

★ Member Handbook





Welcome to the US Family Health Plan at Pacific Medical Centers, a program for retirees, retiree and survivor family members, and active-duty family members. This member handbook has been prepared by Pacific Medical Centers to describe plan benefits and how to receive services at Pacific Medical Centers (PMC).

Please read your handbook carefully!

This handbook contains a summary of eligibility requirements, medical coverage, co-payments, definitions of terms, exclusions, and other provisions of the US Family Health Plan as they apply to those who enroll in the US Family Health Plan at Pacific Medical Centers.



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HOW THE PLAN WORKS

The US Family Health Plan (USFHP) is a managed care plan, designed to provide comprehensive medical benefits to enrolled individuals at a low out-of-pocket cost. A managed care plan is an organized system of healthcare delivery that relies on a primary care provider (PCP- a pediatrician, family practitioner or internist) to arrange all of your healthcare needs with specific providers and hospitals. Payment for these services is handled by the Plan. Covered benefits are available only from Plan providers except during a medical emergency. There are no claim forms when plan-approved providers are used, and you are responsible only for the co-payment.

Because the Plan provides or arranges for your care and pays the cost of all authorized services, every effort will be made to provide efficient and effective delivery of healthcare services. By avoiding unnecessary or inappropriate care, the government can afford to offer a more comprehensive range of benefits, such as mammograms and immunizations. In addition to providing comprehensive healthcare services and benefits for accidents, illness, and injury, the Plan emphasizes preventive services.

GETTING STARTED

Each person covered by the Plan receives a US Family Health Plan membership identification card. Present this card any time you receive medical services. It's a good idea to carry your card (and those of your children) with you, in case of an emergency.

Please take a moment to look at your card and verify that the information is correct. If it is incorrect, call Member Services at 206-621-4090 or 1-800-585-5883. If your card is lost or damaged, please contact Member Services and request a replacement.

It's important to identify yourself as a US Family Health Plan member before receiving care from any provider or facility. Present your US Family Health Plan card at the beginning of all appointments, when registering at a facility or emergency room, and before beginning any relationship with a healthcare provider or facility. If you are currently receiving medical services outside the US Family Health Plan system, you will need to transfer your care to Plan-approved providers in order to receive coverage. Your primary care provider and staff will assist you in transferring your care and records to the Plan. Remember that in order to be covered, all outside services must be coordinated by your primary care provider (PCP).

ELIGIBILITY

To enroll in the plan, you must be an eligible beneficiary of the Military Health System (MHS) living in the zip-code-defined area served by the US Family Health Plan at Pacific Medical Centers. This includes most of the Puget Sound area. **You must also be registered in the Defense Enrollment Eligibility Reporting System (DEERS)** as eligible to receive healthcare benefits and have a valid military I.D. In order to maintain your coverage, keep your DEERS record up-to-date. If you have any questions about your DEERS eligibility, call 1-800-538-9552.

Eligible beneficiaries include:

1. Husbands, wives, and unmarried dependent children (until their 21st birthday, or their 23rd birthday if full-time students) of active-duty sponsors.
2. Retirees, their spouses or survivors, and unmarried dependent children.
3. Eligible former spouses of active-duty or retired service members.
4. Spouses who have not remarried and qualified unmarried children of active-duty or retired service members who have died.
5. National Oceanic Service (NOS) members who retired prior to July 19, 1963, or have had continuous service since prior to that date.
6. Family members of NOS members listed above.
7. Retired lighthouse keepers and their family members.
8. Medal of Honor recipients.
9. Qualifying reactivated reservist family members.

Retired reservists become eligible for enrollment on their sixtieth (60th) birthday.

If you are an inpatient on the date your coverage is scheduled to begin, your coverage will not be effective until the date you are discharged from the hospital or other inpatient treatment facility. If you are an inpatient on the date your coverage is scheduled to end, coverage will continue until the date of your discharge. Coverage will be for facility charges only.

While dependent family members of active-duty sponsors are eligible to enroll in the US Family Health Plan, the active-duty members of the uniformed services are not. Active-duty sponsors are automatically enrolled in TRICARE Prime, or TRICARE Prime Remote, if appropriate, at the Military Treatment Facility (MTF).

Family members must keep their military identification cards (and DEERS eligibility) up-to-date in order to be eligible to continue to receive US Family Health Plan benefits.

Changes Affecting Eligibility

New family members of already enrolled families (e.g. adopted or newborn children, new spouses) may join the Plan at any time during the enrollment year.

Additions to Your Family

If your family has a birth or legal adoption, a new application form must be completed and submitted within 30 days of the addition of the new family member to obtain coverage. New enrollment applications are available from Enrollment Management at 206-621-4568.

Newborns are automatically covered under the plan, but must be reported to the Enrollment Department within 30 days of birth and must be enrolled on DEERS within 60 days of birth, or coverage will cease.

Change of Address

Please send your new address to:
US Family Health Plan at Pacific Medical Centers
Enrollment Management
Dept 4568
PO Box 34936
Seattle, WA 98124-1936

If you move out of the US Family Health Plan zip-code-defined service area, you will no longer be eligible for coverage under the Plan. You must submit a disenrollment letter to reinstate full TRICARE Standard and/or Medicare benefits.

NOTE: If an active-duty Plan member sponsor is planning to retire, he/she must inform the Enrollment department of his/her desire to continue in the Plan. If the member has retired and no enrollment fee has been paid as of the date of retirement, the member will automatically be disenrolled.

ENROLLMENT IN US FAMILY HEALTH PLAN

Once accepted into the Plan, the beneficiary's place will be reserved and membership will be renewed automatically each year unless his/her eligibility status changes, he/she moves out of the area, or fails to pay applicable enrollment fees. Upon disenrollment a beneficiary can continue to see his or her primary care physician under TRICARE Standard, Extra or Medicare and TRICARE for Life, as long as the beneficiary is still eligible in DEERS.

Enrollment Fees

Retirees, retiree family members, and survivors of military retirees who do not participate in Medicare Part B are required to pay an enrollment fee. There is no enrollment fee for active-duty family members. The enrollment fee is payable at the time of enrollment in the Plan.

You may pay your enrollment fee in one payment, monthly, or in quarterly installments. You can pay by check, money order, credit card or allotment. Please make your check or money order payable to US Family Health Plan.

Enrollment Fee Amounts:

1. Individual Enrollment: \$230 annually OR \$57.50 quarterly
2. Family Enrollment: \$460 annually OR \$115 quarterly

If you are Medicare-eligible and currently enrolled in Medicare Part B, your portion of the enrollment fee will be waived if you submit a copy of your Medicare card indicating Part B coverage. Should you become Medicare-eligible while enrolled in the Plan and have chosen to pay the enrollment fee quarterly, please submit a copy of your Medicare card indicating Part B coverage to the enrollment department, and your enrollment fee will be pro rated for the remainder of the enrollment year.

Whenever possible, all family members should be enrolled at the same time, and payment of the applicable fee should be made in accordance with DoD requirements.

Quarterly Payment of Enrollment Fees

If you choose to pay your enrollment fee on a quarterly basis, please remember the following:

1. When paying enrollment fees on a quarterly basis, you will receive a bill 30 days prior to your next quarterly payment due date.
2. If you fail to make a timely payment, you will be subject to disenrollment. You will be responsible for the deductible and cost shares applicable under TRICARE Standard for any healthcare received after the termination date.
3. If you are disenrolled for non-payment of your quarterly enrollment fees, you may not reenroll in the Plan for 12 calendar months. You may use TRICARE Standard or TRICARE Prime during this lockout period.

Retired sponsors with eligible family members living at different addresses must coordinate the enrollment fee payment for all family members enrolling in the Plan. For example, if a single family member is enrolled and the enrollment fee has been paid based on an individual status, any additional family member living at a different address will not be enrolled without payment of the additional fee.

Enrollment Portability

As a US Family Health Plan member, you keep your coverage when you move or travel within our service area or when you move or travel to an area served by a different USFHP contractor. If you will be moving to a region served by another contractor and wish to transfer your enrollment, please call Enrollment Management at 206-621-4568 for information on how to do so. Your transfer will be effective once you choose a new primary care provider and return a signed enrollment application to the contractor in your new region.

Transferring Enrollment to Another US Family Health Plan Region

If you are moving to another state that has a US Family Health Plan program, you may transfer your enrollment. Simply contact the new plan to begin the transfer process. Please call Member Services at 206-621-4090 to find out if another US Family Health Plan exists where you are relocating, or go to www.usfhp.org. US Family Health Plan Members who are not TRICARE-eligible may transfer enrollment between US Family Health Plan programs only.

Transferring Enrollment to a Managed Care Support Contractor

As a US Family Health Plan enrollee, you may transfer enrollment after moving, permanently or temporarily, to a new location. TRICARE-eligible enrollees who are relocating to another contractor's region are allowed two enrollment transfers each enrollment year as long as the second transfer is back to the original contractor for that enrollment year. The following enrollees have the ability to transfer twice when relocating:

1. Enrollees in beneficiary categories who are required to pay enrollment fees.
2. Medicare-eligible enrollees who are not active-duty family members.

3. TRICARE-eligible enrollees who are not relocating may transfer to a different contractor once during an enrollment period, but may not transfer back during that same enrollment period.
4. US Family Health Plan Members who are not TRICARE-eligible may transfer enrollment between US Family Health Plan programs only.

Split Enrollment

Split enrollment refers to multiple family members enrolled in TRICARE Prime/USFHP under different contractors. A family will pay enrollment fees totaling no more than the standard fee regardless of the enrollment location of each family member. If your family has a split enrollment arrangement, be sure to provide the enrollment office in each TRICARE region with proof of payment of your enrollment fee. This will ensure that you pay your fee only once per family. You must also monitor your combined enrollment year catastrophic cap accumulations. Each contractor maintains catastrophic cap accumulations separately. Please notify us when your family's combined payments have met or exceeded the cap.

DISENROLLMENT

Once you have been accepted in the Plan, your membership will be renewed automatically for each successive year unless you move out of the area, your eligibility status changes in DEERS, or you fail to pay applicable enrollment fees.

To disenroll, you must submit your request in writing. Submission can be either by fax or mail.

USFHP

Att: Enrollment Management Department

1200 12th Ave S Qtrs 8/9

Seattle, WA 98144

Fax: 206-621-4464

If you are acting on behalf of a family member via a Designated Power of Attorney, your signature and a copy of your DPOA are required with the letter. If you are disenrolled as a result of non-payment of applicable enrollment fees, you will not be permitted to join the Plan for 12 calendar months.

In compliance with federal regulations, members will be subject to disenrollment if they use Medicare benefits to receive covered services from any provider. If it is determined that you provided false information to the Plan or committed fraud with respect to the Plan, or permitted someone else to do so, your coverage will be terminated at midnight on the date the determination is made (to the extent that the termination of your coverage is permitted by law).

TRICARE

By enrolling in the US Family Health Plan, you have agreed to receive your healthcare through the Plan. The Department of Defense (DoD) has required, as a condition of membership, that you agree not to use your TRICARE Plan Options.

OTHER INSURANCE AND INSURANCE CHANGES

Reporting other health insurance is a Plan requirement. Please call Enrollment Management at 206-621-4568 to report any other insurance plans in which you are enrolled. If you change your insurance coverage, or if you obtain commercial insurance coverage after joining US Family Health Plan, you must report it.

COORDINATION OF BENEFITS (COB)

The US Family Health Plan/TRICARE Prime contract with the DoD requires that any other comprehensive health insurance you have must be billed first before using TRICARE funds to pay your medical bills. After your other insurance pays, US Family Health Plan will pay any eligible balance up to the allowable charge.

Third-Party Liability and Work-Related Injuries

If you receive care for injuries sustained in an accident and another party is responsible for payment, call us at 206-621-4090 or 1-800-585-5883. Accidents of this type may include motor vehicle, slip and fall, product liability, et cetera. You should advise the Plan whether or not you intend to seek compensation. Failure to report this could result in loss of coverage for care related to this injury.

The US Family Health Plan is entitled to reimbursement from the liable party as well as any other legally responsible for indemnifying you (including but not limited to underinsured and uninsured coverage on automobile policies). The covered person, or the covered person's representative or beneficiary, will execute documents and do whatever is necessary for the US Family Health Plan to exercise its subrogation and assignment rights and will do nothing to prejudice this process.

Medicare Eligibles: If you are 65 or Older

For any individual who has Medicare Part B coverage, there is no annual enrollment fee for the US Family Health Plan, and no co-payments for any covered services except prescriptions.

If you are age 65 or older and choose to enroll in the Plan, you do not lose your entitlement to Medicare. You can be enrolled in the US Family Health Plan and have Medicare coverage. However, to avoid duplication of coverage under government-sponsored programs, US Family Health Plan members are not allowed to use their Medicare benefits for services covered by the US Family Health Plan. Members are not allowed to enroll in Medicare-sponsored managed care plans (HMOs) while enrolled in the US Family Health Plan. The use of Medicare benefits by a US Family Health Plan member for covered services is grounds for disenrollment from the Plan.

Members may, however, use Medicare for services not covered by US Family Health Plan, such as chiropractic care. Even though you are now a Plan member, you are advised to continue your Medicare Part B coverage. Retaining such coverage will allow you to avoid penalties or waiting periods should you choose to leave the Plan and use your Medicare benefits. If you become Medicare-eligible during the Plan year, you are advised to accept Medicare Part B coverage when first eligible. If you do, you will avoid

late Medicare Part B enrollment penalties and waiting periods should you later choose to leave the Plan and wish to use your Medicare benefits. Retirees with current Medicare Part B are not required to pay co-payments (except pharmacy) or enrollment fees. Once the enrollment office receives proof of your Medicare Part B then your enrollment and co-payments are waived.

THE ROLE OF YOUR PRIMARY CARE PROVIDER (PCP)

As a member of the Plan, you will establish a relationship with a primary care provider (PCP) who will get to know you, your medical history, and your individual healthcare needs. Our primary care providers are trained in one of the disciplines of Family Practice, Internal Medicine, or Pediatrics. Your PCP sees you for all of your routine health needs, monitors the medications you receive, orders tests or special services like physical therapy when needed, and maintains your medical records. If you have a complex problem, your PCP may refer you to one of US Family Health Plan's many qualified specialists. Your PCP and the Plan specialist will work together as a team to meet your healthcare needs.

The advantage to having a PCP to provide or manage most of your care is simple: you have someone to call when you need care, and there's coordination of care between your PCP and your specialists, hospital, and other facilities. Your medical records are in one place, including your prescriptions. You have someone who helps you navigate the complex world of healthcare. And your PCP takes care of the paperwork, so you don't have to file claims.

CHOOSING YOUR PRIMARY CARE PROVIDER

The first and most important decision each member must make is the selection of a PCP. Each enrollee in your family should select a PCP with whom he or she is comfortable. Family members do not need to select the same PCP, and their selections may be changed upon request.

The Plan's Primary Care Provider List includes family practitioners, pediatricians, internists, and nurse practitioners, with their locations and phone numbers so that a member may choose a PCP convenient to home or work. Lists are provided to all enrollees at the time of enrollment or upon request, by calling a Member Services representative at 206-621-4090 or 1-800-585-5883.

PCP lists are subject to change and are updated on a regular basis. You may check the current status of any PCP by calling your Pacific Medical Center or Member Services. The US Family Health Plan website is also updated with site-specific medical providers on a regular basis. It can be found at www.pacificmedicalcenters.org/usfhp.

UTILIZATION MANAGEMENT

Providing quality medical care in the setting that is most appropriate for your symptoms or condition and simultaneously represents an efficient use of medical resources is an important aspect of our approach to managing care. For instance, care will be provided on an outpatient basis unless inpatient treatment is necessary.

Pre-admission Approvals

The Plan will consider non-emergency hospital admissions in advance to make sure that inpatient care is appropriate. Certain outpatient surgery and diagnostic services may also require Plan authorization.

Authorizations are handled through the Plan's Utilization Management Program. The program uses nationally accepted guidelines for health services utilization in managing the treatment review process.

If you have any questions regarding the pre-authorization approvals for your upcoming scheduled admission or outpatient surgery, call Member Services at 206-621-4090 or 1-800-585-5883.

Medically Necessary Care

One purpose of the utilization management process is to ensure that you receive all the benefits to which you are entitled. It is also intended to make sure that the Plan pays only for care that is medically necessary.

Medically necessary care is defined as service or supplies provided by a hospital, physician, or other provider for the prevention, diagnosis, or treatment of an illness, when those services or supplies are determined to be:

1. Consistent with the condition, illness, or injury of the patient.
2. Provided in accordance with the approved and generally accepted medical or surgical practice prevailing in the geographical locality where, and at the time when, the service or supply is ordered.
3. Delivered in the most appropriate healthcare setting.

THE REFERRAL PROCESS

The Plan pays for covered medical services when they're provided by your PCP or authorized in advance by the Plan. Think of your PCP as the person who guides you to other healthcare providers—specialists, hospitals, rehab facilities, and so on. For example, if you need to see a heart specialist, your PCP will give you a referral to a cardiologist. Once that referral request is authorized by the Plan, you can be assured that the costs will be covered after you make any necessary co-payment.

THE REFERRAL NETWORK

Your PCP has privileges at a hospital in the US Family Health Plan provider network and will refer you to specialists and other medical professionals who are also connected with that hospital. We call this group the "referral network." It is a system that ensures better communication and coordination of care between your PCP and other providers.

If the specialty care you need is not available within the referral network, your PCP will refer you elsewhere. When both your PCP and the Plan authorize you to get care outside of the referral network, such care is covered by the Plan.

ABOUT REFERRALS TO SPECIALISTS

Once your referral is approved by the Plan, a referral authorization will be mailed to you and to the referring provider.

Referral authorizations are valid for only those services or diagnoses indicated. Referrals are valid until the expiration date noted on the referral, regardless of the number of visits indicated. It is very important that you keep track of the number of visits authorized, how many times you have seen the specialist to whom you have been referred, and the date of the referral expiration.

If additional visits are necessary beyond those authorized by your referral, it is your responsibility to obtain another referral for those additional visits with the specialist. Also, if the specialist wishes to refer you either to another specialist or for other services, you must first seek authorization from your PCP.

Plan authorization is required for certain referrals. Medical services for which there is a limited benefit, such as oral surgery or sleep studies, need to be reviewed first to make sure that the services being requested are covered by the Plan. Referrals to non-network providers or facilities require review for authorization to determine whether that particular service could be provided within the network. If authorized, you will receive your copy of authorization in the mail, typically within 7 to 10 business days.

It is important to understand that US Family Health Plan benefits apply only for covered services that are provided by your PCP or authorized in advance by your Plan. The only services for which you do not need a referral in advance are:

1. Obstetrics (you must still use Pacific Medical Centers network providers—check with Member Services for a specialist affiliated with the Plan).
2. Mental health (first eight visits at Pacific Medical Centers).
3. Emergency Care
4. Routine yearly eye exam (at Pacific Medical Centers).
5. Routine annual physical exam (at Pacific Medical Centers).
6. Mammogram (from a Pacific Medical Network Provider).

Please Note: Any non-emergency healthcare services you receive that are not authorized by the US Family Health Plan will not be covered. You may, of course, seek care on your own as long as you are willing to pay for those services on your own. You cannot file these claims for reimbursement nor ask your PCP to complete a referral after the services have been rendered.

HOSPITAL SERVICES

The Plan provides a comprehensive range of hospital benefits when members are hospitalized under the care of a Plan provider. There is an \$11 per day co-payment or \$25 minimum charge per admission for retirees and their family members. Active-duty families and retirees with current Medicare Part B are not subject to the co-payment. All medically necessary services are covered, including:

1. Semi-private room accommodations (a private room may be covered if a Plan provider determines it is medically necessary).
2. Specialized Care units, such as intensive care or cardiac care units.

3. Physician services related to medical treatment or surgery.
4. General nursing services.
5. Operating room, anesthesia, and supplies.
6. Prescribed inpatient drugs.
7. Inpatient physical therapy and rehabilitation at the appropriate level of care.
8. Other medically necessary supplies and services.

If You Are Admitted to a Hospital

If you require hospitalization, your PCP or specialist will make the necessary arrangements for you. All members must use the US Family Health Plan network of inpatient facilities affiliated with their PCP. The hospitals used by Pacific Medical Centers PCPs are:

1. Virginia Mason Medical Center – Seattle
2. Evergreen Hospital Medical Center – Kirkland
3. Children’s Hospital and Medical Center – Seattle
4. Providence Everett Medical Center

If a procedure or service is unavailable at a US Family Health Plan network hospital, both your PCP and the Plan must first provide authorization for you to receive care at a non-network hospital. Emergency care (see page 15) will be covered at any hospital. Remember, your PCP must arrange hospital admissions.

Note: If you are admitted to a hospital as an emergency, your PCP must be notified within 24 hours or the next business day. If you fail to notify your PCP within the required time period, you may be responsible for the cost of your emergency care.

Military Treatment Facility Privileges

As a condition of membership, Plan members are not permitted to use military treatment facilities for non-emergency care, including getting prescriptions filled. However, should you experience a life- or limb-threatening emergency, you are permitted to use the nearest civilian or military emergency facility. You must notify your primary care provider within 24 hours of receiving care. Claims for emergency treatment should be submitted to the Plan for payment.

Extended Care Health Option (ECHO)

This special benefit is available to Active Duty dependents. For more information please go to www.tricare.osd.mil or call Member Service at 206-621-4090 or 1-800-585-5883.

EMERGENCY CARE

For a life-threatening medical emergency, call 911 (or your local emergency response number) or go to the nearest hospital emergency room immediately.

The Plan covers emergency care for sudden and unexpected onset of life-, limb-, or sight-threatening conditions requiring immediate attention.

Examples of **life-threatening** emergencies include:

1. Severe chest pains.
2. Difficulty breathing.
3. Loss of consciousness.
4. Poisoning.

Examples of **non-life-threatening** conditions include:

1. Sprains or strains.
2. Illnesses such as respiratory infections or chicken pox.
3. Backaches, earaches or sore throat.

NOTE: If you are unsure whether your condition meets the definition of an emergency, call your clinic first. If you obtain emergency care without authorization and your visit is determined upon review to have not required emergency treatment, you will be responsible for payment.

At the time of the ER visit, retirees and their family members will be asked to pay a \$30 co-payment.

If you are later admitted as an inpatient, only the inpatient co-payment applies. Active-duty family members and retirees with current Medicare Part B do not co-pay for emergency room visits. Your PCP will provide or coordinate your follow-up care, such as X-rays or removal of stitches. Do not return to the emergency room for follow-up care unless your PCP refers you there. No payment will be made for unauthorized follow-up care. To ensure coverage, notify the Plan office of your emergency room visit within 24 hours or the next business day after receiving care. Call your clinic or, if you are out of the area, call 1-888-958-7347.

AFTER-HOURS SERVICES

US Family Health Plan at Pacific Medical Centers offers several services designed to help you get the care you need for medical problems that require prompt attention and may arise after regular office hours. If you have a medical problem during clinic hours, you should call your clinic. After regular hours, call your clinic number to reach our after-hours service.

Our after-hours service is a resource for information and a special service for you and your family that can mean peace of mind, 24 hours a day, 7 days a week. An after-hours nurse will return your call and offer recommendations, which may include speaking with a doctor, when needed, or a referral to the best source of care. As always, if you experience a life-threatening emergency, go immediately to the nearest emergency room. If you are directed by clinic staff or after-hours staff to receive immediate care in an emergency room or after-hours care center, the Plan will pay the bill for the services. Emergency after-hours prescriptions may be filled at any Bartell Drugs store.

If you obtain treatment without authorization for a condition that is found to be non-emergent, you will be responsible for the bill.

After-Hours Emergency

For a life- or limb-threatening emergency occurring after office hours, call 911 (or your local emergency response number) or go to the nearest emergency room immediately. To ensure coverage, notify the Plan office of your emergency room visit within 24 hours or the next business day after receiving care. Call your clinic or, if you are out of the area, call 1-888-958-7347.

After-Hours Non-Emergency Care

For non-emergency medical conditions requiring prompt attention, call your clinic before seeking care. If you call after office hours, an after-hours nurse who will provide information or authorize treatment at a specific medical facility will return your call.

Examples of conditions that might require after-hours care include:

1. Ear infection.
2. Fever.
3. Some cuts and burns.
4. Serious respiratory infections.

IF YOU ARE TRAVELING

If you become ill or injured and require care while outside the Plan service area (but within the continental United States), that care will be covered by the Plan if authorized by your PCP or an after-hours nurse. When you are outside of the Plan service area (Puget Sound), you may seek urgent care by calling your regular clinic for referral to the nearest approved facility. In a life-threatening situation, go immediately to the nearest emergency room.

Members who receive emergency care without a referral must call their clinic number or 1-800-585-5883 within 24 hours to notify the Plan. Any follow-up care must be coordinated through Pacific Medical Centers and your PCP. If you are unsure if your condition is life-threatening, call your clinic for guidance.

If the emergency or urgent situation occurs while you are traveling outside the United States (OCONUS), simply obtain care and submit your bills, receipts, and treatment information to the Plan Member Services department within seven days of return. If you fail to notify us within the required time period, you may be responsible for the cost of the emergency room care.

Remember: Routine or unapproved follow-up care received outside of the service area is not covered.

Bills for Emergency Care Received Outside the Area

If you receive emergency care when away from home, the Plan will review your claim and, if the care was medically necessary, pay benefits directly to the providers. If you are required to pay at the time of service, submit itemized bills and receipts to the Member Services department along with an explanation of the services and the identification information from your US Family Health Plan card. If approved, payment will be

sent to you. If denied, you will receive notice of the decision, including the reasons for the denial. You may appeal the denial, in accordance with the procedure outlined in the section titled “Appeals Procedure.”

COVERED BENEFITS

The US Family Health Plan provides a comprehensive range of preventive, diagnostic, and treatment services as defined by DoD and the TRICARE Prime uniform benefit. Although a specific benefit or service may be listed as covered, it will be provided and paid for only if, in the judgment of your plan provider, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition.

No oral statement of any personnel shall modify or otherwise affect these benefits, limitations, and exclusions, convey or void any coverage, increase or reduce any benefits under this plan, or be used in the prosecution or defense of a claim under this Plan. Please review the chart on page 17-18 of this handbook for a list of common medical services that are covered by the Plan.

Summary of Benefits

This chart presents an overview of services that are covered by the Plan when they are provided or authorized by your US Family Health Plan primary care provider (PCP).

	Active Duty Family Members	Retirees, Survivors and Family Members	Retirees, survivors & Family Members w/Medicare Part B
Annual Enrollment Fee	\$0	\$230/individual \$460/family	\$0 with proof of Part B
COVERED SERVICES	YOUR COST	YOUR COST	YOUR COST
Annual Physical	\$0	\$0	\$0
Outpatient Visits	\$0	\$12	\$0
Home Healthcare	\$0	\$12/visit	\$0
Emergency Room Visits	\$0	\$30	\$0
Ambulatory Surgery	\$0	\$25	\$0
Inpatient Hospitalization (general)	\$0	\$11/day	\$0
Skilled Nursing Facility Care	\$0	\$11/day	\$0
Ambulance Service	\$0	\$20 per occurrence	\$0

	Active Duty Family Members	Retirees, Survivors and Family Members	Retirees, Survivors & Family Members w/Medicare Part B
COVERED SERVICES	YOUR COST	YOUR COST	YOUR COST
Prescription Drugs:	Co-payment/ prescription	Co-payment/ prescription	Co-payment/ prescription
Retail Pharmacy (30-day supply)			
Name-Brand Drug	\$9	\$9	\$9
Generic Drug	\$3	\$3	\$3
Mail Order (90-day supply)			
Name-Brand Drug	\$9	\$9	\$9
Generic Drug	\$3	\$3	\$3
Durable Medical Equipment (prostheses, supplies)	\$0	20% of cost	\$0
Physical Therapy	\$0	\$12/visit	\$0
Occupational Therapy	\$0	\$12/visit	\$0
Rehabilitation Therapy (including cardiac)	\$0	\$12/visit	\$0
Radiation Therapy	\$0	\$12/visit	\$0
Routine PAP Smear	\$0	\$0	\$0
Well Child Care & Immunizations (up to 24 months of age)	\$0	\$0	\$0
Maternity (Hospital & Professional Services, pre/post natal)	\$0	\$25 minimum	\$0
Eye Exams	\$0	\$12	\$0
Mental Illness:			
Outpatient Mental Health Visits, individual	\$0	\$25/visit	\$0
Outpatient Mental Health Visits, group	\$0	\$17	\$0
Inpatient Hospitalization, Mental Health	\$0	\$40/day	\$0
Partial Hospitalization, Mental Health	\$0	\$25 minimum	\$0
Substance Abuse Treatment (inpatient partial)	\$0	\$40/day	\$0

This summary is not an all-inclusive list. Complete details of benefit coverage and exclusions are available by calling our Member Services department at 206-621-4090.

- 1. If an individual is paying into Medicare Part B, there is no US Family Health Plan enrollment fee for that person.*
- 2. No co-payments are due for Medicare-covered services.*
- 3. If lab services are provided as part of an office visit and a co-payment is collected for the visit, no additional co-pay will be collected. No co-pay will be collected when services are billed and provided as preventive services.*
- 4. One hour of therapy, no more than two times per week, when medically necessary.*
- 5. With authorization, up to 30 days per enrollment year for adults (age 19+); up to 45 days per enrollment year for children under age 19; up to 150 days residential treatment for children and adolescents.*
- 6. Exclusive of drug maintenance programs.*
- 7. Up to 7 days for detox and 21 days for rehab per year. Maximum of one rehabilitation program per year and three per lifetime. Detoxification and rehabilitation days count toward limit for mental health benefits.*
- 8. Unless you are admitted to the hospital, in which case only the inpatient co-payment applies.*
- 9. Prescription drug availability is limited to those prescribed by a Plan provider and covered as a Plan benefit. Availability of non-emergency prescriptions when out of the area is also limited. Over-the-counter medications and supplies are not covered.*

All specialist visits and hospital admissions must be arranged by your PCP (except for unforeseen medical emergencies). Most co-payments are due at the point of service.

Your Benefits and How to Use Them

The preceding chart presents a summary of covered services and co-payments, followed by the added benefits of US Family Health Plan membership. A list of exclusions and limitations appears on pages 19-21. Most co-payments are due at the time you receive medical services or prescriptions. A short glossary of terms is provided in this handbook for your reference. If you have a question about a service or item not listed, call Member Services at 206-621-4090 or 1-800-585-5883.

It's important to understand how to take advantage of your coverage and get the care you need, to avoid any unnecessary costs or paperwork.

Limitations to Benefits

The following are some of the major exclusions and limitations (others may apply).

The Plan does not provide coverage and will not pay for:

1. Abortions (routine).
2. Acupuncture and acupressure.

3. Any mental health or substance-abuse services denied or not preauthorized by the Plan's Utilization Management Program (with the exception of the eight authorized self-referral outpatient mental health visits).
4. Any services, (including vaccinations) provided for employment, licensing, immigration, recreational travel, or other administrative reasons.
5. Artificial insemination, in vitro fertilization, and other such therapies to induce pregnancy.
6. Autopsy and post-mortem examinations.
7. Aversion therapy in connection with alcoholism.
8. Bed-wetting correctional devices.
9. Behavioral therapy.
10. Over-the-counter birth control.
11. Care or supplies not furnished or prescribed by a Plan provider.
12. Care or treatment as a result of being engaged in an illegal occupation or commission of, or attempted commission of, a felony or assault.
13. Charges for missed appointments.
14. Charges or services for which you or your covered family members are not legally required to pay, or that would not have been made if coverage had not existed.
15. Chiropractic and naturopathic services.
16. Complications due to a treatment or a service not covered by the Plan.
17. Corrective lenses and frames.
18. Cosmetic, plastic, or reconstructive surgery not related to medical treatment.
19. Counseling services, unless medically necessary.
20. Dental care.
21. Drug Maintenance programs (e.g. methadone).
22. Education or training.
23. Electrolysis.
24. Food, food substitutes or supplements, and vitamins consumed outside a hospital except for home parental nutrition therapy.
25. Foot care, except in connection with medical care such as diabetic treatment.
26. Hearing aids.
27. Hearing examinations, except in connection with medical treatment.
28. Learning disorder treatment.
29. Massage therapy.
30. Megavitamins and orthomolecular psychiatric therapy.

31. Custodial or convalescent care (care for someone's daily needs, such as eating, dressing, and simple bandage changes) in an institution or home.
32. Organ transplants considered experimental.
33. Orthodontia.
34. Orthopedic shoes and orthotics, except when part of a brace or in connection with medical care such as diabetic treatment.
35. Over-the-counter drugs or vitamins or food supplements.
36. Private hospital rooms, unless ordered by the attending physician for medical reasons or if a semi-private room is not available.
37. Radial keratotomy.
38. Respite care.
39. Retirement homes.
40. Services and drugs not prescribed or authorized by your primary care provider (PCP) or a specialist to whom you were referred.
41. Services not considered medically necessary or clinically appropriate for diagnosis and treatment as determined by a physician.
42. Services not specifically included as covered services in this booklet.
43. Services or procedures that are experimental or of a research nature.
44. Services provided by people who ordinarily reside in your household or the household of your covered family member or who are related by blood, marriage, or legal adoption to you or your covered family member.
45. Services provided or charges incurred prior to the effective date of coverage under the Plan.
46. Services provided or received after the date your coverage terminated under the Plan.
47. Sex change procedures.
48. Smoking cessation programs and prescriptions.
49. Some sexual dysfunction treatment.
50. Sterilization reversals.
51. Transportation for convenience.
52. Visual training.
53. Weight control or weight-reduction services and supplies.
54. Work-related illnesses or injuries that are covered under workers' compensation programs.

Other exclusions may apply. Check with a Member Service representative for further clarification.

PHARMACY

Filling Your Prescription

If you are a first time Plan member and have

1. Refills remaining on your current prescription: Contact your prescription pharmacy and request your refills be transferred to Maxor Pharmacy at 1-866-408-2459. (Prescriptions from a Military Treatment Facility may not be transferable.)
2. No refills remaining: Call your new clinic to request a prescription rewrite. Please allow 10 days for processing new member prescriptions.

Services and Locations

US Family Health Plan members may obtain new and refill prescriptions at any of the on-site pharmacies located at select Pacific Medical Centers or, for clinics that do not have a pharmacy, at selected Bartell Drugs pharmacies in our region. In addition, members may use mail-order service for up to a 90-day supply of approved medications through Maxor mail-order pharmacy. Call Maxor at 1-866-408-2459 to request a mail-order form. Send it in with your new prescription or, for a refill, with your prescription number, plus a check or credit card number for your co-payment. Your prescription order is processed promptly. Most orders are shipped via the U.S. Postal Service and are received within 2 weeks of the day you mail the order. Diabetic supplies can also be ordered through mail-order service.

Generic drug substitution is required by all US Family Health Plan providers. If the prescribing physician indicates a clinical reason on the prescription that precludes generic drug substitution, the prescription will be filled with a brand-name product, and the request will be documented by the pharmacist. However, if you insist on a brand-name product instead of the generic substitution, you will be responsible for the difference in the cost between the generic drug and the brand-name drug with no reimbursement from the Plan.

NOTE: Prescriptions will not be mailed without prior payment. No prescriptions can be filled at an MTF.

Prescriptions When Traveling Out of the Area

Maxor will be happy to mail your prescriptions anywhere in the United States. If you require a longer-term prescription for traveling outside the country, you may talk to your PCP before you leave and he/she may write a longer-term prescription if they feel it is indicated.

Prescription Drug Limitations and Exclusions

The Plan will not provide coverage for:

1. Drugs, vitamins, or other items that can be purchased without a prescription, except for insulin and those non-prescription drugs approved by the Pacific Medical Pharmacy and Therapeutics Committee.

2. Drugs used for cosmetic reasons, including but not limited to drugs used for hair growth or for wrinkles.
3. Smoking cessation transdermal systems.
4. Medical supplies such as dressings and antiseptics.
5. Prescriptions written by physicians not affiliated with US Family Health Plan, except when required for emergency care as determined by the Plan.
6. Drugs obtained at a non-Plan pharmacy, except in an out-of-area emergency.
7. Prescription drugs not covered under the TRICARE benefit.
8. Over-the-counter contraceptives.

Co-Payments

The complete co-payment schedule is provided on the chart on page 17. The co-payment (applicable to active-duty family members in all pay grades, and retirees and their family members) for prescription drugs, both retail and mail-order, is \$3 for generic drugs and \$9 for brand-name drugs for a 30-day or 90-day supply. All co-payments are to be paid at the time of service.

NOTE: Prescription drug availability is limited to those prescribed by a Plan provider and covered as a Plan benefit. Availability of non-emergency prescriptions when out of the area is also limited.

CATASTROPHIC LOSS PROTECTION BENEFIT (CATASTROPHIC CAP)

As US Family Health Plan members, your family has a catastrophic loss protection limit (or catastrophic cap) for your healthcare costs. This means there is a limit to your out-of-pocket expenses.

The catastrophic cap for active-duty family members is \$1,000 per enrollment year, per family, and \$3,000 for retirees, retiree family members, and survivors, per family. The enrollment year is based on the 12-month enrollment period. Out-of-pocket expenses that contribute toward your cap include enrollment fees, co-payments, and cost shares. Once your catastrophic cap has been met, you and your family members will not have to pay any more out-of-pocket expenses for the remainder of that enrollment year.

US Family Health Plan encourages you to keep track of your out-of-pocket expenses. If you find a discrepancy in the amount the Plan has credited toward your cap, please send your receipts to:

US Family Health Plan
Member Services
1200 12th Ave S Qtrs 8/9
Seattle, WA 98144

OUTPATIENT SERVICES

At US Family Health Plan clinics and through the referral network, the following services are covered:

1. Office visits to your primary care provider (PCP).
2. Prescription drugs.
3. Authorized office visits to Plan specialists to whom your PCP refers you.
4. Preventive health services: well-baby, well-child, and well-adult care.
5. Covered outpatient surgical procedures and anesthesia upon referral from your PCP.
6. After-hours services at a Plan clinic or designated facility when authorized.
7. Maternity (prenatal and postpartum) and newborn care.
8. Routine eye exams.
9. Emergency room visits for a medical emergency or when authorized by the Plan.

MENTAL HEALTH AND SUBSTANCE ABUSE

What is Covered

The Plan provides medically or psychologically necessary services for the diagnosis and treatment of psychiatric conditions through the Behavioral Health Department at Pacific Medical Centers or other Plan providers.

Services include:

1. Diagnostic evaluation.
2. Psychological testing.
3. Psychiatric treatment (including individual and group therapy).
4. Hospitalization (including inpatient professional services), subject to medical review.

US Family Health Plan patients may self-refer to a Pacific Medical Centers mental health provider or the first eight outpatient mental health visits by calling 206-621-4368. All subsequent services must be authorized by the Plan.

Treatment for chemical/alcohol dependency at an approved inpatient or outpatient treatment facility is covered when pre-authorized by the Plan. Both detoxification and rehabilitation days are counted toward mental health maximums. Substance abuse rehabilitation services are limited to one admission per year, with a maximum of three admissions.

If you or a family member is currently under treatment for a mental health condition or chemical/alcohol dependency from a non-Plan provider, please call your PCP to transfer your care to a Plan provider. The Plan covers only approved services from an approved provider.

What is Not Covered

Drug maintenance programs and conditions where there has not been a medically or psychiatrically diagnosed condition are not covered. Examples of what is not covered include: methadone maintenance, marital or couples counseling, problems in everyday living, expected grief reactions, learning disorders including dyslexia, and sexual dysfunction.

The Plan strongly encourages outpatient services and will approve inpatient services only if medically necessary.

SKILLED NURSING CARE

Inpatient Skilled Nursing Care

The Plan provides inpatient skilled nursing care in an accredited, contracted nursing home facility when it is medically necessary. Coverage includes:

1. Bed, board and skilled nursing services in a sub acute or rehabilitation facility.
2. Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the facility, when authorized by a Plan provider.
3. Other medically necessary treatments and services deemed appropriate.

NOTE: Short- or long-term custodial care is not covered.

Home Care

The Plan provides medically necessary home care, including:

1. Durable medical equipment such as wheelchairs, hospital beds, oxygen, and respirators when arranged by the Plan.
2. Home physical therapy, speech therapy, or occupational therapy for short, defined periods where significant improvement can be expected.

NOTE: Home care is covered only when such care is medically necessary, authorized by the Plan, and is limited to skilled services. Assistance with the ordinary activities of daily living is not covered.

VISION CARE

What is covered

One routine eye examination per year, including refractions and written lens prescription, may be obtained from Pacific Medical Centers.

Medical Eye Exams

If you have a medical condition necessitating eye exams more frequently, your PCP may give you a referral to see an ophthalmologist, a medical doctor who specializes in eye care. Your PCP will determine when it is appropriate to refer you directly to an ophthalmologist and when it is appropriate to be seen by an optometrist.

What is Not Covered

Corrective lenses, frames, contact lenses, and contact lens fittings are generally not covered.

OTHER SERVICES

Ambulance Service

Transportation for a life threatening emergency to the nearest facility for treatment is covered. Other transportation needs are based on medical necessity and TRICARE criteria. If you are a retiree over age 65 or retiree family member and you do not carry Medicare Part B, your co-payment is \$20 per occurrence for ambulance services. Active-duty family members and retirees with current Medicare Part B do not have a co-payment for ambulance services.

NOTE: Ambulance transport from hospital to residence is not a covered benefit.

Diagnostic Services

If authorized by your primary care provider or specialist, the following are covered without an additional co-payment:

1. Pathology/Lab Services.
2. Nuclear Medicine Services.
3. Cardiovascular Studies.
4. Radiology/Ultrasound Services.

However, if you have a PCP or specialist office visit on the same day as the diagnostic services, a co-payment will be collected from retirees over age 65 and their family members who do not carry Medicare Part B for the PCP/specialist visit. Active-duty family members and retirees with current Medicare Part B are not required to pay co-payments for most services.

Durable Medical Equipment

Durable medical equipment may be covered if deemed medically necessary by the Plan, authorized by your primary care provider, and purchased or rented from a Plan provider.

Co-payments are applied for retirees and their family members who do not carry Medicare Part B. Active-duty family members and retirees with current Medicare Part B do not have a co-payment for covered durable medical equipment.

Hospice Care

Hospice care is a program that provides an integrated set of services and supplies designed to care for the terminally ill. This type of care emphasizes palliative care and supportive services, such as pain control and home care. The benefit provides coverage for a humane and sensible approach to care during the last days of life for some terminally ill patients.

NOTE: Eligibility determination and referrals to approved hospice care providers are made by primary care providers or specialists using established medical criteria.

IF YOU GET A BILL

There are no claim forms, bills (except for co-payments), or billing for services covered by the US Family Health Plan. But if you happen to get a bill, we'll help clear up the problem for you. If you ever receive a bill for covered services from your PCP or from a provider to whom your PCP referred you, just forward it to:

US Family Health Plan
Member Services
1200 12th Avenue S Qtrs 8/9
Seattle, WA 98144

Alternatively, you may call Member Services at 206-621-4090 or 1-800-585-5883.

MEMBER SERVICES

If you would like to get information on benefits and services, offer a suggestion, lodge a complaint, or pass along a compliment, the Member Services Department is here to assist you. We can provide assistance on US Family Health Plan benefits and resolve member issues.

To contact the Member Services department, you may call 206-621-4090 or 1-800-585-5883 Monday through Friday, between 8:00 am and 4:30 pm, or write to:

US Family Health Plan
Member Services
1200 12th Ave S Qtr 8/9
Seattle, WA 98144

APPEALS PROCEDURE

Informal Complaint Process

Any plan member who has a complaint concerning personnel, service, quality of care, or contractual benefits should first attempt to resolve concerns by contacting and discussing the matter with a Member Services representative at 206-621-4090 or 1-800-585-5883. Every attempt will be made to resolve the problem to the satisfaction of the member during the initial contact with the Member Services Department.

Level One Appeals

If you believe that a claim or referral was improperly denied, in whole or in part, you may file an appeal. Appeals relating to factual determinations involve issues other than medical necessity (e.g., whether a service is covered under TRICARE policy or regulation). Most appeals must be filed in writing within 90 days of the date of the initial denial determination. A beneficiary or Power of Attorney of the beneficiary may submit appeals. The appeals should include the patient's name, address, and phone number, the sponsor's name and Social Security number, the reason for the appeal, and copies of any other documents related to the issue.

All appeals must be submitted to the Plan in writing at the following address:

US Family Health Plan
Member Services
1200 12th Ave S Qtrs 8/9
Seattle, WA 98144

The appeal should include all pertinent information regarding the issue. Once the appeal is received, it is logged and a receipt letter is sent to the member within five days. The appeal is then reviewed by the Level One Appeals Committee.

A final determination is made within 30 business days of the receipt of the appeal. A written determination that includes the basis for the decision is sent to the member at this time.

Level Two Appeals

If the member is not satisfied with the initial denial determination of the Level One Appeals Committee, the member may submit an additional letter to request that the issue be further reviewed and reconsidered.

A request for consideration of a concurrent review denial (e.g., you, as the patient, are still in the facility) or a request for an expedited reconsideration of a pre-admission/pre-procedure denial must be filed within a much shorter time frame. Contact the Member Services department for further details relating to the appeal process.

The MAXIMUS, an independent review body contracted by DoD, is the final appeals level for medical necessity, appropriateness of care setting, and coverage issues. Member Services can assist you with the appeal process; contact the department at 206-621-4090 or 1-800-585-5883.

MEMBER GRIEVANCES

Any requests for consideration must be sent in writing to the Plan. The address is:

US Family Health Plan
Member Services
1200 12th Ave S Qtrs 8/9
Seattle, WA 98144

Once the grievance is received, a letter confirming receipt of your grievance is sent within 10 days. The issues raised are then reviewed in accordance with the Quality Improvement Program. This requires that the grievance be forwarded to the director responsible for the department involved and that a thorough investigation be conducted. All members will receive a written response within 30 calendar days from the date the grievance was submitted.

You can appeal certain US Family Health Plan/TRICARE Prime decisions. The following issues are subject to reconsideration (i.e., can be appealed) if you, as the beneficiary, and/or your provider are dissatisfied with an initial denial:

1. Medical necessity and appropriateness of the services furnished or proposed to be furnished.
2. Appropriateness of the setting in which the services were or are proposed to be furnished.
3. A determination regarding benefits under this program.

Grievance Review Procedures

The Plan maintains grievance procedures for the resolution of complaints between members and physicians or other healthcare providers of the Plan or Plan operations. A grievance is defined as a formal complaint, presented to the Plan in writing, which thereupon initiates the formal grievance process. A complaint, by contrast, is usually orally reported and orally resolved. However, an informally presented complaint may evolve into a formal grievance if a satisfactory resolution is not achieved.

Confidentiality is an important aspect of the grievance procedure. The member is assured that the information regarding a grievance will be held in confidence by the Plan throughout the investigation and resolution.

Under no circumstances will such information become part of his/her medical record(s).

Compliance with a member's request to remain anonymous is not always possible in resolving a grievance and will be explained as such to the member in advance of proceedings.

CONFIDENTIALITY

Medical and other information provided to the Plan is kept confidential, and will be used by Plan providers and administrators for coordination of care, claims adjudication, program integrity, investigation of fraud or abuse, quality assurance, responding to inquiries from congressional offices, peer review, coordination of benefits with other plans, subrogation of claims, or in review of a disputed claim.

DEFINITION OF TERMS

Accident

A sudden, unforeseen, and unexpected event causing external/internal trauma to the body.

Alcoholism or Drug Addiction Treatment Facility

An institution that is engaged mainly in providing inpatient services for the treatment of alcoholism or drug addiction.

Attending Physician

The physician who is primarily responsible for your care in an inpatient hospital setting.

Authorized Services

Those services authorized by the Plan to be provided to you, upon recommendation by your primary care provider (PCP).

Catastrophic Cap

A cost “cap” or upper limit on out-of-pocket expenses placed on US Family Health Plan-covered medical bills. The enrollment year limit for an active-duty family is \$1,000. Plan retiree families have a catastrophic loss protection limit of \$3,000 per enrollment year.

Contractor(s)

Refers to a US Family Health Plan program or a Managed Care Support Contractor.

Co-payment

The fee you are required to pay for some services.

Covered Services

Those healthcare services unspecified in DoD Regulation 6010.8-R, “Civilian Health and Medical Program of the Uniformed Services (CHAMPUS),” and its accompanying manual, “DoD Regulation 6010.47M,” plus preventive services specified in “A Guide to Clinical Preventive Services: Report of the U.S. Preventive Services Task Force” (Williams & Wilkins, 1996).

Custodial Care

Services and supplies, including room and board and other institutional services, that are provided to an individual (whether disabled or not) primarily to assist in the activities of daily living. Custodial care is not a covered benefit under the US Family Health Plan.

Defense Enrollment Eligibility Reporting System (DEERS)

The nationwide computerized data bank that lists all active and retired military members and their family members. Active and retired service members are listed automatically, but they must list their dependents and report any changes to family members’ status (through divorce, adoption, etc.).

Dependent

The spouse, eligible child, or adult-disabled child of a military sponsor deemed to be entitled to military benefits, as determined by military regulations.

Designated Provider of TRICARE Prime

A public or nonprofit entity that was a transferee of a Public Health Service hospital and designated by public law to provide the TRICARE Prime Uniformed Benefit. The US Family Health Plan at Pacific Medical is a Designated Provider of TRICARE Prime. There are six designated providers in the United States.

Durable Medical Equipment

Medical equipment such as wheelchairs, hospital beds, oxygen, and respirators. Covered when medically necessary and arranged by the Plan.

Eligible Person

A MHS beneficiary who meets the requirements set forth in the eligibility section of this handbook.

Emergency

Sudden and unexpected onset of life-, limb-, or sight-threatening conditions requiring immediate attention.

Enrollee or Member

A uniformed services beneficiary who voluntarily and affirmatively seeks and is accepted for enrollment in the US Family Health Plan as his or her chosen way of obtaining the healthcare services specified in the selected enrollment option from the Military Health System (MHS). Eligibility for enrollment is based on (1) eligibility to receive care in the MHS, and (2) residency within a US Family Health Plan service area.

Family Member

The spouse or child of an active-duty or retired uniformed sponsor.

Home Health

The Plan provides medically necessary home care including durable medical equipment such as wheelchairs, hospital beds, oxygen, and respirators when arranged by the Plan, as well as home physical therapy, speech therapy, or occupational therapy for short, defined periods where significant improvement can be expected.

Hospital

An institution that (1) provides medical care and treatment of sick and injured persons on an inpatient basis; (2) is properly licensed or permitted legally to operate as such; (3) has a physician on call at all times; (4) has licensed graduate registered nurses on duty 24 hours a day; (5) maintains facilities for the diagnosis and treatment of illness and major surgery; and (6) meets the required standards of the Joint Commission on Accreditation of Healthcare Organizations. The definition of hospital may also include (1) alcoholism or drug-addiction treatment facility; (2) psychiatric hospital; (3) ambulatory surgical facility; and (4) freestanding birth center—provided the facility is licensed in the state in which it operates and is operating within the scope of its license. In no event will the definition include an institution or any part of one that is a convalescent/extended-care facility, or any institution that is used primarily as (1) a rest facility; (2) a nursing facility; (3) a facility for the aged; or (4) a place for custodial care.

Illness

Any physical or mental sickness or disease that manifest symptoms and requires treatment by a licensed provider. This definition also includes pregnancy (for the purpose of defining coverage).

Injury

Any accidental bodily damage or hurt sustained while a person is covered under the Plan that requires treatment by a physician.

Inpatient

A person treated in a hospital as a registered bed patient incurring a charge for room and board, upon the recommendation of a physician.

Managed Care Support Contractor (MCSC)

The civilian contractor designated by DoD to operate TRICARE in a particular region in partnership with the MTFs.

Medical Emergency

The sudden and unexpected onset of a medical condition or acute exacerbation of a chronic condition that is threatening to life, limb, or sight, and that requires immediate medical treatment or manifests painful symptoms requiring immediate palliative efforts to alleviate suffering. Medical emergencies include heart attacks, cardiovascular accidents, poisoning, convulsions, kidney stones, and such other acute medical conditions.

Medically Necessary

Service or supply for prevention, diagnosis, or treatment that is consistent with the condition, illness, or injury of the patient. The service or supply must be in accordance with the approved and generally accepted medical or surgical practice prevailing in the geographical locality where, and at the time when, the service or supply is ordered. The fact that any particular physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make that service medically necessary. A service or supply will not be considered as medically necessary if (1) it is provided only as a convenience to the covered person; (2) it is not appropriate treatment for the covered person's diagnosis or symptoms; or (3) it exceeds (in scope, duration, or intensity) that level of care which is needed to provide safe, adequate, and appropriate diagnosis or treatment.

MHS

Military Health System. The system through which eligible members of the uniformed services, retirees, and their family members receive military healthcare benefits.

Military Treatment Facility (MTF)

(Also: Medical Treatment Facility) A military hospital, clinic, or other facility established for the purpose of furnishing medical care to eligible individuals.

Outpatient

A covered person will be considered to be an outpatient if treated on a basis other than as inpatient in a hospital or other covered facility. Outpatient care includes services, supplies, and medicines provided and used at a hospital or other covered facility under the direction of a physician to a person not admitted as an outpatient.

Physician

A legally qualified person acting within the scope of his or her license and holding the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

Plan

The US Family Health Plan as presented in the formal Plan document.

Plan Year

The Plan year is from Oct 1 through Sept 30.

Plan Provider

A Plan provider is a facility and all institutional or professional providers associated with the facility, including those employed by, or under contract to, the facility, or a provider who subcontracts with a Plan provider. The Plan provider's purpose is to render covered and authorized care to enrollees in the Plan, or to manage the Plan on behalf of the facility.

Primary Care Provider (PCP)

Each US Family Health Plan member has a primary care provider who knows the member's medical history, provides most of the member's healthcare, writes referrals for and monitors any specialist care or tests that are necessary, and helps the member prevent medical problems in the future. US Family Health Plan primary care providers specialize in internal medicine, family medicine, family practice or pediatrics.

Provider

A healthcare professional, institution, facility or agency licensed by the appropriate authority and operating according to law, including a hospital, physician, doctor of podiatry (D.P.M.), licensed clinical psychologist (Ph.D.), certified nurse practitioner, physician's assistant, certified nurse midwife, or mental health counselor.

Referral

A formal, written recommendation from a PCP which directs an enrollee to receive healthcare services from another specified care provider. Entitlement to such services shall not exceed the limits of the referral and is subject to all terms and conditions of the group contract. In order for referred services to be paid for by the Plan, authorization is necessary.

Reliant Beneficiary

Any individual, directly or through a family member, who does not have other comprehensive health insurance (other than Medicare) and is reliant on the military healthcare system for care.

Room and Board

Charges made by a hospital or other covered institution for the cost of the room, general duty nursing care, and other services routinely provided to all inpatient, not including special care units.

Semi-Private Charge

The charge made by a hospital for a room containing two (2) or more beds, but does not include the charge made by the hospital for special care units.

Service Area

The zip-code-defined service area is the geographic area in which the US Family Health Plan at Pacific Medical makes covered services available to enrollees. This area is approved by the Department of Defense.

Skilled Nursing Facility (SNF)

An institution that meets all the following requirements: (1) licensed by the appropriate public authority as a skilled nursing facility; (2) accredited in whole or in a specific part as a skilled nursing facility for the treatment and care of inpatients; (3) engaged mainly in providing skilled nursing care under the supervision of a physician in addition to providing room and board; and (4) is a freestanding or designated unit of another licensed healthcare facility.

Special Care Units

A specific hospital unit that provides concentrated special equipment and highly skilled personnel for the care of critically ill patients requiring immediate, constant, and continuous care. This term applies to intensive care, coronary care, and acute care units of a hospital, but does not include surgical recovery or postoperative rooms. The unit must meet the required standards of the Joint Commission on Accreditation of Healthcare Organizations for special care units.

Split Enrollment

Refers to multiple family members enrolled in TRICARE Prime under different Lead Agents/contractors, including Managed Care Support Contractors (MCSCs) and US Family Health Plan (USFHP)-designated providers.

Sponsor

The active-duty or retired military person who gives eligibility for benefits under TRICARE/US Family Health Plan.

TRICARE Prime

This benefit provides the most comprehensive coverage for healthcare benefits at the lowest cost. Each member has a primary care physician who manages all the individual's healthcare. TRICARE Prime is the same plan type as US Family Health Plan.

TRICARE Standard

The new name for the healthcare option formerly known as CHAMPUS. Under TRICARE Standard, eligible beneficiaries may choose any physician they want for healthcare, and the government will pay a percentage of the cost. Eligible beneficiaries are not required to enroll or pay an enrollment fee.

Urgent Care

Healthcare services that are required within several hours, and, in all cases, after the onset of illness or accidental injury that is not life-threatening. Examples of urgent care situations include a sprained ankle or a cut that needs stitches.

US Family Health Plan Member Card

The card issued by the Plan, identifying a military beneficiary as a member of the Plan and including important co-payment and compliance information. It should be kept with you at all times.

QUICK REFERENCE

Medical Emergencies

For life-threatening emergency treatment..... Call 911
(or your local emergency response number)

To arrange for emergency or urgent care:

- In Area.....Call your Pacific Medical Center
- Out of Area..... Call 1-888-958-7347
- Out of CountryNotify Member Services Department within 7 days of return

Enrollment and Member Services

US Family Health Plan at Pacific Medical Centers
1200 12th Ave South Qtrs 8/9, Seattle, WA 98144.....1-888-95USFHP (1-888-958-7347)

Benefit Questions/Complaints/Compliments/Provider Claims

Member Services.....206-621-4090 or 1-800-585-5883

Enrollment Department/Fee Billing

Enrollment Management Team206-621-4568 or 1-888-958-7347

Pharmacy Services

Automated Refill Line for Maxor1-866-408-2459
Mail-order Pharmacy1-866-408-2459
On-site Clinic Pharmacies.....1-866-262-5812

Website: www.pacificmedicalcenters.org

After-Hours Service

You must call your Pacific Medical Center for authorization before using after-hours urgent care centers.

Renton Pacific Medical Center425-227-3700 or 888-958-7347 option 7
Beacon Hill Pacific Medical Center206-326-2400 or 888-958-7347 option 3
Madison Pacific Medical Center206-505-1000 or 888-958-7347 option 5
Northgate Pacific Medical Center206-517-6600 or 888-958-7347 option 6
Totem Lake Pacific Medical Center425-814-5080 or 888-958-7347 option 8
Lynnwood Pacific Medical Center425-744-7153 or 888-958-7347 option 4
Federal Way Pacific Medical Center253-214-1920 or 888-958-7347 option 9
Medalia/Marysville Clinic.....360-658-6800

Urgent after clinic hours or on weekend's prescriptions can be filled at your local Bartell Drugs pharmacy.

Behavioral Health/Substance Abuse Services

Behavioral Health Department at Pacific Medical Centers206-621-4045

Defense Enrollment Eligibility Reporting System (DEERS)

Manpower Data Center Support Office
DSO attention: COA, 400 Gigling Road Seaside, CA 93955-6771
Toll-free Phone 1-800-538-9552 FAX 1-831-655-8317
Website: <http://www.tricare.osd.mil/DEERSAddress>

