UNITED STATES
GENERAL ACCOUNTING OFFICE

Federal Employees Need Better Information For Selecting A Health Plan

U.S. Civil Service Commission

The Federal Employees Health Benefits Act requires that the Civil Service Commission make available to Federal employees sufficient information to enable them to make informed choices among the available health plans. Under current procedures, however, Federal employees do not receive all the information they need in a format that enables them to effectively compare health plans. GAO suggests the use of consolidated publications as one possible way to improve the dissemination of health plan information.

MWD-76-83

JAN. 26, 1976

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

MANPOWER AND WELFARE
DIVISION

B-164562

The Honorable Robert E. Hampton
Chairman, Civil Service Commission

Dear Mr. Hampton:

This report describes the Civil Service Commission's procedures for providing information to Federal employees on available health plans and recommends, on page 13, an alternative method to enable Federal employees to make better informed choices.

We discussed our recommendation with the Director, Bureau of Retirement, Insurance and Occupational Health, and he agreed to explore the feasibility of this alternative.

As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House and Senate Committees on Government Operations not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of this report today to the Chairmen, House and Senate Committees on Appropriations, Government Operations, and Post Office and Civil Service; the Chairman, House Subcommittee on Retirement and Employee Benefits; and the Director, Office of Management and Budget.

Sincerely yours,

Gregory J. Ahart

Gregory J. Ahart
Director

Contents

ABBREVIATIONS

BRIOH	Bureau of Retirement, Insurance and Occupational Health
CSC	Civil Service Commission
FEHB	Federal Employees Health Benefits
GAO	General Accounting Office
GPO	Government Printing Office

GENERAL ACCOUNTING OFFICE
REPORT TO THE CHAIRMAN OF
THE U.S. CIVIL SERVICE
COMMISSION

FEDERAL EMPLOYEES NEED BETTER INFORMATION FOR SELECTING A HEALTH PLAN
U.S. Civil Service Commission

D I G E S T

THE PROBLEM

The Federal Employees Health Benefits Act (5 U.S.C. 3901) requires the Civil Service Commission to make available to all Federal employees sufficient information to enable the employees to make an informed choice among the available health benefit plans. The House Subcommittee on Retirement and Employee Benefits recommended in House Report No. 93-1205, dated July 18, 1974, that the Commission better inform Federal employees of the health plans available to them. (See p. 7.) However, the Commission has not changed its method of providing such information.

Many of the 3 million active and retired Federal employees could make better informed choices in selecting the health plan best suited to their needs if they

--were aware of all the health plans for which they were eligible,

--received annually all the information needed to select a health plan, and

--could more easily compare benefits of the different plans. (See p. 4.)

For Federal employees who want to consider all pertinent information, selecting a health plan can be a difficult, frustrating task because of all the brochures which must be obtained and analyzed in order to make an informed choice. Any employee wanting to consider all 7 health plans for which all employees are eligible (2 Government-wide and 5 employee organization plans which open their membership to all Federal employees) must obtain and review 11 separate brochures; if eligible for any other plans because of

location or membership in an employee organization, the employee would have to obtain and review additional brochures. (See p. 4.)

Most of the brochures are not generally distributed each open season; therefore, the employee usually must ask for them. The employee must then compare costs, coverage, exclusions, and limitations for the seven or more plans. Trying to comprehend the advantages and disadvantages of one health plan is time consuming. Consequently, doing this for seven or more plans and then comparing them to each other on a benefit-by-benefit basis would rarely be attempted by employees. (See pp. 4 to 7.)

A WAY TO GET BETTER INFORMATION TO EMPLOYEES

GAO believes that the Civil Service Commission could provide better information to employees by developing consolidated publications containing schedules which allow employees to compare the benefits of several plans side-by-side. (See p. 8.)

The Commission could, in one publication, provide employees information on plans for which all employees are eligible (seven), by using a table which would enable them to easily compare plans with each other. The publication could also include information on premium rates and other information needed in choosing a health plan. Additional publications could be used to provide information on health plans available only in certain areas and on employee organization plans restricted to certain employees. (See pp. 8 and 9.)

The State of Washington uses such a publication and has found it very flexible. (See app. II.)

Virtually all Federal employees and agency personnel officials with whom GAO talked preferred such a publication to the numerous brochures now provided. (See p. 11.)

Further, the comparative table could produce additional competition between plans, thereby having a positive effect on both benefits and rates. (See p. 11.)

RECOMMENDATION

GAO recommends that the Chairman of the Civil Service Commission consolidate the various informational and health plan brochures into publications which would enhance the Federal employees' ability to readily compare and make better informed choices among the types of health plans available. (See p. 13.)

CHAPTER 1

INTRODUCTION

The Federal Employees Health Benefits (FEHB) program, established by the FEHB Act of 1959 (5 U.S.C. 8901), provides health insurance coverage for about 3 million Government employees and annuitants and 6 million dependents or survivors. The act gave the U.S. Civil Service Commission (CSC) responsibility for program administration. The cost of the program, which is shared by participating employees and the Government, was about $1.6 billion for fiscal year 1974, of which the Government's share was estimated at $960 million.

HEALTH PLANS OF THE FEHB PROGRAM

CSC's Bureau of Retirement, Insurance and Occupational Health (BRIOH) administers the program and contracts for coverage through the following four types of plans:

--Service Benefit Plan: A Government-wide plan under which the carrier, Blue Cross/Blue Shield, generally provides benefits through direct payments to physicians and hospitals. This plan covers about 5.6 million of the 9 million program participants.

--Indemnity Benefit Plan: A Government-wide plan under which the carrier, Aetna Life Insurance Company, provides benefits by either reimbursement to the employees or, at their request, direct payments to the physicians and hospitals. This plan covers about 1.3 million program participants.

--Employee Organization Plans: These plans, available only to individuals (and members of their families) who are members of the sponsoring organizations, provide benefits either by reimbursing employees or, at their request, by paying physicians and hospitals. Twelve such plans provide coverage to about 1.5 million program participants.

--Comprehensive Medical Plans: These plans, available only in certain localities, provide (1) comprehensive medical services by teams of physicians and technicans practicing in common medical centers or (2) benefits in the form of direct payments to physicians with whom the plans have agreements. Thirty-two such plans provide benefits to about 600,000 program participants.

Of the 46 health plans participating in the FEHB program as of January 1975, all Federal employees are eligible to enroll in the 2 Government-wide plans and 5 of the 12 employee organization plans. (To enroll in the five employee organization plans, however, an employee must join the organization as a full or associate member.) In addition some employees may enroll in comprehensive medical plans or employee organization plans restricted to employees in certain locations or agencies.

The FEHB Act requires that two levels of benefits--high and low options--be offered to enrollees under the two Government-wide plans. Premiums are higher and benefits more comprehensive under the high options than under the low options. Employee organization plans and comprehensive medical plans may offer one or two levels of benefits.

INFORMATION TO EMPLOYEES

One of CSC's responsibilities under the FEHB program is to assure that employees receive sufficient information about the program and the various health plans for which they are eligible.

This responsibility is stated in the FEHB Act, as amended, as follows:

> "Information to employees.
>
> (a) The Civil Service Commission shall make available to each employee eligible to enroll in a health benefits plan under this chapter such information, in a form acceptable to the Commission after consultation with the carrier, as may be necessary to enable the employee to exercise an informed choice among the types of plans described by section 8903 of this title.
>
> (b) Each employee enrolled in a health benefits plan shall be issued an appropriate document setting forth or summarizing the--
>
> (1) services or benefits, including maximums, limitations, and exclusions, to which the employee or the employee and members of his family are entitled thereunder;
>
> (2) procedure for obtaining benefits; and
>
> (3) principal provisions of the plan affecting the employee or members of his family." (Underscoring supplied.)

CSC is to provide information on the various health plans each year before the November 15-30 1/ "open season." However, not all eligible employees receive this information. The open season enables employees not enrolled in a plan to enroll and enrolled and retired, enrolled employees to make changes, such as from one plan or option to another or from self-only to self-and-family coverage. Since the inception of the FEHB program in 1960, CSC has used individual brochures to provide information about the program and the various health plans--one brochure for each health plan and one brochure containing instructions on how to change options during open season.

SCOPE OF REVIEW

We examined applicable legislation, its history, and CSC regulations and procedures for the FEHB program.

We interviewed 100 Federal employees in the Seattle, Washington, and Washington, D.C., areas to determine the extent of their awareness of the health benefit plans for which they are eligible and their opinions on the adequacy of the health benefit plan information they now receive from CSC or through their employer agency. We also interviewed Federal agency personnel officials, representatives of the seven health plans for which all employees are eligible, representatives of the National Association of Retired Federal Employees, and CSC and Government Printing Office (GPO) officials. In addition, we solicited written comments from the seven health plans open to all employees.

We discussed the matters contained in this report with the Director, Bureau of Retirement, Insurance and Occupational Health of CSC.

1/Open season for the 1976 contract period was extended to December 31, 1975, pending the repeal of section 1862(c) of the Social Security Act, as amended (42 U.S.C. 1395), which provides that no payment will be made under the Medicare program after January 1, 1976, for benefits covered under the FEHB program unless prior to that date Federal employees are provided with coverage which would supplement the Medicare program.

CHAPTER 2

FEDERAL EMPLOYEES NEED BETTER INFORMATION FOR SELECTING A HEALTH PLAN

Many of the 3 million active and retired Federal employees could make better informed choices in selecting the health plan best suited to their needs if they

--were aware of all the health plans for which they were eligible,

--received annually all the information needed to select a health plan, and

--could more easily compare benefits of the different plans.

For Federal employees who want to consider all the available information, selecting a health plan can be a difficult, frustrating task because of all the brochures which have to be obtained and analyzed. There are separate brochures containing (1) open season instructions, (2) information describing the FEHB program, (3) information to consider in choosing a health plan, (4) premium rates, and (5) benefits and claim submission information on each health plan. An employee wanting to consider all the relevant information on just the 7 health plans open to all employees must obtain and analyze 11 separate brochures. If the employee is eligible for comprehensive medical plans or restricted employee organization plans, he would have to review additional brochures.

EMPLOYEES UNAWARE OF SOME PLANS AND NOT RECEIVING NEEDED INFORMATION

One problem most employees face in selecting a health plan is that during a typical open season, the employee receives only about 4 of the 11 brochures needed to consider just the 7 plans for which all employees are eligible. The brochures for the five employee organization plans for which all employees are eligible are generally not distributed each open season--most employees must request these brochures. The brochure containing information to consider in choosing a health plan and the brochure describing the FEHB program is distributed on a one-time basis, usually when the employee is hired by the Government. A CSC official said it was not

economically feasible to distribute these brochures to all employees each open season. We estimate that it would cost CSC an additional $500,000 annually to provide each eligible employee complete information on all the plans.

The information in these brochures is needed to enable employees to make informed choices among the types of health benefit plans available to them. However, since they are not distributed annually, most employees are not receiving this information.

Most of the 100 Federal employees we surveyed were aware of their eligibility for the two Government-wide plans. However, none knew they were also eligible for five employee organization plans, even though CSC includes in its "Open Season Instruction" brochure a list of these plans and a statement that they are open to all Federal employees.

Such a reference to the employee organization health plans apparently is not sufficient to make employees aware of these plans or the benefits they offer. For example, many of the Federal employees we interviewed said they were interested in a dental care option. They were not aware that one of the employee organization plans for which they were eligible had such an option. However, employees should be aware that to enroll in any of the five employee organization plans they must join the employee organization as an associate or full member and that four of the plans require annual dues of about $30.

Each open season CSC should provide every eligible enrollee with basic information on the FEHB program and on factors to consider in choosing a health plan. In addition, CSC should make employees more aware of their eligibility for the five employee organization plans. Information on these plans should be as widely disseminated as that for the two Government-wide plans because all employees are eligible for them and one offers a dental care option which is not otherwise available.

BENEFITS AMONG PLANS CANNOT BE READILY COMPARED

Assuming that an employee obtained all the needed informational and health plan benefit brochures, he would find that the format of each health plan brochure was somewhat different. Thus, he could not readily compare the benefits of the plans. A 1970 CSC study regarding the feasibility of summary comparisons of health benefit plans stated, in part, that:

"The brochures, as they are presently designed, lack reasonably uniform formats and do not adequately facilitate an 'informed choice' among the plans.

"This was not always true. The brochures followed a reasonably standard outline and format in 1960. At that time, making the brochures as uniform as possible to facilitate comparison was just as important a goal to the Commission as making the brochures precise enough to show the employee's rights under the contract. All brochures used the same style and size of print to describe limitations and exclusions as well as benefits and contained a page entitled 'Benefits in Brief' which facilitated gross comparison with other available plans. Each had a table of contents so that a specific provision could easily be located in a particular brochure and compared with that in another brochure. This requirement of reasonable standardization benefited Federal employees in several ways:

> "Sales pitches were forbidden--and so was the 'fine print' and 'silent treatment' of undesirable features typical of many plan descriptions. As the plans were laid out in standard outline and format, under these strict (and, for many carriers, unusual) standards, carrier after carrier went back to reconsider its proposed benefits. Every contract, without exception, was revised in this process. Some contracts were actually changed after the brochures had gone to press, usually in the direction of liberalizing benefits, always in the direction of greater clarity. [Underscoring supplied.]

"Because of the variation in the philosophies and benefit structures of the health plans, it was impossible to force each plan into precisely the same format. * * *

"Although these differences made a precisely uniform format infeasible, the formats of the brochures were kept similar to the extent possible. This is not the case since that time. Since 1961, the Commission has by choice allowed the brochures to become increasingly dissimilar so that today they contain numerous inconsistencies which cannot be explained by differences in the plans' benefit structures."

The report also stated that although CSC may recommend that an employee read the brochure he is interested in and compare it with other brochures, this task was time-consuming, tedious, and often frustrating. It stated that indications were that the brochures presented so many details that many Federal employees shied away from, or failed in, attempts at making careful comparisons of the plans. Employees became confused and ended up choosing a plan merely on the basis of a few major benefit provisions or a friend's recommendation.

As a result of this study, CSC made the brochures more uniform. However, the brochures still do not enable employees to readily compare benefits among plans.

The Subcommittee on Retirement and Employee Benefits, House Committee on Post Office and Civil Service, has also expressed concern about the information provided to Federal employees on available health plans. In House Report 93-1205, dated July 18, 1974, the Subcommittee recommended that CSC better inform Federal employees about such health plans. However, CSC has not changed its method of providing health plan information to Federal employees.

CHAPTER 3

A PROPOSED ALTERNATIVE

To resolve the problems discussed in chapter 2, CSC should develop publications which consolidate the information employees need to make informed choices among the health plans available.

CSC had previously experimented with schedules summarizing health plan benefits side-by-side in order to enable employees to more readily compare plans. CSC rejected these attempts because it believed that the summarized information could be misleading and that the plans' structures differ considerably in such areas as copayment provisions and lifetime maximum benefits.

We believe that CSC can develop a publication which would

--assure that employees receive information on each plan for which they are eligible;

--describe the plans' benefits as completely as the individual brochures do now;

--accommodate the differences in plan structures;

--include information on open season procedures and what to consider in choosing a health plan;

--include premium rates;

--include high and low option alternatives; and

--allow the employee to readily compare benefits among plans.

The State of Washington has developed an approach which we believe is flexible enough to provide all of the above advantages. Essentially, it consolidates needed information into one publication. (App. II--which has been reduced to about one-half of its actual size--shows the format of the health plan options available to employees of the State of Washington.)

FEASIBILITY OF CONSOLIDATED PUBLICATIONS FOR THE FEHB PROGRAM

CSC officials and some of the carriers expressed a number of reservations regarding the feasibility of developing

consolidated information publications for the FEHB program. The following sections attempt to answer these questions. To a large extent, the answers are based on the manner in which the State of Washington has handled similar problems in developing its publication.

Our answers are intended to illustrate the feasibility of consolidated publications for disseminating information on the FEHB program. However, other consolidated approaches may be just as feasible, or even better for the FEHB program, and CSC should determine the most acceptable approach for the FEHB program.

How could consolidated publications accommodate all 46 health plans of the FEHB program?

Since employees are not eligible for all plans, a series of publications would be needed. One publication could cover the seven health plans for which all employees are eligible. This publication would contain detailed benefit and premium rate information on each plan and other information, such as the open season procedures and factors to consider in choosing a health plan. All eligible employees should receive this publication each open season.

In addition, to cover the comprehensive health plans related to particular geographical areas, six more publications would be needed. An employee would receive one of these publications if he were located in an area which offered an FEHB comprehensive health plan (31 States do not have such plans). The comprehensive health plan publications could contain from three to six plans depending on the number of plans in a particular geographical area. (For suggestions on how the publications could be compiled and distributed, see app. I.) These publications would contain information only on the comprehensive health plans and would supplement the publication every employee would receive. One additional publication would be needed to cover the seven employee organization plans which are not available to all Federal employees.

Thus, most Federal employees would receive only one or two publications. A few would receive three if they lived in an area which had a comprehensive plan and were employed by an agency which had a restricted employee organization plan.

This approach would be more informative and should be less confusing to employees than analyzing and comparing individual brochures.

Could consolidated publications constitute a contractual statement of benefits?

The individual health plan brochures now constitute a contractual statement of benefits offered by each plan. The explanations of benefits for each plan in consolidated publications could be as inclusive as they are in the individual brochures.

How would consolidated publications enable the employee to more readily compare benefits among plans?

The easiest way to answer this question is to refer to appendix II. (See p. 15.) The example shown presents six health plans side-by-side in a columnar format and lists various benefit categories down the left-hand side. Thus if an employee wants to compare plans in terms of hospital room-and-board coverage, he simply reads the comparative information, from left to right, to determine the coverage and limitations provided under each plan.

How would high and low option be treated in consolidated publications?

In the publication which all employees would receive and in the restricted employee organization publications, there could be a high option section and a separate low option section. The employee could then compare high and low option coverages among plans.

Only one comprehensive plan has a low option. The benefits under this option could be included in a separate column next to the high option column for that plan.

How can consolidated publications cover all the differences among the plans in structure, exclusions, and limitations?

As shown in the example in appendix II, these differences could be accommodated by having a section which narratively explains the structural differences among plans. In addition, the comparative table itself could accommodate structural differences as well as definitions, exclusions, and limitations by providing appropriate categories under the benefits column. For example, benefit number 23 in the State of Washington publication shows the "major medical payment formula." This formula applies only to the first two plans, but is included to fully explain how payments are made under those plans. In addition,

the terms "major medical" plan and "basic plus major medical" plan are defined in the publication. (See p. 16.) The exclusions and limitations of each plan are shown under "benefit category 26," page 25.

Would consolidated publications cost more?

If consolidated publications were used and distributed as we suggest, it would cost more than the individual brochures as currently used. GPO estimated that printing costs for the eight consolidated publications would be about $720,000. CSC's cost estimate for the 1976 brochures was about $627,000. The cost estimate for the consolidated publications, however, is based on the assumption that they will be distributed to all Federal employees and will contain information on all health plans for which the employees are eligible. CSC's estimate would have increased by about $500,000 if it included the cost of providing complete information for just the seven plans for which all employees are eligible. Therefore, although the consolidated publications would cost more than the current brochures, they would provide considerably more information and enable Federal employees to make a better informed choice of health plans.

What do employees and personnel officials think of the consolidated publications?

Using the State of Washington publication as an example, we questioned 100 Federal employees and 4 Federal agency personnel officials on the desirability of having a consolidated publication for the 7 plans for which all employees are eligible instead of the individual brochures. Virtually all of them preferred the consolidated publication. We found that, at least since 1969, employees have been formally suggesting consolidated, comparative formats to CSC as well as to their own agencies.

Based on our interviews and on statements in CSC files, we believe active and retired Federal employees and Federal personnel officials would prefer consolidated health insurance publications.

Are there other advantages to consolidated publications?

Because the benefits of each plan would be laid out side-by-side, allowing employees to readily compare benefits among plans, we believe there would tend to be greater competition among plans. This increased competition could result in improved benefits and incentives to minimize rate increases.

What are the disadvantages of the consolidated publications?

We have not identified any significant disadvantages other than a slight increase in costs. We discussed the desirability of consolidated publications with representatives of the seven FEHB plans available to all Federal employees. Most agreed that a more effective method was needed for providing health plan information to employees. However, they expressed the following concerns about the proposed consolidated publication approach:

--The descriptive wording used in the publications for each plan should be mutually acceptable to both CSC and the carrier.

--Consolidated publications would be lengthy documents.

--A plan's description should not be shortened or summarized just to make more manageable publications.

--Because plans are subject to annual changes in benefits and administrative procedures, the consolidated publications format could be costly due to extensive annual revision.

--The language describing the benefits is very technical and the consolidated publications might confuse employees.

We propose that the wording in the consolidated publications be agreed upon by each carrier and CSC and that it be just as inclusive as it is in the present brochures.

The number of annual revisions to the consolidated publications should not differ from the annual revisions currently made to the individual brochures. The wording would be no more technical than it is now.

Consequently, the concerns expressed by the carriers need not, in our opinion, constitute a disadvantage to the use of the consolidated publications approach. Of course, developing and implementing a new system for providing health plan information would initially require extra effort by CSC and the carriers. After the first year or two, however, procedures should become routine.

In discussing this report, the Director, BRIOH, stated that CSC is considering alternatives to the present system and intends to explore the idea of a side-by-side format.

CHAPTER 4

CONCLUSION AND RECOMMENDATION

CONCLUSION

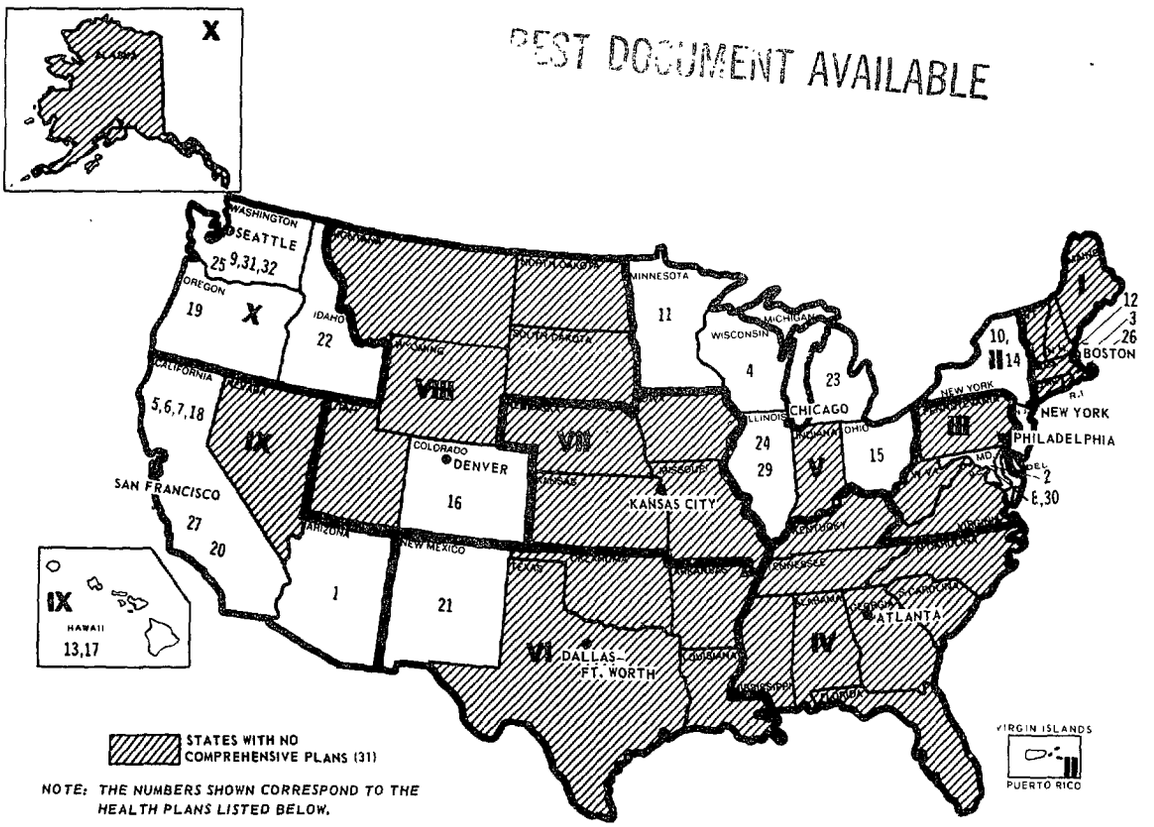
CSC should develop a better way of providing information on health plans to Federal employees. It is unrealistic to expect Federal employees to make informed choices among the types of plans available when they have to contend with the procedures now being used.

Our review has indicated that Federal employees, agency personnel officials, and even some health plan representatives prefer consolidated publications containing all the information needed to enable employees to compare plans and make an informed choice among the types of plans available.

RECOMMENDATION TO THE CHAIRMAN OF THE CIVIL SERVICE COMMISSION

We recommend that CSC consolidate the FEHB program health plan information now contained in numerous brochures into publications which would enhance the Federal employees' ability to readily compare and make more informed choices among the types of health plans available. The consolidated publication contained in appendix II and the proposal discussed in chapter 3 outline one possible approach to resolving this situation.

APPENDIX I



NOTE: THE NUMBERS SHOWN CORRESPOND TO THE HEALTH PLANS LISTED BELOW.

ONE WAY COMPREHENSIVE PLANS COULD BE DIVIDED INTO SIX CONSOLIDATED PUBLICATIONS

The following table shows how comprehensive plans could be divided into publications using the Federal regions as general boundaries. The plan corresponding to each number is listed on the right. The geographical location of the plan is shown on the above map.

Publication No.	Region(s) involved	Comprehensive plans in publication	Total plans in publication
1	I & II	1, 10,12,14,26,28	6
2	III	2, 8, 30 (high and low option)	4[a]
3	V	4, 11, 15, 23, 24, 29	6
4	VI, VIII, lower IX	1, 13, 16, 17, 21	5
5	Upper IX	5, 6, 7, 18, 20, 27	6
6	X	9, 19, 22, 25, 31, 32	6

[a]Includes a separate column for the low option.

COMPREHENSIVE PLANS

1. Arizona Health Plan (Arizona)
2. Columbia Medical Plan (Maryland)
3. Community Health Care Center Plan (Connecticut)
4. Compcare Health Plan (Wisconsin)
5. DePaulo Health Plan, Inc. (California)
6. Family Health Program (California)
7. Foundation for Medical Care (California)
8. Group Health Association (Washington, D.C.)
9. Group Health Cooperative Plan (Puget Sound)
10. Group Health Incorporated Family Doctor Plan (New York-New Jersey)
11. SSS Plan (Puerto Rico)
12. Harvard Community Health Plan (Massachusetts)
13. HMSA Plan (Hawaii)
14. Health Insurance Plan (H.I P.) (Greater New York)
15. Kaiser Community Health Foundation Plan (Cleveland)
16. Kaiser Foundation Health Plan (Denver)
17. Kaiser Foundation Health Plan (Hawaii)
18. Kaiser Foundation Health Plan (Northern California)
19. Kaiser Foundation Health Plan (Oregon)
20. Kaiser Foundation Health Plan (Southern California)
21. Lovelace-Bataan Health Program (New Mexico)
22. Medical Service Bureau Plan (North Idaho)
23. Metro Health Plan (Michigan)
24. Michael Reese Health Plan, Inc. (Illinois)
25. National Hospital Association Plan (Oregon-Washington)
26. RIGHA Health Plan (Rhode Island)
27. Ross-Loos Medical Group (Los Angeles)
28. SSS Plan (Puerto Rico)
29. Union Health Service, Inc. (Illinois)
30. University Affiliated Health Plans, Inc. (Washington, D.C.)
31. Washington Physicians Service (Seattle)
32. Western Clinic Plan (Washington)

APPENDIX II

STATE EMPLOYEES INSURANCE BOARD APPROVED

MEDICAL PLANS

THE 1975 OPEN ENROLLMENT PERIOD ENDS ON JULY 15, 1975. THE EFFECTIVE DATE OF NEW ENROLLMENTS AND COVERAGE CHANGES WILL BE AUGUST 1, 1975. THE FOLLOWING CHANGES MAY BE MADE DURING THE 1975 OPEN ENROLLMENT:

Enroll For The First Time

Transfer Between State Medical Plans

Add Dependents To Your Present Coverage

Drop Dependents From Your Present Coverage

To make any of the above changes in your coverage, or corrections to your personal history (address etc.) write the necessary changes on your pre-printed enrollment form, sign and date and return the first 2 copies of your pre-printed form to your payroll/retirement office. You must sign and return the first 2 copies of the form to your payroll/retirement office even if you do not wish to make any changes.

New premium rates become effective on the July payroll for August 1, 1975 coverage. (See back cover.)

NEW EMPLOYEES AND DEPENDENTS WHO BECOME ELIGIBLE AFTER THE 1975 OPEN ENROLLMENT PERIOD MUST COMPLETE THE MEDICAL PORTION OF THE INSURANCE ENROLLMENT FORM OR A WAIVER CARD WITHIN 31 DAY AFTER BECOMING ELIGIBLE.

(Most Employees Become Eligible When They Begin Working For The State. See Eligibility Rules On Page 3.)

You may enroll yourself and any eligible dependents without evidence of insurability if you enroll within 31 days after becoming eligible. (See eligibility rules inside.) If you do not enroll within 31 days, evidence of insurability satisfactory to the carrier (and provided at your expense) may be required. Transfers between plans are not permitted outside of an open enrollment period. To enroll, complete the medical portion of the insurance enrollment form and submit it to your agency payroll office. If you do not wish to enroll, submit a waiver card. Read inside before making your choice.

SAVE THIS PAMPHLET FOR FUTURE REFERENCE

This is a certificate of coverage. This pamphlet is not a contract. The benefits are subject to the terms, conditions, and limitations of the contracts between the State Employees Insurance Board and the carriers. Benefit payments are based solely on the contracts. Please read this pamphlet carefully before you choose a plan. The State Employees Insurance Board cannot control the extent or quality of services offered by the various carriers. Before enrolling you should assure yourself that the plan you are interested in offers the convenience and level of care that you and your family will feel comfortable with. This pamphlet was prepared by the Insurance Benefits Section, Washington State Department of Personnel, 600 South Franklin Street, Olympia, Washington, with the approval of the carriers.

AUG 1 7 '75

APPENDIX II

YOUR QUESTIONS ANSWERED

Q. DO ANY SPECIAL RULES APPLY DURING THE 1975 OPEN ENROLLMENT PERIOD?

A Yes The special rules are shown below:

1 Make changes and corrections (if any) on the pre printed enrollment form, sign and date and return the 1st 2 copies to your payroll/retirement office YOU MUST RETURN YOUR SIGNED AND DATED PRE-PRINTED FORM EVEN IF YOU DO NOT WISH TO MAKE ANY CHANGES. No evidence of insurability is required for any enrollments or tranfers during the open enrollment period. Eligible people who have not been previously covered under a State plan may enroll as new employees during this period, including employees and dependents whose coverage has been previously declined on evidence of insurability

2 Employees will be permitted to transfer between State plans For any plans having pre-existing condition restrictions (except maternity), people covered on and before July 30, in any State plan will be considered to have satisfied required waiting periods, regardless of the length of time they were so covered

3 With respect to basic maternity benefits under Plan I, people not previously covered, or who were previously covered under Plan II and who change to Plan I will not be eligible for the basic maternity benefits for conceptions occuring prior to the beginning of coverage under Plan I.

4 Enrolled eligible females who change from Plan I to Plan II during the open enrollment period will remain eligible for the $300 Plan I maternity benefit for an existing pregnancy if, at the time of conception, they were covered under Plan I

5 Employees transferring from Plan I to Plan II, who have satisfied any part of their 1975 deductible under the major medical portion of Plan I, will have it credited to the Plan II deductible. However, any such expenses credited to the Plan II deductible which exceed $50 will not be eligible for payment under Plan II

6 For employees transferring from Plan II to Plan I Any expenses credited to satisfy the 1975 Plan II deductible (plus any out-of-pocket expenses paid as a result of having paid 20% of expenses over the deductible of Plan III will be credited to the deductible of Plan I. However, Plan I will **not pay** any expenses incurred prior to the beginning of coverage under Plan I.

Q. WHAT IS AN OPEN ENROLLMENT PERIOD?

A An open enrollment period is a period set by the State Employees Insurance Board to allow employees to:

1 Enroll in a state medical plan without evidence of insurability (for employees who did not enroll within 31 days after becoming eligible).

2. Add eligible dependents to their medical plan without evidence of insurability (for dependents who were not enrolled within 31 days after they became eligible)

3. Change from one state medical plan to another without evidence of insurability.

Open enrollment periods will not be held more than once a year Future open enrollments will be announced in advance

Q. UNDER THE STATE'S MEDICAL INSURANCE PROGRAM, DO I HAVE A CHOICE OF PLANS?

A. Yes There are two plans available statewide:
PLAN I (basic plus major medical plan underwritten by Washington Physicians Service and Blue Cross, Washington-Alaska, Inc.)
PLAN II (straight major medical plan underwritten by Blue Cross, Washington-Alaska, Inc.)

Panel medicine plans are available as a third option when an employee resides in a part of the state that is served by one of the approved panel plans. The available panel plan's service areas are shown below·

GROUP HEALTH COOPERATIVE OF PUGET SOUND—Snohomish, King, and Thurston Counties, the City of Chehalis, and those parts of Lewis, Grays Harbor and Mason Counties within a 25-mile radius of the Olympia Group Health facility.
KAISER FOUNDATION HEALTH PLAN—Clark and Skamania Counties, Washington, and the Portland, Oregon metropolitan area
INLAND HEALTH ASSOCIATION—Stevens, Pend Oreille, and Spokane Counties
WESTERN CLINIC—Pierce County

Q. WHAT IS A "MAJOR MEDICAL" PLAN?

A. The term "major medical" is used in the insurance industry to apply to a method of claim payment The term does **not** apply to the size of your individual medical bills The major medical payment formula begins with a **deductible** which you must pay out of your own pocket. After the deductible, the plan pays a **percentage** of your covered medical expenses All of the benefits under Plan II, for example, are paid under this type of formula

Q. WHAT IS A "BASIC PLUS MAJOR MEDICAL" PLAN?

A. This type of plan pays some medical expenses in **full** (or up to a specified amount) These are the "basic" benefits. Such plans also pay some other expenses under the "major medical" payment formula described above Plan I is a "basic plus major medical plan."

Q. WHAT IS A "PANEL MEDICINE" PLAN?

A. Panel medicine plans are also sometimes called "group practice" plans or "health maintenance organizations" A panel medicine plan is a health care plan operated by an organization that employs or contracts for its own physicians and other staff, owns its own hospital and/or clinics, and primarily provides medical **services** rather than cash payment for medical expenses Because you normally go to a panel plan's own facilities for most treatment, you may enroll in those plans only when you live in their service area.

Q. WHAT THINGS SHOULD I CONSIDER IN SELECTING MY STATE MEDICAL PLAN?

A. **You can be enrolled in only one state plan. Because you cannot normally change plans outside of an open enrollment period, your choice of a plan is a very important decision.**

No plan pays all medical expenses in full. To choose a plan, you should first read **all** of the provisions for **all** of the plans available in your area of residence The summary of benefits in this pamphlet is arranged so that you can compare the benefits and provisions easily Next, consider your family's health history. What coverage is provided for the medical expenses you can foresee? What portion of the service will be provided or paid for by each of the plans? Also, consider the coverage each plan provides for major illnesses and accidents that can strike anyone unexpectedly. All of the state's plans provide good coverage for the large medical expenses, but the coverage does vary from plan to plan Evaluate each plan's coverage for the major expenses as well as the minor ones.

What limitations or exclusions (if any) apply to medical services you might want? Some provisions require that you be covered for a period of time in order to have certain care provided or paid for. (For one example, compare the maternity benefits in all plans.) Consider these waiting periods carefully Waiting periods are waived for some people. **See the special rules applying to people who enroll or re-enroll during the 1975 open enrollment period.**

Consider your choice of a doctor under each plan Each of the panel medicine plans maintains a staff of medical doctors from which you choose your family physician. He will refer you to the care of specialists as needed. If you enroll in Plan II, your health care may be provided by any licensed medical doctor, osteopath, chiropractor, or podiatrist you choose. You may also go to any of these practitioners if you are covered by Plan I except that practitioners employed by or contracting with any of the state's four panel medicine plans are not covered under Plan I.

Consider coverage for preventive care. Panel medicine plans provide some types of care which are designed to prevent disease and illness Preventive care is not covered under Plans I and II.

Consider the premiums you will have to pay. **Do not select a plan based on premium alone.** However, you should calculate how much your annual premiums would be for each of the available plans in your area. Your personal philosophy about medical coverage is also an important factor. Some people feel they can afford to pay part of their medical expenses out of their own pocket, but want to be protected against catastrophic illnesses and accidents or a succession of smaller expenses that add up in a year. Because they are taking a larger part of the risk, they want to pay a smaller premium. Plan II was designed with these people in mind. Other people want more extensive coverage for common minor medical expenses as well as the major ones. These people are willing to pay a higher premium for the more extensive coverage, and they usually choose Plan I or a panel medicine plan where available You can see that selection of a medical plan is a decision that must be made by each individual This pamphlet has been designed to give you the information upon which to base your decision

APPENDIX II

Q. WHICH STATE EMPLOYEES ARE ELIGIBLE TO ENROLL IN THE INSURANCE BOARD'S MEDICAL PLANS?

A. The following state employees are eligible to enroll in any of the state plans:

1. FULL-TIME EMPLOYEES: Those who work the full-time workweek in their agency.
2. PERMANENT PART-TIME EMPLOYEES: Those who do not work full-time, but who are under continuous employment by an agency, and who are scheduled to work at least 80 hours per month.
3. CAREER SEASONAL EMPLOYEES: Those who work at least 80 hours per month during a designated season for a minimum of three months per year and who have an understanding of continued employment with their agency season after season. These employees become eligible to enroll when they return to state employment for their second season.
4. APPOINTED AND ELECTED OFFICIALS: Legislators are eligible on the date their term begins. All other elected and full-time appointed officials of the legislative and executive branches of state government are eligible on the date their term begins or they take the oath of office, whichever occurs first.
5. JUDGES: Justices of the Supreme Court and judges of the Court of Appeals and the Superior Courts, become eligible on the date they take the oath of office.
6. RETIRED STATE EMPLOYEES: These employees are eligible if they are receiving a benefit from the Washington State Public Employees' Retirement System, the State Teacher's Retirement System, the State Judges Retirement System, or the Washington State Patrol Retirement System. The surviving spouse of a deceased retired employee may continue coverage as long as that spouse is receiving a benefit from the retirement system.

NOTE: Temporary employees (those scheduled to work for six months or less) are not eligible to enroll in the State medical plans.

Q. WHAT IF BOTH HUSBAND AND WIFE ARE ELIGIBLE STATE EMPLOYEES?

A. In this case, each must enroll separately as an employee. All dependent children must be enrolled under one parent. This method of enrolling allows both employees to receive the State's premium contribution. Also, in some instances the coverage is slightly higher for an "employee" than it is for a "dependent spouse." Insuring separately as two employees allows both husband and wife to receive the higher benefits.

Q. HOW IS THE STATE CONTRIBUTION APPLIED?

A. The state's insurance contribution is $35.00 per month. The first 75¢ of the contribution is applied to Part A of the life insurance program. If you enroll in Parts B, C, or D of the life insurance program the remaining $34.25 will be applied to these premiums. Any remaining portion of the state contribution will be applied toward your medical insurance premium. This priority of distribution was established in order to maximize the employees opportunity for income tax deduction of health premiums.

Q. CAN I CHANGE TO ANOTHER STATE PLAN WHENEVER I WANT TO?

A. No. With one exception, you may change from one state plan to another only during an open enrollment period. **Consider the available plans carefully before you make your initial choice.** If you are enrolled in a panel medicine plan and you transfer **out of** that plan's service area, you may enroll in any approved plan in your new locality within 31 days after the date you move. (If you are in a statewide plan and you are transferred **into** a panel plan service area, you may not change your enrollment to the panel plan until the next open enrollment period.)

Q. ARE MY DEPENDENTS ALSO ELIGIBLE FOR STATE MEDICAL COVERAGE?

A. Yes. You may enroll the following persons as your dependents.

Plan I (Underwritten by Washington Physicians Service and Blue Cross, Washington-Alaska, Inc.)

and

Plan II (Underwritten by Blue Cross, Washington-Alaska, Inc.)

1. Wife or husband.
2. Children who are unmarried and under 19 years of age.
3. Unmarried children 19 years old but less than 24 years old who are dependent upon the employee for maintenance and support, and who are registered students in regular, full-time attendance at an accredited secondary school, college, university, vocational school, or school of nursing.
4. Dependent children who have reached their nineteenth birthday but are incapable of self-sustaining employment because of mental retardation or physical handicap that began while eligible will continue to be eligible during the duration of their physical or mental handicap

Group Health Cooperative Plan

1. Wife or husband.
2. Children who are unmarried and under 21 years of age.
3. Unmarried children 21 years old but less than 24 years old who are dependent upon the employee for maintenance and support, and who are registered students in regular, full-time attendance at an accredited secondary school, college, university, vocational school, or school of nursing.
4. Dependent children who have reached their twenty-first birthday but are incapable of self-sustaining employment because of mental retardation or physical handicap that began while eligible will continue to be eligible during the duration of their physical or mental handicap

Kaiser Foundation Health Plan

1. Wife or husband.
2. Children who are unmarried and under 21 years of age.
3. Unmarried children 21 years old but less than 23 years old who are full-time students at an accredited college and are not gainfully employed.
4. Dependent children who are incapable of self-support due to mental retardation or physical handicap incurred prior to attaining age 21, and who were members when they attained age 21.

Inland Health Association Plan

1. Wife or husband
2. Unmarried children under age 19 years
3. Unmarried children 19 years old but less than 23 years old who are chiefly dependent upon the employee and who are regularly attending classes at an accredited institution of education.
4. Unmarried dependent children who have reached their 19th birthday and who are incapable of self-sustaining employment by reason of their physical handicap or mental retardation that began while eligible.

Western Clinic Plan

1. Wife or husband
2. Unmarried children under 22 years of age residing with the employee
3. Dependent children who have reached their 22nd birthday who are incapable of self-sustaining employment because of mental retardation or physical handicap which began while eligible will continue to be eligible during the duration of the physical or mental handicap

Q. IF I ACQUIRE NEW DEPENDENTS AFTER I AM ENROLLED, HOW CAN I ENROLL THEM?

A. If you acquire additional eligible dependents through marriage, birth, or adoption, you may enroll them without evidence of insurability within 31 days after they become eligible. To enroll your new dependents, submit a SEIB Health Change Notice (form IE-21) to your payroll office. On the form list the name(s) of dependent(s) you wish to add.

Coverage for new dependents will normally begin on the first of the month following a premium payment for their coverage. However, your newborn children will be covered from birth if they are enrolled within 31 days after they are born.

Q. CAN I CONTINUE MY STATE MEDICAL PLAN WHEN I RETIRE FROM STATE SERVICE?

A. If you are enrolled in a state medical plan, you may continue coverage after retirement if you are going to receive a monthly benefit from a State Retirement System. You can also continue dependent coverage for any eligible dependents who are insured under your active-employee coverage at the time of retirement.

The state makes no premium contribution for retired employees. You must pay the full premium after retirement.

To continue your coverage after retirement, you must submit a new insurance enrollment form to your retirement system. They should receive your insurance enrollment form at least 30 days before the effective date of your retirement. You may not change plans at the time of retirement.

APPENDIX II

Q. HOW DOES COVERAGE UNDER THE STATE MEDICAL PLANS APPLY TO A PERSON WHO IS ELIGIBLE for MEDICARE?

A When a person becomes eligible for Medicare, coverage under the state plans changes People become eligible for Medicare at age 65. Since July 1, 1973, some disabled people under age 65 also are eligible for Medicare. (Contact your nearest U S. Social Security Office for details) Medicare has two parts **Part A** covers hospital expenses and **Part B** covers medical expenses. Coverage under the state plans assumes you are enrolled in both parts of Medicare

Medicare Coordinated Coverage Under Plans I and II

For people **over age 65,** Plans I and II have a Medicare Supplement plan For these people, the benefits and premiums are the same whether they are in Plan I or II The coverage under both Supplements works this way.

To Supplement Part A of Medicare (hospital benefits), the Supplement pays Medicare's $92 deductible, the $23 per day of hospital charges that Medicare does not pay for your 61st through 90th day of hospital confinement, and the $46 per day of hospital charges that Medicare does not pay when you use your 60-day lifetime reserve of hospital days.

To Supplement Part B of Medicare (medical benefits), the Supplement pays Medicare's $60 deductible, and the 20% of medical expenses that Medicare does not pay IIf Medicare does not allow a full medical charge, the difference between Medicare's allowance and the usual and customary charge will also be paid by the Supplement) **The Supplement also pays** 80% of the following charges up to a lifetime maximum of $20,000 after the patient has paid the first $100 for these expenses in a calendar year· hospital expenses incurred after the complete exhaustion of Medicare's hospital benefits (including the 60-day lifetime reserve), out-of-hospital prescription drugs, chiropractic care not covered by Medicare, medical expenses incurred outside of the U S , cost of blood and derivatives that are not replaced, special duty registered nurses (but not visiting nurses or convalescent or nursing home care). $1,000 of the $20,000 lifetime maximum is automatically replaced each year.

In Plans I and II, people **under age 65 who are eligible for Medicare** pay the under 65 premiums. Also they have basically the same scheduled benefits as people in their plan who do not have Medicare There are two main differences though The **first** difference is that for these people, after Medicare pays its benefits first, Plan I or II will apply its "under 65" benefits to the covered expenses that Medicare did not pay. Under this method of payment, you can receive payment for up to 100% of your covered expenses but payment in excess of 100% will not be made The **second difference** is that you can receive a refund of the premium you must pay for Part B of Medicare for coverage of a person under age 65 At the end of each calendar year (or termination of your state coverage), a refund will be made of the premiums paid for Part B for a person under age 65

care Coordinated Coverage Under the State's Panel Medicine Plans

The state's four panel medicine plans also have benefits designed to supplement Parts A and B of Medicare. All plans provide benefits on the assumption that people eligible for Medicare are enrolled in both parts **People under age 65** who are eligible for Medicare pay the same premiums and receive the same benefits as a prson over age 65 For details about the panel plans' Medicare Supplements, contact the plan involved.

Q. DO I NEED TO TAKE ANY SPECIAL STEPS WHEN SOMEONE LISTED ON MY INSURANCE ENROLLMENT FORM BECOMES ELIGIBLE FOR MEDICARE?

A Yes. The coverage under all state medical plans assumes that you are enrolled in **Parts A and B** of Medicare if you are eligible. You should enroll in Medicare about two months before you become eligible in order to have your Medicare coverage begin on the earliest possible date. About 90 days before you or your spouse attain age 65 you will receive a letter and enrollment form advising you of changes in your coverage and premium changes You must sign the enrollment form and return it to your payroll/retirement office.

Q. IF I HAVE A QUESTION ABOUT THE STATE MEDICAL PLANS, WHO CAN ANSWER IT FOR ME?

A For questions about enrollment and administration of the state medical plans, contact your agency personnel or payroll office. If you have a question about a specific claim, you should contact the carrier involved. If you are not able to obtain the information you want from these sources, contact the Insurance Benefits Section, Department of Personnel, 600 South Franklin, Olympia, Washington 98504.

Q. ARE THERE CIRCUMSTANCES WHEN AN EMPLOYEE MAY RETAIN GROUP COVERAGE WHEN NOT ACTIVELY AT WORK?

A. Yes. An insured employee who is not actively at work may retain their state group coverage

1 Between seasons of employment if they are a career seasonal employee
2 Up to 24 months during an authorized educational leave without pay or during a lay off because of a reduction in force, provided they do not enroll in another employer-sponsored plan, or
3. Up to 12 months during an authorized leave other than an educational leave.

Also, a female employee who leaves state service because of pregnancy may pay full premiums and retain full coverage until 60 days after her pregnancy terminates or she returns to any active employment, whichever comes first.

Except for employees whose employment is terminated because of total disability, an employee retaining coverage as outlined above makes premium payments through his payroll office. Employees whose employment is terminated due to disability pay premiums through the Benefits Section Payments must be made by the 15th of each month for coverage in the following month Checks or money orders must be payable to the **State Treasurer.** The state does not make premium contributions for employees who are not actively on the payroll.

When a person's employment is terminated because of total disability, and he qualifies for continuation of coverage as a "retired employee", he must continue his coverage through his retirement system. The one-year limitation for continuation of coverage does not apply to disabled employees who retire.

Q. IF I WANT TO DROP STATE COVERAGE FOR MYSELF OR MY DEPENDENTS, HOW DO I DO IT?

A. You may drop medical coverage at any time. If you want to drop coverage for yourself and/or your dependents, complete an SEIB Health Change Notice form listing the coverage you want to delete, and return the form to your payroll/retirement office. The deleted coverage will normally end on the last day of the month following your last premium payment.

It is your responsibility to submit an SEIB Health Change Notice form to your payroll/retirement office when your dependents become ineligible (because of age, etc.) If you continue premium deductions for an ineligible dependent, it does not mean that the ineligible dependent is covered. If you drop coverage on yourself or an eligible dependent, evidence of insurability may be required to re-enroll at a later date. You may not re-enroll dependents under the Kaiser plan until the next open enrollment.

Q. IF AN EMPLOYEE OR DEPENDENTS BECOME INELIGIBLE FOR STATE GROUP COVERAGE, CAN THEY CONVERT TO ANOTHER PLAN WITH THE SAME CARRIER?

A. Yes. All of the state plans have a conversion privilege. However, under the individual conversion plans, coverage and/or premiums will be different than the state plan with the same carrier. Persons wishing to convert must enroll in the appropriate conversion plan within 31 days after state group coverage ends. If a person converts within 31 days, conversion coverage will be retroactive to begin the day after group coverage ends. You should obtain details about the conversion coverage, premiums, and enrollment in advance. To obtain information about the conversion plans, contact the carrier that underwrites your plan.

Q. WHY IS ALCOHOLISM COVERED UNDER ALL OF THE INSURANCE BOARD'S MEDICAL PROGRAMS?

A National statistics indicate that alcoholics tend also to have other medical problems at a much higher rate than non-alcoholics. By covering the other ailments, but not covering the alcoholism itself, the cost to the State employees medical programs would be higher. This is because the other ailments could be expected to recur if the alcoholism itself were not treated. For this reason, the State Employees Insurance Board has long covered alcoholism in each of the State medical plans. (See descriptions of coverage in Benefit 19, Page 9.)

As an employer, the State has a forward looking policy which recognizes alcoholism as a treatable illness Under this policy employees cannot be penalized if they seek treatment for their illness. If you have a drinking problem or supervise an employee whose performance is affected by abuse of alcohol, assistance and referral to an approved alcoholic treatment facility may be obtained from the Employee Advisory Service, Washington State Department of Personnel, phone (206) 753-3260 (or SCAN 234-3260).

All inquiries are kept in the strictest confidence.

APPENDIX II

Q. HOW DO I CLAIM BENEFITS UNDER PLANS I AND II?

A. After you enroll, you will receive a claim kit containing ID cards, claim forms, and a booklet describing your chosen plan. Washington Physicians Service (WPS) is a state-wide organization of medical bureaus. Blue Cross, Washington-Alaska, Inc. is part of a nation-wide organization providing hospital and other health coverage. Since these two organizations **jointly** underwrite Plan I but Blue Cross, Washington-Alaska, Inc. underwrites Plan II **alone**, the claims procedures for the two plans are different. Claim forms for Plan I or Plan II are available at your payroll office, from the Benefits Section, Department of Personnel, 600 South Franklin, Olympia, or from the carrier of your plan. Use of the proper form and procedure will speed the processing of your claims.

PLAN I CLAIMS

Plan I Claims For People Not Covered By Medicare

Type of Service	Claims Procedure
WPS participating physicians (see list in claim kit) and Blue Cross hospital charges.	Show the hospital's or doctor's billing office your ID card. They will submit claims for you to the appropriate Blue Cross office or local medical bureau.
Non-participating physicians (those not on WPS list), laboratory, X-ray, and other medical expenses **except drugs.** (Also use this procedure for doctor care received in Yakima County or outside of Washington State.)	Submit completed 3-part WSP claim form and an **itemized bill** to medical bureau serving your county. Some providers of care will do this for you. Ask when you receive care. Claims for Yakima County residents and permanent out-of-state residents should be sent to King County Medical, Seattle.
Prescription drugs (covered under major medical).	*Submit completed drug and medicine record form to the medical bureau serving your county* **Do not** submit drug bills with form—save them for tax purposes.

Plan I Claims For People Covered By Medicare (Under Or Over Age 65)

1. **First,** make sure that all hospital and medical bills are claimed to Medicare. Many providers of care will do this for you (ask when you receive care). Medicare will return a form called an "Explanation of Medicare Benefits."
2. **Next,** make a claim for the state's coverage. You do this by submitting the "Explanation of Medicare Benefits" and a completed 3-part WPS claim form to the medical bureau serving your county. Claims for Yakima County residents or permanent out-of-state residents go to King County Medical, Seattle.
3. Some expenses are not covered by Medicare at all but are covered under the state's coverage. These expenses include costs for prescription drugs, blood and derivatives if not replaced, special duty registered nursing, medical care received outside the U.S , and medical care received after Medicare benefits have been exhausted. **You do not need to claim these special expenses to Medicare.** Drug expenses should be claimed using the drug claim procedure listed above for people not covered by Medicare. The other special expenses not covered by Medicare should be claimed by submitting the 3-part WPS claim form along with itemized bills to the medical bureau serving your county.

Addresses

The addresses of medical bureaus are on a special sheet in your claim kit. The address for submitting claims to Medicare can be obtained from your nearest Social Security Administration Office.

NOTE: For Plan I claims to which the major medical deductible applies, WPS prefers that you save the bills and submit your claim when you have satisfied the deductible.

PLAN II CLAIMS

Plan II Claims For People Not Covered By Medicare

Type of Service	Claim Procedure
Expenses for hospital care (Covered under major medical.)	Show the billing office your ID card. They will submit claims for you
Non-hospital medical expenses (doctor visits, laboratory, x-ray, etc.) **except drugs.** (Covered under major medical)	Submit completed 2-part Blue Cross claim form and itemized bills. (Clark and Skamania County claims go to Blue Cross of Oregon Others go to Blue Cross, Washington - Alaska.) Many providers of care will submit claims for you. Ask when you receive care.
Prescription drugs. (Covered under major medical.)	Submit completed Blue Cross drug record (Clark and Skamania County claims go to Blue Cross of Oregon. Others go to Blue Cross, Washington-Alaska.)

Plan II Claims For People Covered By Medicare (Under Or Over Age 65)

1. **First,** make sure that all hospital and medical bills are claimed to Medicare. Many providers of care will make claims for you. (Ask when you receive care.) Medicare will return a form called an "Explanation of Medicare Benefits."
2. **Next,** make a claim for the state's coverage. You do this by submitting the "Explanation of Medicare Benefits" and a completed 2-part Blue Cross claim form. Clark and Skamania County claims go to Blue Cross of Oregon All others go to Blue Cross, Washington-Alaska, Inc.
3. Some expenses are not covered by Medicare at all but are covered under the state's coverage. These expenses include costs for prescription drugs, blood and derivatives if not replaced, special duty registered nursing, medical care received outside of the U.S., medical care received after Medicare benefits have been exhausted. **You do not need to Claim these expenses to Medicare.** Drug expenses should be claimed using the drug claim procedure listed for people not covered by Medicare. The other special expenses not covered by Medicare should be claimed by submitting the 2-part Blue Cross claim form along with itemized bills. Clark and Skamania County claims go to Blue Cross of Oregon All others go to Blue Cross, Washington-Alaska, Inc.

Addresses

Blue Cross, Washington-Alaska, Inc., P O. Box 327, Seattle, Washington 98111. Send claims from Clark and Skamania Counties to: Blue Cross of Oregon, 100 S W. Market, Portland, Oregon 97207. The address for submitting claims to Medicare can be obtained from your nearest Social Security Administration Office.

NOTE: Blue Cross prefers that you submit your claims soon after expenses are incurred—even if your deductible is not yet satisfied

Q. WHEN DOES COVERAGE BEGIN UNDER THE STATE MEDICAL PLANS?

A. 1975 open enrollments become effective on August 1, 1975. For people who enroll within 31 days after they become eligible (new employees, etc.), coverage normally begins on the first of the month following their first premium payment This is usually the first of the month following the first payroll deduction, however, for some employees who are paid on lag payrolls, the effective date is one month later For some enrolled people, there are additional restrictions on the beginning of coverage.

Under **Plans I and II,** if an enrolled employee is in a hospital when they would normally become covered, their coverage does not begin until they leave the hospital Dependents who are in a hospital on the day they would normally become covered (or within 31 days before) do not become covered until they have been out of all hospitals for 31 days

Under **Kaiser Foundation Health Plan,** people in the hospital on the day their coverage would normally begin may be moved to the Kaiser-Permanente Hospital In this case, their coverage begins when they go to the Kaiser-Permanente Hospital. Otherwise, coverage begins when they leave the non-Kaiser-Permanente Hospital

Under **Inland Health Association,** an enrollee who is in a hospital on the day that coverage would otherwise commence may be moved to the Tri-County Hospital Coverage begins on the date the enrollee is under the care of an Association physician

Under **Group Health Co-operative,** people in the hospital on the day their coverage would normally begin may be moved to the Group Health Hospital In this case, their coverage begins when they go to the Group Health Hospital Otherwise, coverage begins when they leave the non-Group Health Hospital

Under **Western Clinic,** coverage begins on the first day of the month following the first premium payment provided the patient is under the care of a Western Clinic physician or transfers their care to such physician on that date

NOTE: Even though coverage begins, restrictions may apply to pre-existing conditions under any plan. (See Summary of Benefits #21.)

Q. WHAT IS THE STATE EMPLOYEES INSURANCE BOARD?

A. The State Employees Insurance Board was established by the State Legislature to design medical, life, liability, income protection, and accidental death and dismemberment plans for State agency and Higher Education employees The Board is composed of The Director of the Department of Personnel, a representative of the Governor, a representative of a union and a representative of an association certified to represent bargaining units of employees under the Board's jurisdiction, an administrator and two faculty members from the State's Higher Education System, a State Senator and a State Representative

Carriers to underwrite the plans are selected through competitive bidding (except those Panel Plans which the Board is required to offer by law) All insurance carriers and health care contractors licensed to do business in Washington were given an opportunity to bid

SUMMARY OF BENEFITS UNDER MEDICAL PLANS APPROVED BY THE INSURANCE BOARD FOR STATE EMPLOYEES

WAITING PERIODS SHOWN BELOW ARE WAIVED FOR SOME EMPLOYEES AND DEPENDENTS. SEE SPECIAL RULES FOR 1975 OPEN ENROLLMENT PERIOD ON PAGE 2.
BENEFITS DESCRIBED BELOW APPLY TO PEOPLE NOT ELIGIBLE FOR MEDICARE, FOR MEDICARE COORDINATED BENEFITS SEE PAGE 4.

BENEFITS	PLAN I underwritten by WASHINGTON PHYSICIANS SERVICE AND BLUE CROSS, WASHINGTON-ALASKA, INC. (Basic Plus Major Medical Plan) Unless a restriction is stated below, the benefits listed apply to employee and dependents THIS PLAN IS AVAILABLE STATEWIDE.	PLAN II underwritten by BLUE CROSS, WASHINGTON-ALASKA, INC. (Straight Major Medical Plan) Unless a restriction is stated below, the benefits listed apply to employee and dependents. THIS PLAN IS AVAILABLE STATEWIDE.	GROUP HEALTH COOPERATIVE OF PUGET SOUND (Panel Medicine Plan) Unless a restriction is stated below, the benefits listed apply to employee and dependents THIS PLAN IS AVAILABLE ONLY TO RESIDENTS OF SNOHOMISH, KING AND THURSTON COUNTIES, THE CITY OF CHEHALIS, AND THOSE PARTS OF LEWIS, GRAYS HARBOR, AND MASON COUNTIES WITHIN A 25-MILE RADIUS OF THE OLYMPIA GROUP HEALTH FACILITY.	KAISER FOUNDATION HEALTH PLAN (Panel Medicine Plan) Unless a restriction is stated below, the benefits listed apply to employee and dependents. THIS PLAN IS AVAILABLE ONLY TO RESIDENTS OF CLARK AND SKAMANIA COUNTIES, WASHINGTON AND THE PORTLAND, OREGON, METROPOLITAN AREA. (MEMBERS MAY USE KAISER-PERMANENTE FACILITIES IN OTHER REGIONS WHILE TRAVELING—SOME PARTS OF CALIFORNIA, COLORADO, HAWAII, OHIO.)	INLAND HEALTH ASSOCIATION (Panel Medicine Plan) Unless a restriction is stated below, the benefits listed apply to employee and dependents THIS PLAN IS AVAILABLE ONLY TO RESIDENTS OF STEVENS, PEND OREILLE, AND SPOKANE COUNTIES.	WESTERN CLINIC (Panel Medicine Plan) Unless a restriction is shown below, benefits listed apply to employees and dependents THIS PLAN IS AVAILABLE ONLY TO RESIDENTS OF PIERCE COUNTY.
1. HOSPITAL ROOM AND BOARD	Paid in full up to the semi-private room rate for up to 365 days per confinement for a covered illness or accident Cardiac and intensive care units are also paid in full Custodial or convalescent care is not covered Maternity is not covered under this benefit. See maternity provision under benefit 10.	80-90% of the usual and customary semi-private room rate is covered under major medical payment formula (see benefit 23) for covered illnesses and accidents. Cardiac and intensive care units are covered under this benefit Custodial or convalescent care is not covered See benefit 10 for the only maternity expenses that are covered.	Provided in full for covered conditions when Group Health Hospital or Group Health approved hospital is used This includes cardiac and intensive care units when prescribed by a Group Health physician.	Provided in full up to 365 days per covered condition per calendar year when Kaiser-Permanente Hospital is used. This includes private room and any specialized care when prescribed by a Permanente Clinic physician. Custodial and convalescent care is not covered.	Provided in full for covered conditions when confined in Tri-County Hospital. No limitation on hospital days. Paid at 80% for covered conditions for confinement in a non-IHA hospital when approved in advance by the IHA Medical Director (Also see Benefits 22 and 25).	The following room and board benefits apply when hospitalized in St. Joseph, Tacoma General, or Allenmore Hospitals for treatment of a covered condition by a Clinic physician. (Hospital care for maternity is provided at Tacoma General Hospital only) For the employee, room and board is provided in full up to the four-bed ward rate for up to 180 days for each covered condition. For dependents, room and board is provided in full up to $80 per day for up to 90 days per covered condition. Private room for employee or dependents is provided in full under this benefit for up to 30 days when isolation is required by the hospital. Intensive care and cardiac units are provided in full under this benefit for up to 30 days when prescribed by a Clinic physician.
2. OTHER HOSPITAL SERVICES	Paid in full for in-hospital services, supplies, equipment and medicines which are prescribed by a doctor for medical treatment of a covered illness or accident. Personal comfort items such as radio, T V., etc. are not covered.	80-90% covered under major medical (see benefit 23) for in-hospital services, supplies, equipment, and medicines which are prescribed by a doctor for treatment of covered illness or accident. Personal items such as radio, T.V., etc. are not covered.	Provided in full when confined in Group Health Hospital or other approved Hospital under the care of a Group Health physician. Personal comfort items such as telephone, T.V., etc. are not covered.	Provided in full in a Kaiser-Permanente Hospital when prescribed by a Permanente Clinic physician Personal comfort items such as radio, T V., etc., are not covered.	Provided in full for covered conditions in Tri-County Hospital. Paid at 80% for covered conditions for confinement in a non-IHA hospital when approved by IHA physician. (Also see benefits 22, 25) Items such as radio, T V etc, are not covered.	Provided in full for employees up to 180 days for each covered condition when prescribed by a Clinic physician. Provided in full for dependents for the first 30 days and at 80% for the next 60 days. Personal comfort items such as radio, T.V., etc., are not covered.
3. HOSPITAL OUTPATIENT CARE	Paid in full for first treatment of covered accidents within 72 hours after the accident. For covered illnesses, hospital charges for outpatient care are covered under major medical (see benefit 23) and doctor care is provided as an office visit (see benefit 5) If an outpatient surgical procedure is performed, or if the patient is immediately confined as an inpatient, all outpatient charges are paid in full.	80-90% covered under major medical payment formula (see benefit 23) for covered illnesses and accidents.	Provided in full for covered illnesses and accidents when Group Health Hospital or Medical Center is used.	Outpatient care is provided for a charge of $2 per visit for covered illnesses and accidents.	Provided in full for covered illnesses or accidents when Tri-County Hospital or an IHA Medical Center is used.	Emergency treatment shall be furnished in St. Joseph, Tacoma General or Mary Bridge Children's Hospitals by Clinic physicians or by non-Clinic physicians when specifically authorized in advance by a Clinic physician. In addition, 80% of the hospital charges are covered for emergency accidents within 12 hours after the accident and 50% of the hospital charges are covered for emergency illnesses.
4. EMERGENCY AMBULANCE	Paid in full at the usual and customary rate for local professional ambulance service to or from the nearest hospital qualified to give necessary care in connection with a life endangering medical emergency an accident, or a period of	80-90% covered under major medical payment formula (see benefit 23) for local professional ambulance service to or from the nearest hospital qualified to give the necessary care in connection with a life endangering medical emer-	Paid in full within the Group Health service area when approved by a Group Health physician. (See also benefit 25).	Paid in full for ambulance service to the Kaiser-Permanente Hospital within a 30-mile radius of a Kaiser-Permanente facility when authorized by a Permanente Clinic physician.	Covered up to $35 when approved by an IHA physician.	Paid in full for employee only when approved by a Clinic physician.

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	commencement. Ambulance benefits are not provided for maternity.	gency, an accident, or a period of confinement. Ambulance benefits are not provided for maternity.				
5. DOCTOR VISITS	Doctor visits at the usual and customary rate, including consultations with specialists, are paid in the following way for all covered illnesses and accidents: Hospital visits (up to 365 days per confinement) and all home and office visits are paid in full except that the first home or office visit per dependent per calendar month is covered only under major medical (see benefit 23). Prescription drugs and injections provided in the doctor's office are covered only under major medical (see benefit 23). The supplemental accident benefit may be applied to dependents' first visits in a month if the visits result from an accident (see benefit 22). Doctor visits for maternity are provided only under benefit 10.	All office, home, and hospital doctor visits are 80-90% covered under the major medical payment formula (see benefit 23) for covered illnesses and accidents.	Hospital and office visits are provided in full for covered illnesses and accidents when Group Health physician is used. Necessary consultations with specialists are also provided under this benefit. Home visits are also provided within designated geographic limits (call GHC for details).	Hospital visits for covered illnesses and accidents are provided in full when Kaiser-Permanente Hospital and Permanente Clinic physicians are used. Office visits are provided for a charge of $2 and home visits for a charge of $3 when Permanente Clinic physicians are used.	Hospital and office visits are provided in full for covered illnesses and accidents when an IHA physician is used. Necessary consultations with specialists outside of an IHA facility are paid at 80% when referred by an IHA physician.	Hospital visits for covered illnesses and accidents are provided in full when under the care of a Clinic physician at St. Joseph, Tacoma General, or Allenmore hospitals. For the employee, all home and office visits for covered conditions are also provided in full. For dependents, office visits are provided for a charge of $1 per visit and home visits for a charge of $5 per visit plus 50 cents per mile outside of Tacoma city limits one way. Consultations with Clinic or other Tacoma specialists are provided at the above rates when prescribed by a Clinic physician or at the reasonable request of the patient.
6. DIAGNOSTIC X-RAY AND LABORATORY	Paid in full at the usual and customary rate for covered accidents and illnesses.	80-90% covered under major medical payment formula (see benefit 23) for covered illnesses and accidents.	Provided in full when prescribed by a Group Health physician for covered illnesses and accidents.	Provided in full as prescribed by a Permanente Clinic Physician for covered illnesses and accidents. $2 per office visit is charged.	Provided in full for covered illnesses and accidents when prescribed by an IHA physician. Paid at 80% for diagnostic procedures at non-IHA facilities when referred by an IHA physician.	Provided in full as prescribed by a Clinic physician for covered accidents and illnesses.
7. SURGERY	Surgical charges at the usual and customary rate, including assistant surgeon and anesthesiologist, are paid in full for covered accidents and illnesses. For surgery of the oral region, the services of a dentist are paid in full at the usual and customary rate only for the reduction of a fracture or dislocation of the jaw or facial bones, excision of tumors or cysts from the jaws, cheeks, lips, tongue, gums, roof and floor of the mouth; and incision of salivary glands and ducts. The following types of surgery are not paid in full but are paid under the major medical payment formula shown in benefit 23. 1. Charges for cosmetic surgery necessary (a) because of a non-occupational accident occurring while covered, or (b) to repair a congenital anomaly in a covered child, or (c) for restoration purposes necessitated by previous surgery performed while covered. Other cosmetic surgery is not covered. 2. Charges for the services of a dentist for treatment of accidental injuries to natural teeth sustained while covered, including initial replacement of such teeth, provided treatment begins within twelve months from the date of the accident. Dental care and dental procedures not specified under benefit 7, and routine foot care (such as trimming of corns, calluses and toenails) are not covered.	Major or minor surgery is 80-90% covered under major medical payment formula (see benefit 23) for covered illnesses and accidents. This coverage also applies to assistant surgeon and anesthesiologist. Cosmetic surgery is covered only if it is necessary (a) because of a non-occupational accident occurring while insured, or (b) to repair a congenital anomaly in a covered child, or (c) for restoration purposes necessitated by previous surgery performed while covered. Other cosmetic surgery is not covered. Surgery of the oral region: Services of a dentist are covered only for the reduction of a fracture or dislocation of the jaw or facial bones; excision of tumors or cysts of the jaws, cheeks, lips, tongue, gums, roof and floor of the mouth; incision of salivary glands and ducts; treatment of accidental injury to natural teeth sustained while covered, including initial replacement of such teeth, provided treatment begins within 12 months from the date of the accident. Dental care and dental procedures not specified above are not covered. Provisions for surgery related to certain complications of pregnancy are shown in benefit 10. Routine foot care such as the trimming of corns, calluses, and toenails is not covered.	Provided in full for covered illnesses and accidents when Group Health facilities and Permanente Clinic physicians are used. Assistant surgeon and anesthesiologist are included in this benefit. Voluntary sterilizations are provided when approved and performed by a Group Health physician. Voluntary sterilizations are elective surgeries and are performed when staff is available. Cosmetic and dental surgery and surgery to correct conductive deafness are not covered.	Provided in full for covered illnesses and accidents when Kaiser-Permanente facilities and Permanente Clinic physicians are used. This benefit includes assistant surgeon and anesthesiologist when required. Cosmetic and dental surgery is not covered.	Provided in full for covered illnesses and accidents when IHA physicians and facilities are used. Assistant surgeon and nurse anesthetist included in this benefit. Paid at 80% for surgery at non-IHA facilities when referred by an IHA physician. Surgery for conductive deafness is not covered. Dental surgery is not covered except for accidental injury to natural teeth performed within six months after such accident. Cosmetic surgery is not covered except as made necessary by accidental injuries.	Provided in full for covered accidents and illnesses when Clinic physician or specialists provided by the Clinic are used. This benefit includes assistant surgeon and anesthesiologist when required. Cosmetic and dental surgery are not covered.
8. X-RAY AND RADIATION THERAPY	Paid in full at the usual and customary rate for covered accidents and illnesses.	80-90% covered under major medical payment formula (see benefit 23) for covered illnesses and accidents.	Provided in full when prescribed by a Group Health physician.	Provided in full as prescribed by a Permanente Clinic physician. $2 per office visit is charged.	Patients requiring this treatment are referred to an approved non-IHA facility and 80% of the cost of such treatment is paid.	Provided in full as prescribed by a Clinic physician.
9. PREVENTIVE CARE AND MEDICINE	Preventive care is not covered. Preventive care includes such things as routine screening examinations or tests not required by an illness or accident, immunizations, care for exogenous obesity, contraceptive devices and drugs, and food supplements.	Preventive care is not covered. Preventive care includes such things as routine screening examinations or tests not required by an illness or accident, immunizations, care for exogenous obesity, contraceptive devices and drugs, and food supplements.	Periodic health evaluations are provided in full when sufficient current medical history is not available to Group Health. Periodic weight control and smoking withdrawal programs and child care classes and family planning counseling are available to Group Health members.	Routine physical examinations by a Permanente Clinic physician are provided at patient's request. $2 per office visit is charged. Physical exams requiring a physician's certificate are provided at an additional charge. Immunizations for polio, diphtheria, tetanus, whooping cough, smallpox, and measles are provided at a cost of $3 per office visit.	Periodic health evaluations are provided in full when an IHA physician is used. Physical exams requiring a doctor's certificate are not covered. Preventive services also include immunizations, family planning and well child care.	Physical examinations by Clinic physicians are provided as needed. Immunizations are also provided for contagious or infectious diseases.

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BENEFITS	PLAN I	PLAN II	GROUP HEALTH COOPERATIVE	KAISER FOUNDATION	INLAND HEALTH	WESTERN CLINIC
10. MATERNITY BENEFIT	The basic maternity benefit under this plan will be provided to enrolled female employees, spouses and unmarried dependent children provided they are insured under Plan I at the time of conception. The plan covers up to $150 of the hospital and infant nursery care and up to $150 for doctor costs for pregnancy. Benefit is payable at any termination of pregnancy, including normal delivery, legal abortion, miscarriage or Caesarian section. In addition, the following complications of pregnancy are covered under the major medical payment formula (See Benefit 23): Caesarean section, surgical operations for extra-uterine pregnancy or for other complications requiring intra-abdominal surgery after termination of pregnancy, pernicious vomiting of pregnancy (hyperemesis gravidarum), and toxemia with convulsions (eclampsia of pregnancy). Complications of less severity are covered only under the $300 basic maternity benefit above.	Expenses related to maternity are not covered except that the following complications of pregnancy are 80-90% covered under major medical payment formula shown in benefit 23; caesarean section, surgical operations for extra-uterine pregnancy or other complications requiring intra-abdominal surgery after termination of pregnancy, pernicious vomiting of pregnancy (hyperemesis gravidarum), and toxemia with convulsions (eclampsia of pregnancy). Complications of less severity are not covered. Complications listed above are covered for enrolled female employees, spouses, and unmarried dependent children.	This benefit is provided for enrolled female employees, spouses, and unmarried dependent children for a fee of $287.50. This plan provides hospital in full when Group Health hospital or other Group Health approved hospital is used. Prenatal, delivery and postnatal physician's care is provided in full when Group Health physician is used.	This plan provides maternity benefits for enrolled female employees, spouses, and unmarried dependent children. If continuously enrolled for 10 months before delivery, full obstetrical care (including Permanente Clinic physician and Kaiser-Permanente hospital services) are provided in full after patient pays any supplemental charges such as $2 charge for office visits. If the 10-month enrollment requirement is not met, a fee of $120 is charged for this coverage (payable 30 days before confinement) plus any supplemental charges. Baby care is provided in full during mother's confinement.	Maternity benefits will be provided for enrolled female employees, spouses, and unmarried dependent children. For a fee of $140, IHA will provide full prenatal, delivery and postnatal care for any pregnancy in which conception occurs while continuously enrolled, when such care is rendered by an IHA physician. Pediatric care for newborns is provided in full at IHA facilities.	When a female employee or an employee's female dependent is continuously covered under this plan from time of conception, full obstetrical care is provided for a maternity charge of $50 when a Clinic physician is used. Hospital room and board and other hospital services are provided as for any other condition under the care of a Clinic physician. Hospital care for maternity is provided only at Tacoma General Hospital. (See benefit 1 for hospital room and board provisions.) For newborns, while the mother is confined, the Clinic pays the daily nursery charge up to $35 per day. Other well-baby care after delivery is provided in full by Clinic physicians. The service charge for incomplete abortions requiring hospitalization is $35. Therapeutic abortions are provided for a service charge of $50.
11. PRESCRIPTION DRUGS	In-hospital drugs are paid in full. Out-of-hospital drugs requiring written prescription, drugs administered in doctor's office and insulin are covered under major medical (benefit 23). Drugs for preventive medicine, obesity, contraceptives, or not requiring a prescription are not covered.	Drugs requiring a written prescription and insulin are 80-90% covered under the major medical payment formula (see benefit 23). Drugs prescribed for preventive medicine or obesity and contraceptives are not covered.	Provided in full when prescribed by a Group Health physician for treatment of illness or accident. Dietary supplements, tranquilizers, and drugs not listed in the GH Formulary are not covered. Contraceptive drugs and devices are provided when prescribed by GH physician.	In-hospital drugs are provided in full as prescribed by a Permanente Clinic physician. Out-of-hospital drugs may be purchased at reasonable rates at Kaiser-Permanente pharmacies when prescribed by a Permanente Clinic Physician.	In-hospital drugs are provided in full when prescribed by an IHA physician. Out-of-hospital drugs prescribed by an IHA physician are provided at a substantial savings when purchased at an IHA facility and included in the IHA formulary.	In-hospital drugs are provided in full as prescribed by a Clinic physician. Drugs administered by injection at the Clinic are also paid in full. Other drugs are not covered.
12. ORTHOPEDIC APPLIANCES	Charges for the following appliances when prescribed by a doctor to treat a covered accident or illness are covered under the major medical payment formula (see benefit 23): casts and splints; crutches, trusses or braces (or rental of such appliance if customarily rented); oxygen and rental of equipment for its administration; rental of a wheelchair, hospital-type bed, iron lung or other durable medical-surgical equipment; artificial eyes or limbs for initial replacement of natural eyes or limbs; and internal prosthetic devices. Such items as hearing aids, corrective shoes, post-operative shoes, arch supports, foot castings, and eye glasses are not covered.	Charges for the following appliances when prescribed by a doctor to treat a covered accident or illness are covered under the major medical payment formula (see benefit 23): cast and splints; crutches, trusses or braces (or rental of such appliance if customarily rented); oxygen and rental of equipment for its administration; rental of a wheelchair, hospital-type bed, iron lung or other durable medical-surgical equipment; artificial eyes or limbs for initial replacement of natural eyes or limbs; and internal prosthetic devices. Such items as hearing aids, corrective shoes, post-operative shoes, arch supports, foot castings, and eye glasses are not covered.	Temporary appliances are furnished for use during treatment up to a maximum of six months. Casts for filling and purchase of hearing aids, artificial eyes, arch supports, corrective shoes, braces, artificial members, and nontherapeutic devices are not covered.	Not covered.	Temporary orthopedic appliances are loaned by IHA at no cost up to six months when approved by an IHA physician. Permanent appliances are not covered.	Temporary orthopedic appliances are loaned free of charge by the Clinic when prescribed by a Clinic physician. When purchase of a temporary appliance is necessary, the Clinic pays 50% of the cost. Permanent appliances are not covered.
13. BLOOD AND ITS DERIVATIVES	Administration of blood and derivatives is paid in full for covered illnesses and accidents. Charges for blood or derivatives will only be paid if the blood cannot be replaced.	Administration of blood and derivatives is 80-90% covered under the major medical payment formula (see benefit 23). Charges for blood or derivatives will be paid only if the blood cannot be replaced.	Not covered except that administration of blood and its derivatives is provided in full.	Blood and derivatives are provided without charge if replaced. If not replaced, Kaiser-Permanente provides administration only and patient pays for blood or derivatives used.	Blood and derivatives are provided without charge if replaced. If not replaced, IHA provides administration only and patient pays for blood and derivatives used.	Not covered except that administration of blood or derivatives is provided in full.
14. MENTAL AND NERVOUS CONDITIONS	Inpatient treatment for mental and nervous conditions is covered under the major medical payment formula (see benefit 23) up to a maximum of $1,500 per year. Outpatient psychiatric care is not covered.	Inpatient treatment for mental and nervous conditions is 80-90% covered under the major medical payment formula (see benefit 23) up to a maximum of $1,500 per year. Outpatient psychiatric care is not covered.	Up to 16 in-patient and/or out-patient psychiatrist visits per calendar year are provided in full. Additional visits within the year cost $5.75 each. In addition to the above, GHC will provide up to $500 per calendar year for in or out-patient care in the treatment of mental and nervous conditions including alcohol and drug abuse. The care may be rendered in or out of GHC facilities and is subject to approval by the Co-operative.	Inpatient and outpatient psychiatric care is provided up to an annual service value of $1,000 with the patient paying 50% of the cost. This benefit is provided for care in Kaiser-Permanente facilities or if referred to another nongovernmental facility by a Permanente Clinic physician. See benefit 22 for additional coverage.	Up to 7 days of hospitalization at Tri-County Hospital per diagnosis is provided in full.	Upon referral by a Clinic physician, in- or out-of-hospital diagnosis and up to 15 therapeutic visits per year are provided. Chronic conditions, drug addiction, and court-ordered treatment are not covered. The Clinic pays for 50% of the cost of hospital treatment for mental conditions exceeding $200 for up to 15 days hospitalization per year when prescribed by Clinic physician.
15. BONE AND EYE BANK CHARGES	Bone and eye bank charges for covered illnesses and accidents are covered under the major medical payment formula (see benefit 23).	Bone and eye bank charges for covered illnesses and accidents are 80-90% covered under the major medical payment formula (see benefit 23).	Paid in full for a covered illness or accident.	Not covered.	Not covered.	Not covered.

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16. **SPECIAL DUTY NURSING**	Special duty registered nurses are covered only under the major medical payment formula (see benefit 23). Special nursing which is part of the cost of cardiac and intensive care units is paid in full under benefit 1.	Special duty registered nurses are 80-90% covered under the major medical payment formula (see benefit 23) for covered illnesses and accidents. Special nursing which is a part of a cardiac or intensive care unit is also covered.	Special duty nursing is provided in full when prescribed by a Group Health physician for a covered illness or accident.	Provided in full when hospitalized in a Kaiser-Permanente Hospital for up to 365 days per calendar year when prescribed by a Permanente Clinic physician.	In-hospital special duty nursing is provided in full for covered conditions when prescribed by an IHA physician.	Not covered except when it is part of the charge for intensive care or cardiac units. See benefit 1.
17. **PHYSIO-THERAPY**	In-hospital physiotherapy is paid in full at the usual and customary rate. Outpatient physiotherapy by a registered physiotherapist is covered as an office visit when prescribed by a doctor. See benefit 5 for rules applying to office visits for employees and dependents.	80-90% covered under major medical payment formula (see benefit 23) for covered illnesses and accidents. Physiotherapy must be prescribed by a doctor and provided by a registered physiotherapist.	Provided in full as ordered by a Group Health physician for covered illness or accident.	Out-of-hospital physiotherapy for covered illnesses and accidents is provided for a charge of $2 per visit when prescribed by a Permanente Clinic physician. In-hospital physiotherapy is provided in full when received at a Kaiser-Permanente Hospital.	Physiotherapy is provided in full for covered conditions when prescribed by an IHA physician.	Provided in full for employee when Clinic facilities and staff are used. A charge of $1 per visit is made for dependents.
18. **EYE REFRACTIONS**	Not covered.	Not covered.	Provided in full when Group Health optometrists are used. Eye glasses are available at special member rates when purchased through Group Health's optical department. Contact lenses, including the examination and fitting, are not covered.	A charge of $2 per visit is made for eye refractions and examinations. Glasses may be purchased at reasonable rates at Kaiser-Permanente optical facilities.	Provided in full upon referral by an IHA physician. Eye glasses are not provided.	Provided in full for employees when Clinic facilities and staff are used. A charge of $1 per refraction is made for dependents. Eye glasses are not provided.
19. **ALCOHOLISM**	Therapeutic treatment of the physical effects of alcoholism is covered as any other illness. Treatment of the mental and nervous causes of alcoholism is covered as any other mental or nervous condition (see benefit 14). Inpatient treatment in an approved alcoholism treatment facility is also covered.	Therapeutic treatment of the physical effects of alcoholism is covered as any other illness. Treatment of the mental and nervous causes of alcoholism is covered as any other mental or nervous condition (see benefit 14). Inpatient treatment in an approved alcoholism treatment facility is also covered.	Included in the nervous and mental condition benefit (see benefit 14).	Covered the same as a mental and nervous condition (see benefit 14). Psychiatric benefits for alcoholism include care in the SWARF Program when referred by a Permanente Clinic physician.	Benefits for alcoholism limited to $500 for inpatient treatment upon referral by an IHA physician.	Treatment for alcoholism is covered up to $360 per year per family member in an approved alcoholic treatment facility.
20. **DRUG ADDICTION**	Therapeutic treatment of the physical effects of drug addiction is covered as any other illness. Treatment of the mental and nervous causes of drug addiction is covered as any other mental or nervous condition (see benefit 14)	Therapeutic treatment of the physical effects of drug addiction is covered as any other illness. Treatment of the mental and nervous causes of drug addiction is covered as any other mental or nervous condition (see benefit 14).	Included in the nervous and mental condition benefit (see benefit 14).	Covered as a mental and nervous condition (see benefit 14).	Treatment for drug addiction is not covered.	Treatment for drug addiction is not covered.
21. **CONGENITAL AND PRE-EXISTING CONDITIONS**	Congenital conditions are covered as any other conditions. See benefit 7 for details on surgery for some congenital conditions. Pre-existing conditions are those that are treated or diagnosed within 3 months before enrollment. Such conditions are not covered under the major medical part of this plan until the person having the condition has been insured for one year. This waiting period does not apply to the basic benefits.	Congenital conditions are covered as other conditions. See benefit 7 for details on surgery for some congenital conditions. Conditions treated or diagnosed within 3 months before enrollment are not covered under this plan for one year afterward	Covered as any other condition. See all previous benefits	Congenital conditions and pre-existing conditions are covered in the same way as other conditions when services are rendered at Kaiser-Permanente facility. Services at non-Kaiser-Permanente facilities when referred by a Permanente Clinic physician, are covered in accordance with the Supplemental benefits. (See benefit 22.)	Covered as any other condition. See all previous benefits.	Conditions for employees: After a six month waiting period, these are covered up to $1,000 exclusive of service of Western Clinic physicians, surgeons and/or technicians. For dependents, conditions known when coverage commences are not covered. Chronic conditions manifesting themselves within the first six months of coverage are regarded as pre-existing and no benefits are provided. Chronic conditions first manifesting themselves more than six months after coverage is effective, covered up to $1,000 excluding the value of services rendered by Clinic. These exclusions do not include services by physicians and technicians on the Clinic staff. Congenital anomalies (conditions and malformations present at birth) covered to $1,000 when newborn child covered under Clinic contract.

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BENEFITS	PLAN I	PLAN II	GROUP HEALTH COOPERATIVE	KAISER FOUNDATION	INLAND HEALTH	WESTERN CLINIC
22. SUPPLEMENTAL BENEFITS	This plan has a supplemental accident benefit which pays up to $300 per non-occupational accident for doctor, hospital, and registered nursing care expenses resulting from an accident that are not paid by other parts of this plan. (For example, this benefit will be applied to dependents' first office visits that result from an accident and are not paid by the doctor visit benefit). To be covered under this benefit, expenses must be incurred within 90 days after the accident. This benefit does not cover drugs.	Not applicable to this plan. Covered under other provisions.	Artificial kidney machine and related treatment prescribed by a Group Health physician are covered up to $10,000 per calendar year with patient paying 20%. Initial training on machine paid in full.	In addition to the basic benefits described in this newspaper, the following Supplemental Benefits are provided to an annual maximum payment of $25,000 per member for the aggregate of all the following: 1. EMERGENCY BENEFITS WITHIN THE SERVICE AREA: Health Plan will pay 80% of reasonable charges for emergency medical, hospital and ambulance services from non-Kaiser-Permanente providers, in case of (a) a life-threatening illness requiring hospitalization, or life-threatening injury; or (b) a member, not of his own or his guardian's volition, being taken to a non-Kaiser-Permanente provider for emergency care for non-life-threatening illness or injury; subject to all other provisions regarding emergency-care benefits. 2. BENEFITS OUTSIDE THE SERVICE AREA: After payment of the $1,000 described elsewhere in this newspaper under "Emergency Benefits" for out-of-area injuries or illness, Health Plan will pay 80% of reasonable costs for care; subject to all other provisions regarding out-of-area emergency care. 3. PSYCHIATRIC CARE: After the base benefits for psychiatric conditions have been exhausted, Health Plan will pay 50% of the cost of care, subject to all provisions regarding psychiatric conditions. 4. CONGENITAL CONDITIONS: If referred in writing by a Permanente physician, Health Plan will pay 80% of the reasonable cost of care for congenital conditions requiring treatment at non-Kaiser-Permanente facilities. 5. CHRONIC RENAL DIALYSIS AND KIDNEY TRANSPLANTS: If referred in writing by a Permanente physician, Health Plan will pay 80% of the reasonable cost of care for chronic renal dialysis or kidney transplants.	As indicated above, IHA will provide 80% of approved care in facilities other than its Medical Centers and Tri-County Hospital. Such benefits are payable up to $20,000 per enrollee.	Not applicable to this plan. Covered under other provisions.
23. MAJOR MEDICAL PAYMENT FORMULA	You will note that some benefits under Plan I are paid in full at the usual and customary rate (basic coverage) and that other benefits are paid under "major medical." The major medical portion of this plan has a $100 deductible per person per calendar year with a maximum of three deductibles per family per year. If two or more family members are injured in the same accident, one deductible applies to the expenses incurred as a result of that accident. Excluded items may not be counted toward the deductible. For those items covered under major medical, the following payment formula is used: After the required deductible is satisfied, Plan I pays 80% of the reasonable charges for covered expenses up to a lifetime maximum of $20,000. This maximum is in addition to the benefits that are paid in full. Up to $1,000 of the maximum is restored automatically each year.	This plan has a $50 deductible per person per calendar year with a maximum of three deductibles per family per year. If two or more family members are injured in the same accident, one deductible applies to the expenses incurred as a result of that accident. Excluded items may not be counted toward the deductible. None of the benefits of Plan II are paid in full. All Plan II benefits are paid in the following way: After the required deductible is satisfied, this plan pays 80% of the reasonable and customary expenses for covered illnesses and accidents up to $2,000 per year. The plan then pays 90% of the reasonable covered expenses above $2,000 for the remainder of that calendar year, subject to a lifetime maximum of $50,000. Up to $5,000 of the maximum benefits is restored automatically each year. The full maximum may be restored with evidence of insurability.	Not applicable to this plan. Covered under other provisions.	Not applicable to this plan. Covered under other provisions.	Not applicable to this plan. Covered under other provisions.	Not applicable to this plan. Covered under other provisions.

APPENDIX II

24. COVERED PHYSICIANS AND OTHER PRACTITIONERS	Physician services covered by this plan may be provided by a licensed medical doctor, chiropractor, osteopath, podiatrist, or dentist (see benefit 7 for extent of covered services of a dentist). Services of physicians employed by or contracting with any of the state's panel medicine plans are not covered.	Physician services covered by this plan may be provided by any licensed medical doctor, chiropractor, osteopath, podiatrist, or dentist (see benefit 7 for extent of covered services of a dentist).	Group Health employs a staff of medical doctors, optometrists, psychologists, and psychiatric social workers to provide services listed above at Group Health's facilities. You choose your family physician from among those associated with the plan. In the event an enrollee receives services from a practitioner of healing arts not on the GHC staff, the enrollee may obtain reimbursement of reasonable charges for covered services rendered within the service area and subject to Section 26 of this newspaper. In addition, the enrollee must complete a GHC claim form for these services only. All x-ray exams ordered by such practitioner must be received at the GHC facility. Manipulative treatment of the spine is limited to five per year and to one series of x-ray exams in connection with those treatments. (See also Section 26) Group Health facilities must be used except as provided in benefit 25 or upon referral by a Group Health physician.	The Kaiser Foundation contracts with Permanente Clinic for medical doctors and employs optometrists to provide the service outlined above within Kaiser-Permanente facilities You choose your family physician from among those associated with the plan Kaiser-Permanente facilities must be used except as provided in benefit 25 or upon referral by clinic physician.	IHA employs a regular staff of medical doctors to provide the services listed above within the IHA facilities. Referrals and consultations with non-IHA physicians are covered as noted above up to the maximums listed in benefit 22 You choose your family physician from among those associated with the plan. IHA facilities must be used except as provided in benefits 22 and 25 or upon referral by an IHA physician.	The clinic employs a regular staff of doctors to provide the services listed above within Clinic facilities. Consultations with staff specialists included as above. Consultations are provided with recognized Tacoma specialists upon referral by a Clinic physician or upon reasonable request and prior approval by Clinic administration. You choose your family physician from among those associated with the plan. Clinic facilities must be used, except as provided in benefit 25.
25. AREA WHERE BENEFITS ARE PROVIDED	Coverage is available worldwide but covered individuals must have a permanent residence in the United States, Canada, or Puerto Rico. Hospital confinement in Washington or Alaska must be in a Blue Cross, Washington-Alaska, Inc., participating hospital to be covered.	Coverage is available worldwide but covered individuals must have a permanent residence in the United States, Canada, or Puerto Rico Hospital confinement in Washington or Alaska must be in a Blue Cross, Washington-Alaska, Inc., participating hospital to be covered.	Coverage shown above applies to services received at Group Health's facilities within the Group Health service area (see addresses below). Emergency care outside the service area is covered in the following way: The first $555 is subject to patient payment of 10%, or $55, whichever is greater Any portion over $555 is payable at 80%, by Group Health and 20% by the patient. Of the above, $30 may be used for transportation to point of initial care and up to $100 for necessary and approved transportation to Group Health Cooperative.	Coverage outlined above applies to services received at Kaiser-Permanente facilities. (See addresses below.) Emergency care for accidental injury while you are temporarily more than 30 miles from a Kaiser-Permanente facility will be reimbursed up to $1,000 until it is medically feasible to travel to a Kaiser-Permanente facility. (See benefit 22 for additional coverage.) Emergency care for illness when you are both more than 30 miles from your home and from a Kaiser-Permanente facility, will be reimbursed to the extent services would have been covered at a Kaiser-Permanente facility. Care that could have been foreseen (e.g., full-term childbirth), or which could be postponed until return is not reimbursed. Emergency accidents or illnesses treated at non-Kaiser-Permanente facilities within the service area (because of circumstances beyond the member's control) will be reimbursed as stated in Section 22. For all treatment in non-Kaiser-Permanente facilities, Kaiser Foundation Health Plan must be informed within 48 hours of initial emergency treatment and patients must be moved to Kaiser-Permanente facilities as soon as medically practical. Any limitations that apply to care at Kaiser-Permanente facilities also apply to out-of-area care	Coverage shown above applies to services which are provided at IHA facilities within the IHA service area (see addresses below) and at other approved medical facilities upon referral by an IHA physician. Emergency care rendered outside of the IHA service area is covered at 80% after a $25 deductible, up to a maximum of $20,000. (When medically feasible IHA will arrange for such emergency patients to be moved to an IHA facility.)	Coverage shown above applies to services which are received at Clinic owned or approved facilities within the Clinic (see addresses below). Necessary emergency care outside the service area or county of residence is paid in full for the employee up to $1,000. Such emergency care for dependents is covered up to $1,000 with a $25 deductible.
26. EXCLUSIONS AND LIMITATIONS	In addition to any exclusions and limitations outlined above, this plan does not cover occupational illnesses and accidents; custodial, convalescent or rehabilitative care; sterilization; sterility, impotency or frigidity; routine well baby care and circumcision, admission or treatment primarily for rehabilitative care (including, but not limited to, speech and occupational therapy), exogenous obesity; care not medically necessary for treatment of illness or injury; orthoptic care, charges in excess or usual and customary rates; and charges patient is not legally obligated to pay or which are reimbursable through a governmental agency	In addition to any exclusions and limitations outlined above, this plan does not cover occupational illnesses and accidents; custodial, convalescent, and rehabilitative care; sterilizations; sterility, impotency or frigidity; routine well baby care and circumcision; exogenous obesity; admission or treatment primarily for rehabilitative care (including, but not limited to, speech and occupational therapy); care not medically necessary for treatment of an illness or injury, orthoptic care; charges in excess of usual and customary rates, and charges the patient is not legally obligated to pay or which are reimbursable through a governmental agency.	In addition to any exclusions and limitations outlined above, this plan does not cover conditions covered by Workmen's Compensation or similar statute or private occupational insurance, dental care, orthoptic care not prescribed by Group Health physician, care for sterility, impotency, and frigidity, tuberculosis, conditions resulting from major disaster, major epidemic, or military action, and care not provided at Group Health facilities except as expressly provided above Drugs prescribed for the above exclusions and limitations are not covered.	In addition to any exclusions and limitations outlined above, this plan does not cover conditions requiring specialized facilities (such as inpatient care for tuberculosis, post-polio and neuromuscular rehabilitation, conditions covered by Workmen's Compensation, military service-connected conditions, dental care, and corrective appliances acupuncture, speech therapy and podiatric services. Benefits for self-inflicted injuries or illness, drug addiction and alcoholism are limited to the psychiatric care coverage described in benefits 14 and 22	In addition to any exclusions and limitations above, this plan does not cover occupational illnesses or accidents; eyeglasses, hearing aids, artificial eyes; dental care; injuries resulting from organized sports or races; attempted suicide, willful misconduct; conditions resulting from major disaster, major epidemic or military service; organ transplant, hemodialysis or other procedure for treatment of kidney failure; cardiac bypass surgery; hospital care for tuberculosis limited to 14 days per confinement, and care not provided by or prescribed by IHA physicians except as expressly provided above.	In addition to any exclusions and limitations outlined above, this plan does not cover conditions covered by Workmen's Compensation, organ transplants, sterility, sterilization, frigidity, impotency, insanity or confinement in state mental hospital, tuberculosis, polio, intentionally self-inflicted injuries, injuries received while engaged in a felony, illnesses or injuries for which benefits will be paid under any U.S. law, injuries resulting from acts of war, dental care, and care not provided by or prescribed by Western Clinic physicians except as expressly provided above.

ADDRESSES OF FACILITIES OF THE STATE'S FOUR PANEL MEDICINE PLANS

Group Health Cooperative of Puget Sound

Kaiser Foundation Health Plan

Inland Health Association

Western Clinic

APPENDIX II

APPENDIX II

Monthly Premiums Effective August 1, 1975

The full monthly premiums for all approved plans are shown below. Retired employees and eligible employees who are off of the state payroll (on unpaid leave, etc.) pay the full premium shown below. On the chart below, "employee" means an employee, a retired employee, or the eligible surviving spouse of a deceased retired employee.

	PLAN I-WPS BLUE CROSS	PLAN II BLUE CROSS	GROUP HEALTH COOPERATIVE	KAISER FOUNDATION	INLAND HEALTH ASSOCIATION	WESTERN CLINIC
IF ALL PERSONS COVERED ARE UNDER 65						
Employee (under 65)	$33.67	$13.31	$26.40	$20.89	$30.57	$24.34
Employee and Spouse (both under 65)	66.64	29.62	52.80	41.78	56.42	45.80
Employee and Spouse (both under 65) and Child(ren)	94.43	37.00	76.60	60.78	75.00	65.48
Employee (under 65) and Child(ren)	61.46	20.69	48.50	Note 1	52.16	44.92
IF SOME PERSONS COVERED ARE OVER 65						
Employee (over 65)	15.00	15.00	14.10	10.72	11.59	8.77
Employee and Spouse (Employee over 65)	47.97	31.31	40.50	31.61	42.46	30.23
Employee and Spouse (Spouse over 65)	48.67	28.31	40.50	31.61	42.46	33.22
Employee and Spouse (both over 65)	30.00	30.00	28.20	21.44	23.18	17.55
Employee and Spouse (Employee over 65) and Child(ren)	75.76	38.69	64.30	50.61	60.84	50.84
Employee and Spouse (Spouse over 65) and Child(ren)	76.46	35.69	64.30	50.61	60.84	53.82
Employee and Spouse (both over 65) and Child(ren)	57.79	37.38	52.00	40.44	41.55	38.16
Employee (over 65) and Child(ren)	42.79	22.38	37.90	Note 2	29.96	29.38

NOTE 1: Under the Kaiser plan, an active employee under 65 with one child pays $41.78. An active employee under 65 with two or more children pays $60.78.

NOTE 2: Under the Kaiser plan, an active employee over 65 with one child pays $31.61. An active employee over 65 with two or more children pays $50.61.

MADE

Distribution of The State Contribution

The state contribution for each eligible state employee is $35.00 per month.

1. The first 75¢ is applied to the $2,700 Part A life and AD&D insurance coverage provided to every eligible employee (see life insurance pamphlet),
2. Next, the remaining $34.25 is applied toward the cost of additional life insurance (Parts B, C and D) for which you voluntarily enroll.
3. Finally, any portion of the $35 still remaining is applied toward the medical insurance plan of your choice (full premium rates shown above).

If the above applications do not use up your entire $35 contribution, any remainder will be lost to you. Consider your medical and life insurance enrollments carefully to make the most effective use of your $35 state contribution.

A Word About Medicare and Your Premiums

PEOPLE UNDER AGE 65 ON MEDICARE

Some disabled people under 65 are also eligible for Medicare. People eligible for Medicare and under 65 who wish to enroll in Plans I or II pay the "under 65" rates. Such people who wish to enroll in any one of the state's panel medicine plans pay the "over 65" rates. (See page 4 for Medicare coordinated coverage.)

YOU MUST ENROLL IN BOTH PARTS OF MEDICARE

People eligible for Medicare (whether under or over 65) must enroll in Part A and B of Medicare. A few people over 65 are not eligible for Part A of Medicare because they have not worked enough time under Social Security. If you are over 65 and not eligible for Part A of Medicare, contact your payroll office for special premium rates that apply to you. Everyone may enroll in Part B of Medicare if they enroll promptly when they first become eligible. The state provides no special premium rates or benefits for people who are eligible and do not enroll in Part B of Medicare. See page 4 for further information about the state's Medicare coordinated coverage.

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