearinghouse	$25 copayment per office visit Outpatient surgery is subject to a $75 copayment per procedure or visit. See Section 5(c) for hospital charges	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Outpatient surgery is subject to a $100 copayment per procedure or visit. See Section 5(c) for hospital charges.
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.		
Not covered:	*All charges*	*All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Skilled nursing facility	Nothing	$35 copayment per office visit or on an inpatient basis.
Professional services provided in – • Hospital outpatient department • Ambulatory surgical center • Provider's office	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Under Standard Option –The calendar year deductible is $350 per person ($700 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when they do not apply.
- Under High Option - We have no calendar year deductible or Plan coinsurance. Most outpatient services are subject to a copayment.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).

Benefit Description	You pay After the calendar year deductible...	
Note: The Standard Option calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as • Semiprivate room accommodations • Special care units such as intensive care or cardiac units • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$350 inpatient copayment per person per hospitalization	$500 inpatient copayment per person per hospitalization
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood and blood derivatives • Dressing, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services	$350 inpatient copayment per person per hospitalization	$500 inpatient copayment per person per hospitalization

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	According to the benefit of the specific item you take home, i.e., hospital bed, pharmacy items, etc.	According to the benefit of the specific item you take home, i.e., hospital bed, pharmacy items, etc.
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Non-covered facilities, such as nursing home, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care, except when medically necessary*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines administered at the facility • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood derivatives • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing See section 5(b) for professional services	Nothing See section 5(b) for professional services
Rehabilitative therapies	**High Option**	**Standard Option**
Physical therapy, occupational therapy, speech therapy- 2 months per condition per calendar year for the services of each of the following in a certified rehabilitation facility: • Qualified physical therapist • Qualified speech therapists; and • Qualified occupational therapists	$350 inpatient copayment per person per hospitalization	$500 inpatient copayment per person per hospitalization
Not covered: Long-term rehabilitative therapy	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
Skilled nursing facility (SNF) benefit: When full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and authorized by the Plan, you will receive up to 60 days per calendar year.	Nothing	Nothing
Not covered: • *Custodial care* • *Rest cures* • *Domiciliary or convalescent care* • *Personal comfort items such as telephone or television*	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**
Supportive and palliative care for a terminally ill member is covered in the home or a hospice facility. Services could include: • Inpatient and outpatient care • Drugs • Biologicals • Medical appliances and supplies that are used primarily for the relief of pain and symptom management • Family counseling These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately 6 months or less	Nothing	Nothing
Not covered: Independent nursing, homemaker services	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Ground and air ambulance transportation to a Plan facility, Plan designated facility, or non-Plan designated facility, when medically appropriate and ordered or authorized by a Plan doctor.	20% of charges	20% of charges (No deductible)

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Under Standard Option –The calendar year deductible is $350 per person ($700 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when they do not apply.
- Under High Option –We have no calendar year deductible or Plan coinsurance. Most outpatient services are subject to a copayment.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.

What is a medical emergency?

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

What to do in case of emergency:

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

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

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

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

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

Emergencies outside our 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 do so. If you are hospitalized in a non-Plan facility and a Plan doctor believes that better care can be provided in a Plan hospital, you will be transferred when medically feasible with ambulance charges covered in full.

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

Benefit Description	You pay After the calendar year deductible…	
Note: The Standard Option calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Emergency within our service area	**High Option**	**Standard Option**
• Emergency or urgent care at a Plan doctor's office • Emergency or urgent care at a Plan urgent care center	$25 copayment per office visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
• Emergency care at a Plan or Plan designated emergency department • Emergency care at a non-Plan facility, including doctors' services	$100 copayment per member per visit $100 copayment per member per visit	$150 copayment per member per visit $150 copayment per member per visit
Not covered: Elective care or non-emergency care	*All charges except at Plan doctor's office or Plan urgent care center*	*All charges except at Plan doctor's office or Plan urgent care center*
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency or urgent care at a doctor's office • Emergency or urgent care at an urgent care center	$25 copayment per member per visit	$25 copayment for primary care services or $35 copayment for specialty care services per office visit
• Emergency care at a hospital, including doctors' services	$100 copayment per member per visit	$150 copayment per member per visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Professional ambulance service which include both ground and air ambulance transportation, when medically appropriate and approved by the Plan. See Section 5(c) for non-emergency service.	20% of charges	20% of charges (No deductible)
Not covered: Cabulance	*All charges*	*All charges*

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Under Standard Option –The calendar year deductible is $350 per person ($700 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when they do not apply.
- Under High Option –We have no calendar year deductible or Plan coinsurance. Most outpatient services are subject to a copayment.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay After the calendar year deductible…	
Note: The Standard Option calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Professional Services	**High Option**	**Standard Option**
We cover all diagnostic and treatment services for the treatment of mental health and substance abuse conditions that are clinically necessary and recommended by the member's primary physician and approved by the Plan Medical Director or designee.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnostic and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Consultation services • Psychiatric treatment (individual, family and group therapy) by providers such as psychiatrists, psychologists, or clinical social workers • Diagnosis, treatment and counseling for alcoholism and drug addiction • Medication management visits • Alcohol and drug education • Diagnostic tests	$25 copayment per office visit Nothing for diagnostic tests See Section 5(f) for mental health prescription drug coverage.	$25 copayment for primary care services or $35 copayment for specialty care services per office visit Nothing for diagnostic tests See Section 5(f) for mental health prescription drug coverage.

Benefit Description	You pay After the calendar year deductible…	
Diagnostics	**High Option**	**Standard Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	Nothing	Nothing
Inpatient diagnostic tests provided and billed by a hospital or other covered facility.	$350 inpatient copayment per person per hospitalization.	$500 inpatient copayment per person per hospitalization.
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
• Hospitalization (including inpatient professional services) • Detoxification • Diagnostic tests • Diagnostic evaluation • Consultation services	$350 inpatient copayment per person per hospitalization	$500 inpatient copayment per person per hospitalization
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization	$25 copayment per office visit. $25 copayment per day for partial hospitalization; no day limit.	$25 copayment for primary care services or $35 copayment for specialty care services per office visit. $25 copayment per day for partial hospitalization; no day limit.
Not Covered	**High Option**	**Standard Option**
Not covered: *Mental health inpatient and outpatient treatment that the Plan excludes are:* • *Psychiatric evaluation or therapy that is court ordered as a condition of parole or probation unless determined by a Plan provider to be necessary and appropriate* • *Psychological testing that is not medically necessary* • *Services that are custodial in nature* • *Assessment and treatment services that are primarily vocational and academic in nature (i.e., educational testing)* • *Services provided under a Federal, state, or local government* • *Services rendered or billed by a school or a member of its staff* • *Continued services if you do not substantially follow your treatment plan*	*All charges*	*All charges*

Not Covered - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Not Covered (cont.)	**High Option**	**Standard Option**
• *Treatment not authorized by a Plan provider, provided by the Plan, or specifically contracted for by the Plan*	*All charges*	*All charges*

Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorization must be renewed periodically.
- Under Standard Option –We have no calendar year deductible under the prescription drug benefits.
- Under High Option –We have no calendar year deductible under the prescription drug benefits.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy**.**
- **We use a formulary.** Prescriptions written by Plan physicians are dispensed in accordance with the Plan's drug formulary. A drug formulary is a list of preferred pharmaceutical products that our pharmacists and physicians have developed to assure that you receive quality prescription drugs at a reasonable price. Non-formulary drugs will be covered only if based on medical necessity and if prescribed by a Plan doctor. For information about specific formulary drugs, please call Customer Service at 1-888-901-4636.
- A generic equivalent to a brand name drug will be dispensed if it is available. If your physician believes that a name brand product is medically necessary, or if there is no generic equivalent available, your physician may prescribe a name brand drug. You pay a higher copayment when a brand name drug is prescribed.
- **These are the dispensing limitations.** Prescription drugs prescribed by Plan doctors and filled at Plan pharmacies will be dispensed for up to a 30-day supply. You will be required to pay a copayment for each 30-day supply. If your prescription is written for more than a 30-day supply, such as a 90-day supply, you are responsible for three copayments, one for each 30-day supply. Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications should call our Customer Service at 1-888-901-4636.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells that drug. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Under Federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. Generic drugs cost you and your plan less money than a name-brand drug.

Benefit Description	You pay	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy: • Drugs (including injectable)s for which a prescription is required by Federal law • Insulin • Diabetic supplies, including needles, syringes, lancets, urine and blood glucose testing reagents; a copayment charge applies per item per each 30-day supply • Compound dermatological preparations • Disposable needles and syringes for the administration of covered prescribed medications • Allergy serum • Vitamin D for adults 65 and older Intravenous fluids and medication for home use are covered under (Section 5(a) for Treatment therapies)	$20 copayment for generic formulary drugs or $40 copayment for brand name formulary drugs (including insulin and diabetic supplies), 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). $60 copayment for non-formulary drugs when prescribed by a Plan doctor. 25% coinsurance up to $200 per 30-day supply for preferred specialty drugs when prescribed by a Plan doctor. 50% coinsurance up to $500 per 30-day supply for non-preferred specialty drugs when prescribed by a Plan doctor. Nothing for allergy serum.	$20 copayment for generic formulary drugs or $40 copayment for brand name formulary drugs (including insulin and diabetic supplies), 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). $60 copayment for non-formulary drugs when prescribed by a Plan doctor. 25% coinsurance up to $200 per 30-day supply for preferred specialty drugs when prescribed by a Plan doctor. 50% coinsurance up to $500 per 30-day supply for non-preferred specialty drugs when prescribed by a Plan doctor. Nothing for allergy serum.
Women's contraceptive drugs and devices, including over-the-counter emergency contraceptives, such as the morning after pill.	Nothing	Nothing
Mail Order Drug Program • Prescription medications mailed to your home by the Group Health mail order pharmacy. (Mail order issues up to a 90 day supply)	2 times the applicable prescription drug copayment for a supply of 90 days or less of each prescription or refill. Mail order not available for specialty drugs.	2 times the applicable prescription drug copayment for a supply of 90 days or less of each prescription or refill. Mail order not available for specialty drugs.
Limited benefits: • Drugs to aid in tobacco cessation when prescribed and dispensed as part of the GHC-designated tobacco cessation program.	Nothing	Nothing
• Sexual dysfunction drugs; dosage limits set by the Plan. Contact Customer Service at 1-888-901-4636 for details.	50% coinsurance	50% coinsurance
Not covered: • *Drugs available without a prescription or for which there is a nonprescription equivalent available* • *Drugs obtained at a non-Plan pharmacy except when due to an out-of-area emergency*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• *Vitamins and nutritional substances, including dietary formulas and special diets, except for the treatment of phenylketonuria (PKU); total parenteral; and enteral nutrition therapy* • *Oral nutritional supplements* • *Medical supplies such as dressings, antiseptics, etc.* • *Experimental drugs, devices and biological products* • *Drugs for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Replacement of lost or stolen drugs, medicines or devices* • *Weight loss medications* *Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See page 34)*	*All charges*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payment and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9, *Coordinating benefits with Medicare and other coverage*.
- You are not required to receive your care from specified dental providers, although your out-of-pocket costs will be less if you obtain services from providers in the PPO network.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with Medicare and other coverage*.
- The following is a summary of the Plan's dental benefits. Please call the Plan's member Services Department at 1-206-522-2300 or 1-800-554-1907 or you may visit our website at www.deltadentalwa.com for a listing of preferred providers or more information on additional exclusions and limitations.

The Dental program will pay a percentage of the reasonable and customary charge for dental services listed below and will reimburse any dentist, dental hygienist (under the supervision of a dentist), or denturist, that you select. You pay an annual deductible of $50 per member and $150 per family, per year up to $750 maximum benefit, per member per year as well as any amounts over Plan payment. You are not required to receive your care from specified dental providers, although your out-of-pocket costs will be less if you obtain services from providers in the PPO network.

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

Dental Benefits	You Pay	
Service	**High Option**	**Standard Option**
Preventive Care services include: • Prophylaxis (cleaning and polishing of teeth) not more than two (2) procedures in a calendar year • Routine oral examinations, except for orthodontics • Fluoride treatment • Fissure sealants once every two years • 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 • Prescription-strength anti-microbial mouth rinse or toothpaste for patients who have undergone periodontal surgery	Nothing after the deductible	Not covered

Service - continued on next page

Dental Benefits	You Pay	
Service (cont.)	**High Option**	**Standard Option**
• Anti-microbial mouth rinse for pregnant women without regard to prior receipt of periodontal procedures	Nothing after the deductible	Not covered
Restorative Care includes: • Basic periodontal services, limited to occlusal adjustment when performed with a covered root scaling • Major periodontal treatment of the gums and supporting structure of the teeth	PPO Network - 50% of reasonable and customary charges after the deductible Non PPO Network - 70% of reasonable and customary charges after the deductible	Not covered
Not covered: other dental services not shown as covered	*All charges*	*All charges*

Section 5(h). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Consulting Nurse Service	For urgent care information and after hours care 24 hours a day, 7 days a week, call toll-free 1-800-297-6877.
Services for deaf and hearing impaired	Members who are hearing or speech-impaired may use the following number to access a Group Health Facility, staff member, or Group Health provider. Washington: 711 or 1-800-833-6388 Idaho: 711 or 1-800-377-3529
Reciprocity benefit	Plan members who temporarily reside or are traveling outside the service area of this Plan may have access to care with Kaiser Permanente Plans. If you need services when out of the area, and are in the service area of a Kaiser Permanente Plan, you may obtain care from any Kaiser Permanente provider, medical office, or medical center. Applicable cost - shares will apply. If you plan to travel and wish to obtain more information about the benefits available to you, please call our Customer Service Center at 1-888-901-4636.
Travel benefit	If you are traveling, and are outside the Plan's service area by more than 100 miles, certain health services are covered. You pay the applicable copayment per visit for services. Services are covered up to a Plan maximum of $2,000 per person per calendar year. You must pay the provider at the time you receive the services. If the services are covered under this benefit, you will be reimbursed the reasonable charges for the care, up to a maximum of $2,000 per person per calendar year, and the copayment per visit will be deducted from the payment you receive from the Plan. Submit a claim to the Plan for the services on a CMS-1500 form, with necessary supporting documentation, i.e., itemized bills and receipts, along with an explanation of the services, and the identification information from your ID card. Send the claims to Group Health Cooperative, Claims Administration, P.O. Box 34585, Seattle, WA 98124-1585.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file a FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximum. These programs and materials are the responsibility of the Plan and all appeals must follow their guidelines. For additional information contact the Plan at 1-888-901-4636 or visit our website at www.ghc.org.

Additional Benefits

20% Vision Hardware Discount – Shop at convenient Group Health Eye Care locations.

- Get a 20% vision hardware discount on eyeglasses or prescription sunglasses.
- Get a 20% discount on contact lenses once a year.
- Fitting and evaluation fees are not discounted. Call Customer Service at 1-888-901-4636, or go online to www.gheyecare.org for more information.

Dental Benefits Website – Sign in to this site and get a customized page where you can access information like recent dental activity, easy-to-understand explanations about your coverage and more. Visit www.DeltaDentalWA.com for more information.

Additional Services

Group Health Audiology/Hear Center – Get a full range of the latest hearing aid technology from leading manufacturers, as well as other custom devices and accessories at Group Health Medical Centers locations in Everett, Bellevue, Seattle, Tacoma, and Olympia. Go to www1.ghc.org/html/public/services/audiology for more information.

24 Hour Consulting Nurse Service – When you want care advice or need to know if you should get immediate medical attention, Group Health's Consulting Nurse Service can help 24 hours a day. For assistance, call 1-800-297-6877.

Online Services

MyGroupHealth for Members – Online services at www.ghc.org are available to all members. Select doctors and read their profiles, see medical center locations and programs, and browse thousands of health care topics. Plus, you can refill pharmacy prescriptions, view or download your FEHB Brochure, and take the Health Profile to assess your health.

Getting care at a Group Health Medical Center – When you log on to www.ghc.org, you can exchange secure messages with your health care team, check your online medical record, get your lab and test results, and request an appointment.

Mobile App

Our convenient smartphone app - Now you can use your smartphone to access many of the features you enjoy online at MyGroup Health for Members. Plus, there is a symptom checking that guides you through a series of questions that can help you identify potential explanations for your symptoms. Find out all the things you can do at www1.ghc.org/html/public/mobile/index.

Wellness Programs

Health Profile – Uncover your risks and make positive changes with support from Group Health. Learn more once you're registered at www.ghc.org .

Wellness Visits – Schedule immunizations and screening tests based on age and gender. Search for adult wellness visits on www.ghc.org.

Health Coaching Program–A health coach can provide support and information to help you make positive changes for your health including changes in eating habits, physical activity, or managing stress and advice managing chronic health conditions. Call 1-888-375-2006.

Fitness Club and Nutrisystem Discounts – Find out more at www.globalfit.com/grouphealth.

Tobacco Cessation – Giving up smoking isn't easy, but Group Health offers a highly successful programs with a 48% quit rate. For more information, visit https://www1.ghc.org/html/public/services/tobacco.

SilverSneakers® Fitness Program – As a Group Health Medicare Advantage plan member you can participate in this popular program at no extra charge at health and fitness facilities throughout the state. Individuals must have both Part A and Part B to enroll. Find a facility at www.silversneakers.com.

Individual and Family Plans – Consider a range of individual and family plans for those who do not qualify for coverage under the FEHB program. Learn more at www.ghc.org/health_plans.

For more information about these and other benefits available to Group Health members, please call Group Health Customer Service at 1-888-901-4636 toll free or go online to our website at www.ghc.org/fehb

Section 6. General exclusions - Services, drugs and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3. *When you need Plan Approval for certain services.*

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants), or related extra care costs or research costs.
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Procedures, services, drugs, or supplies related to sex transformations.
- Procedures, services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Applied Behavior Analysis (ABA)

Section 7. Filing a claim for covered services

This section primarily deals with post-service claims (claims for services, drugs, or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs, or supplies requiring prior Plan approval), including urgent care claim procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or fill your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your applicable cost-shares.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Facilities will file on the UB-04 form. For claims questions and assistance, contact us at 1-888-901-4636 or at our website at www.ghc.org.

When you must file a claim – such as for services you received outside of the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Note: Canceled checks, cash register receipts or balance due statements are not acceptable substitutes for itemized bills.

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

Phone: 1-888-901-4636

Prescription drugs

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

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

Phone: 1-888-901-4636

Other supplies or services

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

Phone: 1-888-901-4636

Deadline for filing your claim

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

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirement not listed in Sections 3, 7, and 8 of this brochure please visit www.ghc.org/fehb

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing to P.O. Box 34593, Seattle, WA 98124-1593 or calling 1-866-458-5479.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Group Health Cooperative, Member Appeal Department, P.O. Box 34593, Seattle, WA 98124-1593, 1-866-458-5479; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

Step	Description
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 1-888-901-4636. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at 202-606-0737 between 8am and 5pm Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC website at http://www.NAIC.org.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care, up to the benefit limits of this Plan. You must use our providers.

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the program.

When other Government agencies are responsible for your care

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

When others are responsible for injuries

If you or your covered dependent suffers an injury or illness through the act or omission of another person, you must either (1) reimburse us for any benefits that we have paid, in an amount that will not exceed the amount that you recover, or (2) allow us to be subrogated to your (or your covered dependent's) rights (including the right to bring suit) up to the full amount of the benefits that we have paid. All recoveries that you or your covered dependent receives from a third party (whether by lawsuit, settlement or otherwise) must be used to reimburse us for benefits paid. Our share of the recovery will not be reduced because you or your dependent does not receive the full amount of damages claims, unless we agree in writing to a reduction.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact our Customer Service at 1-888-901-4636 for our subrogation procedures.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan may provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. This plan does not cover these costs when provided as part of the clinical trial, except when Group Health Cooperative's exception to clinical trial exclusion criteria are met.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

- **What is Medicare?**

Medicare is a health insurance program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer two Medicare Advantage plans for Federal Employees. Please review the information about Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY: 1-800-325-0778).

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 (TTY: 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee) you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-888-901-4636.

We do not waive any costs if the Original Medicare Plan is your primary payor.

You can find more information about how our plan coordinates benefits with Medicare at www.ghc.org/fehb.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048) or at www.medicare.gov.

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

This Plan and our Medicare Advantage plan: We offer a Medicare Advantage plan known as Group Health Federal Employees Health Benefits Medicare Advantage plan. If you are a Medicare eligible retiree and have Medicare Parts A and B, you can enroll in our Federal Employees Medicare Advantage plan with no increase to your FEHB or Group Health premium. The Federal Employees Medicare Advantage plan enhances your FEHB coverage by lowering cost shares for certain services and/or adding benefits. Your enrollment in our Federal Employee Medicare Advantage plan is in addition to your FEHB High Option or Standard Option enrollment. If you are considering enrolling in the Federal Employees Medicare Advantage plan, please call us at 1-800-446-8882 (TTY: 711), 8 a.m. to 8 p.m., Monday through Friday. Note: you must complete an election form to enroll in the Federal Employee Medicare Advantage plan.

If you are already a member of Group Health for Federal Members and would like to understand your additional benefits in more detail, please refer to your Federal Employee Medicare Advantage Evidence of Coverage.

Below is a summary of features of the Federal Employees Medicare Advantage plans:

High Option:

- Deductible: None
- Office visits: $0 copayment per primary or specialty care visit
- Emergency care: $50 copayment per visit
- Inpatient hospital: $0 copayment per admission
- Outpatient surgery: $0 copayment per visit

- Prescription drugs: $20 copayment generic, $40 copayment brand-name, $60 copayment non-formulary, 25% coinsurance to $200 preferred specialty, 50% coinsurance to $500 non-preferred specialty (up to 30-day supply)

Standard Option:

- Deductible: None
- Office visits: $10 copayment per primary or specialty care visit
- Emergency care: $50 copayment per visit
- Inpatient hospital: $100 copayment per admission
- Outpatient surgery: $50 copayment per visit
- Prescription drugs: $20 copayment generic, $40 copayment brand-name, $60 copayment non-formulary, 25% coinsurance to $200 preferred specialty, 50% coinsurance to $500 non-preferred specialty (up to 30-day supply)

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

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB Plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Clinical Trials Cost Categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application. If you are a participant in a clinical trial this health Plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

Coinsurance is the percentage of our allowance (see definition below) that you must pay for your care. You may also be responsible for additional amounts. See page 21. We also have different coinsurance percentages for some benefits, and in those cases, we specify the percentage that you must pay. For example, there is a 50% coinsurance for certain types of infertility services, and the Plan coinsurance does not apply. Durable medical equipment and ambulance services are others services that require you to pay a coinsurance, and the Plan coinsurance does not apply.

Copayment

A copayment is a fixed amount of money you pay when you receive certain services. See page 21.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g. deductible, coinsurance and copayments) for the covered care you receive.

Covered services

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

Custodial care

Care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training, such as assistance in mobility, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by the Medicare managed care plan, or Medicare, unless provided in conjunction with skilled nursing care and/or skilled rehabilitation services. Custodial care that lasts 90 days or longer is sometimes known as long term care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 21.

Experimental or investigational service

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

Group health coverage

Coverage offered by your employer.

Health care professional A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

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

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

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

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

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

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

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Urgent care claims A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life of health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-serve claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department, 1-888-901-4636. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We Us and we refer to Group Health Cooperative.

You You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program** (FLTCIP) can help cover long term care costs, which are not covered under the FEHB program.

The Federal Flexible Spending Account Program - FSAFEDS

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – FEDVIP

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment**.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia. Review your plan's FEDVIP dental brochure for information on this benefit.**

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses and frames or for contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337, (TTY: 1-877-889-5680).

The Federal Long Term Care Insurance Program - FLTCIP

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337), (TTY: 1-800-843-3557), or visit www.ltcfeds.com.

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

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Summary of benefits for the High Option of Group Health Cooperative - 2015

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	$25 copayment per office visit for primary care or specialist	25
• Diagnostic tests, lab and X-ray services	Nothing	25
Services provided by a hospital:		
• **Inpatient**	$350 per person per hospitalization	44
• **Outpatient**	Nothing/See Section 5(b) for other related cost	45
Emergency benefits:		
• **In-area**	$100 copayment per visit	48
• **Out-of-area**	$100 copayment per visit	48
Mental health and substance abuse treatment:	Regular cost-sharing	49
Prescription drugs:		53
• Pharmacy, for a 30-day supply per prescription unit or refill	$20 copayment for generic prescription $40 copayment for brand name prescription $60 copayment for non-formulary prescription 25% coinsurance up to $200 per 30-day supply for preferred specialty drugs 50% coinsurance up to $500 per 30-day supply for non-preferred specialty drugs	
• Mail order, for a 90-day supply or less per prescription unit or refill	2 times the applicable prescription drug copayment Mail order not available for specialty drugs	
Dental care: See dental schedule for complete coverage	Nothing after deductible.	55
Vision care: Routine eye exam and refractions for eyeglasses	$25 copayment per office visit.	31
Special features:	Flexible benefits option; consulting nurse service; services for deaf and hearing impaired; reciprocity benefit; and travel benefit	57
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $3,000/Self Only or $6,000/Self and Family enrollment per year. Some costs do not count toward this protection	21

Summary of benefits for the Standard Option of Group Health Cooperative - 2015

- Do not rely on this chart alone. All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the $350/individual, $700/family calendar year deductible.

Standard Option Benefits	You Pay	Page
***Medical services provided by physicians:**		
• Diagnostic and treatment services provided in the office	$25 copayment for primary care services or $35 copayment for specialty care services per office visit	25
• Diagnostic tests, lab and X-ray services	Nothing after the deductible is satisfied.	25
***Services provided by a hospital:**		
• Inpatient	$500 per person per hospitalization	44
• Outpatient	Nothing/See Section 5(b) for other related cost.	45
***Emergency benefits:**		
• In-area	$150 copayment per visit	48
• Out-of-area	$150 copayment per visit	48
***Mental health and substance abuse treatment:**	Regular cost-sharing	49
Prescription drugs:	(No deductible, no Plan coinsurance for pharmacy)	53
• Pharmacy, for a 30-day supply per prescription unit or refill	$20 copayment for generic prescriptions $40 copayment for brand name prescriptions $60 copayment for non-formulary prescription 25% coinsurance up to $200 per 30-day supply for preferred specialty drugs 50% coinsurance up to $500 per 30-day supply for non-preferred specialty drugs	
• Mail order, for a 90-day supply or less per prescription unit or refill	2 times the applicable prescription drug copayment Mail order not available for specialty drugs	
Dental care:	Not covered	55
***Vision care:** Routine eye exam and refractions for eyeglasses	$25 copayment for primary care services or $35 copayment for specialty care services per office visit	31
Special features:	Flexible benefits option; consulting nurse service; services for deaf and hearing impaired; reciprocity benefit; and travel benefit	57
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,000/Self Only or $5,000/Self and Family enrollment per year. Some costs do not count toward this protection.	21

Notes

2015 Rate Information for Group Health Cooperative

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to Postal Service employees. They are shown in special Guides published for APWU (including Material Distribution Center and Operating Services) NALC, NPMHU and NRLCA Career Postal employees (see RI 70-2A); Information Technology/Accounting Services employees (see RI 70-2IT); Nurses (see RI 70-2N); Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees and Postal Career Executive Service employees (see RI 70-2IN); and non-career employees (see RI 70-8PS).

Postal Category 1 apply to career employees who are members of the APWU, NALC, NPMHU, or NRLCA bargaining units.

Postal Category 2 rates apply to career non-bargaining unit, non-executive, non-law enforcement and non-law enforcement Inspection Service and Forensics employees.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center

1-877-477-3273, option 5

TTY: 1-866-260-7507

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable *Guide to Federal Benefits*.

Premiums for Tribal employees are shown under the monthly non-postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	541	202.01	122.41	437.69	265.22	108.38	122.41
High Option Self and Family	542	448.57	248.93	971.90	539.35	217.78	248.93
Standard Option Self Only	544	167.03	55.67	361.89	120.63	43.98	55.67
Standard Option Self and Family	545	377.07	125.69	816.98	272.33	99.30	125.69