GHI Health Plan

http://www.ghi.com

2001

A Prepaid Comprehensive Medical Plan with a Point of Service Product

Serving: *All of New York and Northern New Jersey*

Enrollment in this Plan is limited; see page 5 for requirements.

URAC ACCREDITED
202.216.9010 • www.urac.org

Enrollment codes for this Plan:

801 Self Only
802 Self and Family

Authorized for distribution by the:

OPM

United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

FEHB
Federal Employees Health Benefits Program

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Introduction

Group Health Incorporated
441 Ninth Avenue
New York, NY 10001

This brochure describes the benefits of Group Health Incorporated under our contract (CS 1056) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized beginning on page 6. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means Group Health Incorporated.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this prepaid Plan with a Point of Service product

This Plan is a prepaid medical plan that offers a point of service, or POS, product. Within the Plan's network you are encouraged to select a personal doctor who will provide or arrange your care and you will pay minimal amounts for comprehensive benefits.

Because the Plan emphasizes care through participating providers and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a more comprehensive range of benefits than many insurance plans. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan emphasizes preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness. Whenever you need services, you may choose to obtain them from your personal doctor within the Plan's provider network or go outside the network for treatment. When you choose a non-Plan doctor or other non-Plan provider, you will pay a substantial portion of the charges, and the benefits available may be less comprehensive.

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

We also have Point-of-Service (POS) benefits:

Our Prepaid Plan offers Point-of-Service (POS) benefits. This means you can receive covered services from a non-participating provider. These out-of-network benefits have higher out-of-pocket costs than our in-network benefits.

How we pay providers

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

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- GHI is URAC-accredited and is licensed under Article 43 of the New York State Insurance Law as a health services corporation.
- GHI has been in continuous existence for over sixty (60) years
- GHI is a not-for-profit New York corporation

If you want more information about us, call (212) 501-4GHI (4444), or write to GHI, PO Box 1701, New York, NY 10023-9476. You may also visit our website at www.ghi.com.

Service Area

To enroll with us, you must live or work in our service area. This is where our providers practice. Our service area is: all of New York and the New Jersey counties of Bergen, Essex, Hudson, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex and Union.

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

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.

- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital service from providers in our GHI BMP network will be the same with regard to deductibles, coinsurance, copays, day and visit limitations when you follow a treatment plan that we approve. Previously, we placed "shorter day or visit limitations" on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.

- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling GHI at (212) 501-4444, or checking our website, www.ghi.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:

    - Speak up if you have questions or concerns.
    - Keep a list of all medicines you take.
    - Make sure you get the results of any test or procedure.
    - Talk with your doctor and healthcare team about your options if you need hospital care.
    - Make sure you understand what will happen if you need surgery.

- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- Your share of the non-Postal premium will increase by 16.7% for Self Only or 12.7% for Self and Family.
- Under the Substance Abuse benefit section, the 60 visit outpatient care limitation and the 30 day inpatient care limitation has been eliminated.
- Under the Prescription Drug benefits section, the following benefit changes were made:
    - The Retail Drug copays have been increased from $20 for a name brand drug which is not listed on the preferred prescription drug formulary, to $30 for a brand name drug which is not listed on the preferred prescription drug formulary.
    - The Maintenance Drug copay has been increased from $20 for a name brand drug to $30 for a name brand drug.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (212) 501-4GHI (4444).

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims. If you use our point-of-service program, you can also get care from non-Plan providers, but it will cost you more.

- **Plan providers**

A "provider" is any duly-licensed doctor, dentist, podiatrist, qualified clinical psychologist, optometrist, chiropractor, nurse, certified midwife, nurse practitioner/clinical specialist, or qualified clinical social worker and any other duly-licensed, registered or certified practitioner or privately-operated facility permitted to perform or render care or service described in this brochure.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site.

What you must do to get covered care

Within the Plan's network, you are encouraged to select a personal doctor who will provide or arrange your care, in which case you will pay minimal amounts for comprehensive benefits. When you choose a non-Plan doctor or other non-Plan provider, you will pay a substantial portion of the charges, and the benefits available may be less comprehensive.

- **Primary care**

You may seek care from covered, doctor, dentist, podiatrist, qualified clinical psychologist, optometrist, chiropractor, nurse, certified midwife, nurse practitioner/clinical specialist, or qualified clinical social worker and any other duly-licensed, registered or certified practitioner or privately-operated facility permitted to perform or render care or service described in this brochure.

- **Specialty care**

You may see the specialist of your choice, whenever you and your family feel you need care. Here are other things you should know about specialty care:

- If you have a chronic or disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause; or

- drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
- reduce our service area and you enroll in another FEHB Plan,

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (212) 501-4GHI (4444). If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

These provisions apply only to the benefits of the hospitalized person.

Circumstances beyond our control

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

Services requiring our prior approval

For certain services, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, is medically necessary, and follows generally-accepted medical practice.

We call this review and approval process precertification. Your physician must obtain precertification for the following services:

- High-tech nursing
- Infusion therapy
- Mental Health and Substance Abuse
- Non-emergency hospital admissions
- All inpatient hospital admissions for maternity care and skilled nursing facilities

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

- **Copayments**

A copayment is a fixed amount of money you pay to the provider when you receive services.

Example: When you see a participating provider you pay a copayment of $10 per office visit and when you go in the hospital, you pay nothing.

- **Deductible**

A deductible is a fixed expense you must pay for certain covered services and supplies before we start paying benefits for them. Copayments do not count towards any deductible.

The calendar year deductible for certain services is:

- For nursing service, you pay an annual deductible of $150 per individual or family.
- For appliances, oxygen or equipment, you pay an annual deductible of $100 per individual or family.
- For referred ambulatory, laboratory tests and diagnostic x-rays, you pay a $25 deductible per referral.
- Catastrophic services, you pay a $5000 annual deductible.

NOTE: If you change plans during open season, you do not have to start a new deductible under your plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

And, if you change options in this plan during the year, we will credit the amount of covered expenses already applied towards the deductible of your option to any deductible of your new option.

- **Coinsurance**

Any amount in excess of 50% of the Plan's fee schedule for POS services provided by non-participating providers.

Your out-of-pocket maximum for deductibles, coinsurance, and copayments

After your out-of-pocket expenses total $5000 per person in any calendar year for covered services provided by a non-participating provider, GHI will then pay catastrophic benefits at 100% of reasonable and customary charges as determined by the Plan. Out-of-pocket expenses are calculated based upon the reasonable and customary charge for covered catastrophic services. Covered catastrophic services include: 1) surgery, 2) administration of anesthesia, 3) chemotherapy and radiation therapy, 4) covered in-hospital service and diagnostic services, and 5) maternity. However, expenses for the following services do not count toward your out-of-pocket maximum:

- Home and office visits and related diagnostic services
- Nursing, Appliances, Oxygen and Equipment
- Dental services
- Vision services
- Prescription drugs

Section 5. Benefits -- OVERVIEW

(See page 6 for how our benefits changed this year and page 55 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at (212) 501-4GHI (4444) or at our Web site at www.ghi.com

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

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
  - Plan providers or non-Plan providers can provide or arrange your care. Limit out-of-pocket costs by using participating providers.
  - The calendar year deductible for certain services is:
    - For nursing services, you pay an annual deductible of $150 per individual or family.
    - For appliances, oxygen or equipment, you pay an annual deductible of $100 per individual or family.
    - For referred ambulatory laboratory test and diagnostic x-rays, you pay a $25 deductible per referral.
    - Catastrophic services, you pay a $5000 annual deductible.

  We added asterisks - * - to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description **Note: A calendar year deductible applies to some of the benefits in this Section (see above). We use an asterisk -*- when it does not apply.**	You pay
Diagnostic and treatment services*	
Professional services of physicians • In physician's office	$10 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Professional services of physicians • In an urgent care center • Office medical consultations • Second surgical opinion	$10 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
• During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment	No copay for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.

Diagnostic and treatment services continued on next page

Diagnostic and treatment services* (continued)	**You pay**
At home	$10 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Lab, X-ray and other diagnostic tests*	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	No additional copay if you receive these services during your office visit. Nothing if you receive these services from a participating lab. POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount.
Preventive care, adult*	
Routine screenings, such as: • Blood lead level – One annually • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including •• Fecal occult blood test	No additional copay if you receive these services during your office visit. Nothing if you receive these services from a participating lab. POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount.
•• Sigmoidoscopy, screening – every five years starting at age 50	$10 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	No additional copay if you receive these services during your office visit. Nothing if you receive these services from a participating lab. POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount.
Routine Pap test Note: The office visit is covered if Pap test is received on the same day; see *Diagnosis and Treatment*, above.	No additional copay if you receive these services during your office visit. Nothing if you receive these services from a participating lab. POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount.

Preventive care, adult continued on next page.

Preventive care, adult* (continued)	**You pay**
Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	No additional copay if you receive these services during your office visit. Nothing if you receive these services from a participating lab. POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount.
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
• Routine immunizations and boosters (the cost of the immunization is not covered).	$10 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Preventive care, children*	**You pay**
• Childhood immunizations recommended by the American Academy of Pediatrics • Examinations done on the day of immunizations (through age 22)	No copay for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
• Examinations, such as: •• Eye exams to determine the need for vision correction •• Ear exams to determine the need for hearing correction	$10 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
• Well-child care charges for routine exa minations, immunizations and care (through age 22)	No copay for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.

Maternity care*	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You must precertify your normal delivery. Maternity admissions should be precertified no later than the second trimester. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	A single $10 copay for all pre- and post-natal care from a participating provider. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Not covered: Routine sonograms to determine fetal age, size or sex. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the plan has ended.	*All charges.*
Family planning*	
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs) Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	$10 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Not covered: reversal of voluntary surgical sterilization, genetic counseling.	*All charges.*
Infertility services*	**You pay**
Diagnosis and treatment of infertility, such as: • In vitro fertilization (limited to three transfers per lifetime) • Embryo transfer • Artificial insemination • Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	$10 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Not covered: • *Cost of donor sperm*	*All charges.*

Allergy care*	You pay
Testing and treatment Allergy injections Treatment materials (such as allergy serum)	$10 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Not covered: • *Provocative food testing and sublingual allergy desensitization*	*All charges.*

Treatment therapies*	You pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 24. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis	In a doctor's office, nothing for a participating provider. POS: In a doctors office, 50% of the Plan's fee schedule, for non-participating providers, and any difference between our fee schedule and the billed amount.
• High-tech nursing and infusion therapy •• IV infusion therapy •• Parenteral and enteral therapy •• Other home IV therapies Note: Contact us at (212) 615-4662 prior to receiving services to ensure coverage. • Intermittent home nursing service •• Provided by a Registered Nurse or Licensed Practitioner •• Authorized and supervised by a doctor •• Intermittent visits less than 2 hours per day	Nothing for a participating provider. POS: All charges for non-participating providers.
• Growth hormone therapy (GHT). This benefit is provided under our Prescription Drug Benefits.	Generic drug: $5 copay per prescription or refill Name brand drug, listed on formulary: $15 copay per prescription or refill Name brand drug not on formulary: $30 copay per prescription or refill
Not covered: • *Treatment for experimental or investigational procedures.* • *Therapy necessary for transsexual surgery.*	*All charges.*

Rehabilitative therapies*	You pay
Physical therapy, occupational therapy and speech therapy – • 60 visits per condition for the services of each of the following: •• qualified physical therapist; •• speech therapist; and •• occupational therapist. Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other daily living activities. Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction.	$10 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges.*
Hearing services (testing, treatment, and supplies)*	
• Hearing testing	$10 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Not covered: • *hearing aids*	*All charges.*

Vision services (testing, treatment, and supplies)*	You pay
• Medical and surgical benefits for diagnosis and treatment of diseases of the eye.	$10 per visit for participating provider. For non-participating providers, you pay 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount.
• Examination of the eyes to determine if glasses are required: once each calendar year. • One set of single vision or bifocal lenses (toric kryptok or flat top 22mm): once each calendar year. • One pair of basic frames from available styles: one every two years. • Contact lenses for certain unusual medical conditions (such as post cataract surgery or keratoconus treatment). • Replacement of broken lenses with lenses of the same prescription and material originally supplied.	Nothing for services provided by participating opticians, optometrists and vision centers. POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount.
Not covered: • Frames at any time unless lenses are also provided. • Replacement or repair of frames. • Certain bifocals and trifocals, tinted, plastic and oversized lenses and sunglasses and frames other than basic frames; contact lenses for cosmetic purposes. • Charges in excess of the maximum GHI allowance.	*All charges.*
Foot care*	
Podiatric services, including the routine treatment of corns, calluses, and bunions, and the partial removal of toenails, are limited to 4 visits per calendar year.	$10 per visit for participating provider. For non-participating providers, you pay 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount.
Not covered: • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Orthodic devices for the feet.*	*All charges.*

Orthopedic and prosthetic devices	You pay
• Artificial limbs and eyes; stump hose. • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy. • Orthopedic devices, such as braces. • Ostomy supplies. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy.	20% of the Plan's fee schedule for a participating provider. POS: 50% of the Plan's fee schedule and any difference between our allowance and the billed amount for a non-participating provider. Note: $100 deductible applies per individual or family. There is a combined maximum of $25,000 per year per person with these benefits and private duty nursing.
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *corrective appliances for treatment of tempormandibular joint (TMJ) pain dysfunction syndrome.*	*All charges.*
Durable medical equipment (DME)	**You pay**
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • hospital beds; • wheelchairs; • crutches; • walkers; • blood glucose monitors; and • insulin pumps. Note: Call us at (212) 615-4662 as soon as your Plan physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	20% of the Plan's fee scheduled for a participating provider. POS: 50% of the Plan's fee schedule and any difference between our allowance and the billed amount for a non-participating provider. Note: $100 deductible applies per individual or family. There is a combined maximum of $25,000 per year per person with these benefits and private duty nursing.
Not covered • *Hearing aids and air purification devices* • *Alarm and Alert Services*	*All charges.*

Home health services*	You pay
The following conditions must be met: • Home health care must be provided and billed by a certified home health agency, which has an agreement with GHI to provide home health care services. • You must remain under the care of a medical doctor. • The services are provided according to a plan of treatment approved by the attending medical doctor. • Medical evidence substantiates that you would have required further inpatient care had the home health care not been available. • The home health care begins within 5 days after the discharge from the hospital. The following services are covered: • Part-time or intermittent nursing care by a registered professional nurse (R.N.) or a home health aide under the supervision of a registered professional nurse. • Physical therapy. • Respiration or inhalation therapy. • Prescription drugs. • Medical supplies which serve a specific therapeutic or diagnostic purpose. • Other medically necessary services or supplies that would have been provided by a hospital if the subscriber were still hospitalized.	Nothing for a participating provider. POS: All charges for a non-participating provider.
Private Duty Nursing services rendered at home or in the hospital by a registered nurse (R.N.) or when an R.N. is not available by a licensed practical nurse (L.P.N).	Nothing for a participating provider. POS: 50% of the Plan's fee schedule and any difference between our allowance and the billed amount for a non-participating provider. Note: $150 annual deductible applies per person or family. There is a combined maximum of $25,000 per calendar year per person with these benefits and Durable Medical Equipment.
Not covered: • *Homemaking services, including housekeeping, preparing meals, or acting as a companion or sitter.* • *Services and supplies related to normal maternity care.* • *Services and supplies provided following a noncovered hospital admission or admission to a facility that is not a participating facility.* • *Services and supplies provided when the subscriber would not have required continued inpatient care.* • *Services and supplies provided by a non-participating facility for home health care.* • *High-tech nursing and infusion therapy*.	*All charges.*

Alternative treatments*	
Chiropractic services	$10 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Not covered: • *chiropractic maintenance sessions* • *naturopathic services* • *hypnotherapy* • *biofeedback* • *acupuncture*	*All charges.*
Educational classes and programs*	
Self management programs are available for: • Diabetes • Arthritis • Asthma • Hepatitis C • Multiple sclerosis • Digestic health solutions	Nothing.

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

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look at Section 5 (c) for charges associated with facility (i.e., hospital, surgical center, etc.).
- YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prostethic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information.	$10 per office procedure for a participating provider. Nothing for a participating provider in a hospital or a participating ambulatory surgery center. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.

Surgical procedures continued on next page.

Surgical procedures (continued)	**You pay**
• Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs). Note: Devices are covered under 5(a). • Treatment of burns	$10 per office procedure for participating providers. Nothing for a participating provider in the hospital or a participating ambulatory surgery center. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.
Not covered: • *Reversal of voluntary sterilization.* • *Elective cosmetic surgery.* • *Cost of donor sperm.* • *Stand-by services.*	*All charges.*
Reconstructive surgery	
• Surgery to correct a functional defect or correct a condition caused by injury or illness if: •• the condition produced a major effect on the member's appearance and •• the condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.	$10 per office procedure for participating providers. Nothing for a participating provider in the hospital or a participating ambulatory surgery center. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.
• All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast •• treatment of any physical complications, such as lymphedemas •• breast prostheses and surgical bras and replacements (see Prosthetic devices). Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$10 per office procedure for participating providers. Nothing for a participating provider in the hospital or a participating ambulatory surgery center. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*

Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures, and • Removal of impacted teeth • Other surgical procedures that do not involve the teeth or their supporting structures.	$10 per office procedure for participating providers. Nothing for a participating provider in the hospital or a participating ambulatory surgery center. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in the treatment of teporomandibular joint (TMJ) pain dysfunction syndrome.*	*All charges.*

Organ/tissue transplants	You pay
Limited to: • Cornea • Human Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • National Transplant Program (NTP) – We will cover transplants approved as safe and effective for a specific disease by the Federal Drug Administration (FDA) or National Institute of Health, or which our Medical Director determines is medically necessary, appropriate and advisable on a case-by-case basis. We will cover the medical and hospital services, and related organ acquisition costs. Eligibility for transplants will be determined and approved in advance solely by our Medical Director upon recommendation of your PCP. Additionally, all transplants must be performed at hospitals specifically approved and designated by us to perform these procedures. Specialty physician experts from our designated centers of excellence will provide clinical review and support to the Medical Director's decision.	$10 per office procedure for participating providers. Nothing for a participating provider in the hospital or a participating ambulatory surgery center. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.
We cover: • We cover related medical and hospital expenses of the donor when we cover the recipient up to a maximum of $10,000 per transplant. • Travel expenses up to a maximum of $150 per person per day and $10,000 per lifetime of the recipient if the recipient patient lives more than 75 miles from the transplant center. This includes food and lodging for the recipient patient and one adult family member (two, if the recipient is a minor) to the city where the transplant takes place. Note: The benefit period begins five (5) days prior to surgery and extends for a period of up to one year from the date of surgery. There is a separate lifetime maximum benefit up to $1,000,000 per recipient for each type of covered transplant.	See above.

Organ/tissue transplants continued on next page.

Organ/tissue transplants (continued)	**You pay**
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient)	Nothing for a participating provider in the hospital or a participating ambulatory surgery center. POS: Any difference between our fee schedule and the billed amount for non-participating providers
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Hospital ambulatory surgical center	Nothing for a participating provider in the hospital or a participating ambulatory surgery center. POS: Any difference between our fee schedule and the billed amount for non-participating providers.
Not covered: • *Office* • *Services administered by the same practitioner performing surgery*	*All charges*

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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the facility charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are addressed in Section 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing for a Plan facility.

Inpatient hospital continued on next page.

Inpatient hospital (continued)	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	Nothing for a Plan facility
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Non-covered facilities, such as nursing homes, extended care facilities, and schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Long term rehabilitation*	*All charges.*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service	Nothing for a Plan facility.
• Diagnostic laboratory tests, X-rays, and pathology services	$25 copayment
• Chemotherapy and radiation	Nothing for chemotherapy and radiation provided in a participating facility. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.

Outpatient hospital continued on next page.

Outpatient hospital or ambulatory surgical center (continued)	**You pay**
Note: Limited benefits for inpatient dental procedures — Hospitalization for certain dental procedures is covered when a doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia, impacted teeth, and heart disease; the need for anesthesia, by itself, is not such a condition.	
Not covered: blood and blood derivatives not replaced by the member	All charges
Extended care benefits/skilled nursing care facility benefits	**You pay**
Skilled nursing facility (SNF): Limited to 30 days: • Bed, board and general nursing care • Drugs, biologicals, supplied and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by your doctor as governed by Medicare guidelines.	Nothing for a participating provider. POS: All charges for a non-participating provider.
Not covered: • *custodial care*	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member in the home or hospice facility. Services include: • inpatient/outpatient care; and • family counseling under the direction of a doctor. Note: Your provider must certify that you are in the terminal stages of illness, with a life expectancy of approximately six months or less. The hospice must have an agreement with us or recognized by Medicare as a hospice.	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
• Ambulance services for each trip to or from a hospital for medically necessary services. This includes the use of an ambulance for emergency outpatient care and maternity care, to the nearest facility.	All charges in excess of $100.
Not covered: • *Air ambulance* • *Ambullette services*	*All charges*

Section 5 (d). Emergency services/accidents

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

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

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

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

Note: If you were admitted to the hospital from the Emergency Room the $25 copay is waived.
A participating GHI provider must provide your follow-up care. We cover care provided by a non-participating provider at 50% of the Plan's fee schedule.

Benefit Description	You pay
Emergency within the service area	
• Emergency medical/surgical care at a doctor's office • Emergency medical/surgical care at an urgent care center	$10 per office visit for a participating provider. POS: Any difference between our fee schedule and the billed amount for a non-participating provider.

Emergency within the service area continued on next page.

Emergency within the service area (continued)	**You pay**
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: Copay waived if admitted to the hospital. If private physicians who are not hospital employees provide the emergency care, you may receive a separate bill for these services, which we will process as a medical benefit.	$25 copay and any charges that exceed the emergency fee schedule.
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside the service area	
• Emergency medical/surgical care at a doctor's office • Emergency medical/surgical care at an urgent care center	$10 per visit for a participating provider. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: Copay waived if admitted to the hospital. If private physicians who are not hospital employees provide the emergency care, you may receive a separate bill for these services, which we will process as a medical benefit.	POS: $25 copay and 20% of charges per hospital emergency room visit or urgent care center visit for non-participating facilities. Note: For emergency services billed for by a doctor, you pay any difference between our fee schedule and the billed amount
Not covered: • *Elective care or non-emergency care*	*All charges.*
Ambulance	
Professional ambulance service to or from a hospital for medically necessary services. This includes the use of an ambulance for emergency outpatient care and maternity care, to the nearest facility. See 5(c) for non-emergency service.	All charges in excess of $100.
Not covered: air ambulance and ambullette services	*All charges.*

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

IMPORTANT

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.
- Only services rendered by a Participating Provider are covered.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services obtained from a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per visit for outpatient care.

Network mental health and substance abuse benefits -- continued on next page.

Mental health and substance abuse benefits (continued)	**You pay**
• Diagnostic tests	Nothing
• Services provided by a Plan hospital or other Plan facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility based intensive outpatient treatment	Nothing $10 per visit
Not covered: • *Services we have not approved.* • *Facility charges of a non-participating general hospital or facility.* • *Treatment by a non-participating provider.* *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Preauthorization

To be eligible to receive these benefits you must follow your treatment plan and all of our network authorization processes on pages 8 and 31. Contact us at 1-(800) 692-7311

Special transitional benefit

If a mental health or substance abuse professional is treating you under our Plan as of January 1, 2001, you will be eligible for continued coverage with your provider up to 90 days under the following conditions:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the Plan at our request for other than cause

If this situation applies to you, we will allow you reasonable time to transfer your care to a Plan mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage, and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.

Limitation

We may deny your benefits if you do not follow your treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** A licensed doctor must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a pharmacy that participates under the program through PAID Prescription Inc. Coordinated Care Network III. You must fill the prescription at a Plan pharmacy, or by mail for a maintenance medication.
- **We use a formulary.** A formulary is a list of carefully-selected medications that can assist in maintaining quality care for patients while helping to lower the cost of prescription drug benefits. An independent Pharmacy and Therapeutic Committee brought together by Merck-Medco review each drug on the list for safety and effectiveness. Many different pharmaceutical companies, including Merck-Medco, make these drugs.
- **These are the dispensing limitations.** Prescription drugs prescribed by a doctor and obtained at a pharmacy that participates under the program through PAID Prescriptions, Inc. Coordinated Care Network III will be dispensed for up to a 31-day supply. Drugs are prescribed by doctors and dispensed in accordance with the Plan's drug formulary. You pay a $5 copay for a generic drug, a $15 copay per prescription unit or refill for a name brand drug listed on the preferred prescriptions drug formulary and a $30 copay per prescription unit or refill for a name brand drug not listed on the preferred prescription drug formulary.

  - - Mandatory Mail: Your prescription coverage also includes a mandatory mail program. All maintenance medications must be sent to Merck Medco Rx Services. Two refills per prescription will be allowed at any local "preferred" TelePAID pharmacy. When a new maintenance medication is prescribed the patient should request 2 prescriptions. The initial for a 31-day supply to be filled at a retail pharmacy, and the second, for up to a 90-day supply, to be submitted to Merck Medco Rx Services. For all existing maintenance medications at a retail pharmacy, the patient is required to obtain a new prescription, for up to a 90-day supply, to be sent to Merck Medco Rx Services.

  - - Maintenance Drug Program — The maintenance drug program permits long-term prescriptions to be filled for up to a 90-day supply. You pay a $10 copay for a generic drug, and a $30 copay per prescription unit for a name brand.

- **When you have to file a claim.** For drugs obtained at a non-participating pharmacy in an emergency, call 1(800) 272-PAID and obtain a claim form.

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
Each new enrollee will receive a description of our prescription drug program, a combined prescription drug/Plan identification card, a mail order form/patient profile and a preaddressed reply envelope. We cover the following medication and supplies prescribed by a physician from either a Plan pharmacy or by mail. Note: Mandatory mail requirements apply for maintenance drugs: • Drugs for which a prescription is required by law. • FDA-approved prescription drugs and devices for birth control. • Fertility drugs. • Drugs to treat sexual dysfunction (Viagra is limited to six tablets per every thirty-one days). • Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape. • Disposable needles and syringes needed for injection of covered prescribed medication. • Smoking cessation drugs and medication, including nicotine patches (up to 90-day supply). Intravenous fluids and medications for home use through our Participating Provider network for home infusion therapy	Network Retail: $5 generic $15 brand name listed on the preferred prescription drug formulary $30 brand name drug not listed on the preferred prescription drug formulary. Network Mail Order: $10 generic $30 brand name
Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified "dispense as written" for the name brand drug, you have to pay the brand name copay. • We administer an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 1(800) 272-PAID.	Network Retail: $5 generic $15 brand name listed on the preferred prescription drug formulary $30 brand name drug not listed on the preferred prescription drug formulary. Network Mail Order: $10 generic $30 brand name
Not covered: • *Nonprescription medications* • *Drugs obtained at a non-participating pharmacy, except for emergencies.* • *Vitamins and nutritional substances that can be purchased without a prescription.* • *Medical supplies such as dressings and antiseptics.* • *Drugs for cosmetic purposes.* • *Drugs to enhance athletic performance.*	*All Charges*

Section 5 (g). Special Features

Feature	Description
Large Case Management	The Plan provides a large case management program that seeks to provide alternatives for improving the quality and cost effectiveness of care. The large case management program focuses on catastrophic illnesses — for example, major head injury, high-risk infancy, stroke and severe amputations. The large case management process begins when we are notified that you or covered family member has experienced a specific illness or injury with potential long-term effects or changes in lifestyle. Case Managers evaluate individual needs, and the full range of treatment and financial exposures, from the onset of a condition or illness to recovery or stabilization. They review the efforts of the health care team and family with the goal of helping the patient return to pre-illness/injury functioning or of lessening the burden of a chronic or terminal condition. Case Managers provide the family with support and advice ranging from referral to family counseling. If it is determined that involvement of a Case Manager would be both care- and cost-effective, we will obtain the necessary authorization from the patient to proceed. Throughout the process, we will maintain strict confidentiality.
Customer Service AnswerLine	For information and assistance 24 hours a day, 7 days a week, access our automated telephone AnswerLine at (212) 501-4GHI (4444).
Services for deaf and hearing impaired	If you have a question concerning Plan benefits or how to arrange for care, contact (212) 721-4962 (Hearing impaired — TDD) or you may write to us at Post Office Box 1701, New York, NY 10023-9476 or contact our office nearest you. You may also contact the Plan at its website at http://www.ghi.com.
High risk pregnancies	The Plan provides an intensive large case management program as described above.
Centers of excellence for transplants/heart surgery/etc.	We have a special network of hospitals that perform a broad range of cardiac care and organ transplants. These centers are recognized leaders in their respective specialties and their services are available to you at no out-of-pocket expense. Call GHI Managed Care at least 10 days before the hospital admission to pre-certify coverage and for details on how to use this program.
Travel benefit/ services overseas	As a GHI subscriber, you are not restricted to just using members of our provider network. However, if you go outside the network, your out-of-pocket expenses will increase significantly. You will receive 50% of our fee schedule if you use a non-participating provider — you are responsible for the balance of the provider's charge. Also, unlike when you use a network provider, you are responsible for paying the non-participating provider up front and filing a claim form with us for reimbursement.

Section 5 (h). Dental benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We cover hospitalization for certain dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below. We will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia, impacted teeth, and heart disease; the need for anesthesia, by itself, is not such a condition.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit	You Pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. Note: The need for these services must result from an accidental injury caused by external means and services must be completed within one year.	Any difference between our fee schedule and the actual charges.
Not covered: • *Therapeutic service.* • *Other dental services not shown as covered.* • *Charges which exceed the Plan's fee schedule.*	*All charges*

Dental benefits

This Plan provides the following program of dental coverage. The emphasis is on prevention, with preventive and diagnostic dental services covered with no copayments through Participating Plan Dentists. Services by non-participating dentists are covered in accordance with the fees listed below.

Service	You Pay
Examinations (maximum 2 per calendar year)	Nothing for a participating provider. POS: All charges in excess of $10.00
Prophylaxes (under 12 years - maximum 2 per calendar year)	Nothing for a participating provider. POS: All charges in excess of $7.00
Prophylaxes (over 12 years maximum 2 per calendar year)	Nothing for a participating provider. POS: All charges in excess of $10.00
Emergency visits for relief of pain (1 per calendar year)	Nothing for a participating provider. POS: All charges in excess of $10.00
X-rays (Full-mouth series, 1 every 3 years)	Nothing for a participating provider. POS: All charges in excess of $20.00

Dental benefits continue on the next page.

Dental benefits (continued)	
Service	**You pay**
Bitewings (4 per calendar year)	Nothing for a participating provider. POS: All charges in excess of $2.50 per each bitewing
Space maintainers	Nothing for a participating provider. POS: All charges in excess of $65.00
Fluoride Treatments – dependent children to age 22	Nothing for a participating provider. POS: All charges in excess of $5.00

Section 5 (i). Point of service benefits

Point of Service (POS) Benefits

Facts about this Plan's POS option

At your option, you may choose to obtain benefits covered by this Plan from non-participating doctors and hospitals whenever you need care, except for those benefits listed below which are available only through plan providers. Benefits not covered under Point of Service must be received from Plan doctors to be covered.

What is covered

All services are covered under our POS except:

- High-tech nursing and infusion therapy
- Skilled nursing care facility confinements
- Home health care services
- Mental conditions and substance abuse
- Prescription drugs

Remember, only participating providers have agreed to accept the Plan's allowance, except for any applicable copayments, as payment in full. If you choose to receive benefits not covered through non-participating or out-of-network providers, you will be reimbursed at the POS level that in most cases is 50% of the Plan's allowance.

Covered POS benefits are available whether the services are received within or outside the GHI Health Plan's Service Area.

All non-emergency hospital admissions including inpatient admissions for maternity care and skilled nursing facilities must be pre-certified.

There is a $150 annual deductible for nursing services and a $100 annual deductible for appliances, oxygen and equipment. There is also a $25 deductible, per referral, for ambulatory laboratory test and diagnostic X-rays.

In most cases, the POS coinsurance is any amount in excess of 50% of the Plan's fee schedule. The Plan's fee schedule is set at approximately 50% of the New York State 1999 HIAA mean. Members, when receiving POS services, will be responsible for 50% of the Plan's fee schedule plus any difference between our fee schedule and the billed amount.

After your out-of-pocket expenses total $5000 per person in any calendar year for covered services provided by a non-participating provider, GHI will then pay catastrophic benefits at 100% of reasonable and customary charges as determined by the Plan. Out-of-pocket expenses are calculated based upon the reasonable and customary charge for covered catastrophic services. Covered catastrophic services include: 1) surgery, 2) administration of anesthesia, 3) chemotherapy and radiation therapy, 4) covered in-hospital services and diagnostic services, and 5) maternity. However, expenses for the following services do not count toward your out-of-pocket maximum, and you must continue to pay coinsurance and deductibles for these services:

- Home and office visits and related diagnostic services
- Nursing, appliances, oxygen and equipment
- Dental services
- Vision services
- Prescription drugs

If you are in a true emergency situation, POS benefits are available within or outside the GHI's Health Plan's service area.

Emergencies within the service are:

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

Plan pays Emergency fee schedule for emergency care services to the extent the services would have been covered if received from Plan providers.

You pay $25 per hospital emergency room visit or urgent care center visit for emergency services that are covered benefits of this Plan. You also pay charges that exceed the Plan's emergency fee schedule. If the emergency care is provided by private physicians who are not hospital employees, you may receive a separate bill for these services, which will be processed as a medical benefit.

Emergencies outside the service area:

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

Plan pays full emergency fee schedule for emergency care services to the extent the services would have been covered if received from Plan providers; 80% of charges from a non-participating hospital.

You Pay $25 plus 20% of charges per hospital emergency room visit or urgent care center visit for non-participating facilities and nothing for emergency services billed for by a doctor, except charges which exceed the Plan's emergency fee schedule, for services which are covered benefits of this Plan. If the emergency care is provided by private physicians who are not hospital employees, you may receive a separate bill for these services, which will be processed as a medical benefit.

What is covered

- Emergency care at a doctor's office or an urgent care center.
- Ambulance service (see page 28).
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services.

If the medical/surgical care received from non-participating providers is not due to a medical emergency as defined above, the Plan will pay 50% of its fee schedule. Follow-up care after an emergency is covered in full only if received from participating providers.

Section 5 (j). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

Dental services are available at reduced fees

If you should require additional dental services, a GHI dental provider participating in the benefit offer will provide these services at reduced fees. All reduced fees for dental services must be paid directly to the participating dental provider. You must verify that your provider is still participating in the program.

Dental services available in the reduced fee program include:

	DOWNSTATE* **You Pay**	UPSTATE** **You Pay**
DIAGNOSTIC RESTORATIVE (Fillings)		
Resin (anterior) 1 surface	$52.00	$38.00
Resin (anterior) 2 surface	$69.00	$48.00
Resin (anterior) 3 surface	$86.00	$59.00
PROSTHODONTICS REMOVAL		
Complete denture (upper or lower)	$660.00	$441.00
Partial denture resin base (Bilateral Chrome)	$664.00	$453.00
Add tooth to existing partial	$65.00	$54.00
Add clasp to existing partial	$73.00	$59.00
PROSTHODONTICS FIXED		
Bridge pontic (cast metal)	$520.00	$409.00
Porcelain fused to metal	$510.00	$399.00
Full cast crown with porcelain, veneer backing	$552.00	$432.00
ORAL SURGERY		
Extraction (completely covered by bone)	$269.00	$210.00
Soft tissue extraction	$172.00	$118.00
PERIODONTICS (Gum Treatment)		
Gingivectomy (per quadrant)	$200.00	$169.00
Osseous Surgery (per quadrant)	$470.00	$382.00
ENDODONTICS (Root Canal)		
Therapeutic pulpotomy	$82.00	$50.00
Root canals (3 canals)	$466.00	$466.00
Apicoectomy (first root)	$306.00	$314.00
ORTHODONTICS (Braces)		
Diagnostic and planning fee	$912.00	$686.00
Active Treatment Maximum	$2,220.00	$1,680.00

Benefits on this page are not part of the FEHB contract.

* Downstate includes New York, Bronx, Kings, Queens, Richmond, Nassau, Suffolk, Putnam, Orange, Rockland and Westchester Counties and New Jersey

** Upstate includes Eastern, Central, and Western New York Counties.

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan
- Services, drugs, or supplies that are not medically necessary
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice
- Experimental or investigational procedures, treatments, drugs or services
- Services, drugs, or supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies related to sex transformations, or
- Services or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive services from non-plan providers. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file the form HCFA-1500, Health Insurance Claim Form. Facilities will file the UB-92 form. For claims questions and assistance, call us at (212) 501-4GHI (4444).

When you must file a claim, submit the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Submit your claims to: Group Health Inc.
P.O. Box 2832
New York, New York 10116-2832

Deadline for filing your claim

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

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: 88 West End Avenue, New York, NY 10023; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, P.O. Box 436, Washington, D.C. 20044-0436. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms • Copies of all letters you sent to us about the claim • Copies of all letters we sent to you about the claim, and • Your daytime phone number and the best time to call. Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

The Disputed Claims process

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must provide a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

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

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

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

NOTE: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at (212) 615-4662 and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division II at (202) 606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group health plan or if you have automobile insurance that pays health expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

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

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

· What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A.
- Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

· The Original Medicare Plan

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be precertified as required.

We will waive some copayments, coinsurance, and deductibles as follows:

Medical services and supplies provided by physicians and other health care professionals. If you are enrolled in Medicare Part B, we will waive the $10 copay for office visits and deductible and coinsurance for durable medical equipment.

Section 9. Coordinating benefits with other coverage (continued)

The following chart illustrates whether Original Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when…		
a) The position is excluded from FEHB, or……..	……..✓	
b) The position is not excluded from FEHB…….	……..	……..✓
Ask your employing office which of these applies to you.		
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or……	……..✓	
b) Are an active employee……	……..	……..✓

Claims process – You probably will never have to file a claim form when you have both our Plan and Medicare.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at (212) 501-4GHI (4444), or access our web site at http://www.ghi.com

We waive some costs when you have Medicare – When Medicare is the primary payer, we will waive some out-of-pocket costs, as follows:

- Medical services and supplies provided by physicians and other health care professionals. If you are enrolled in Medicare Part B, we will waive the $10 copay for office visits and deductible and coinsurance for durable medical equipment.

· Medicare managed care plan

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1(800) MEDICARE (1(800) 633-4227) or at www.medicare.gov. If you enroll in a Medicare Managed Care plan, the following options are available to you:

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary.

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

· Enrollment in Medicare Part B

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

TRICARE

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

Workers' Compensation

We do not cover services that:

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

Once OWCP or a similar agency pays its maximum benefits for your treatment, we will cover your benefits. You must use our providers.

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 9.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 9.

Covered services

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

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 9.

Experimental or investigational services

Experimental treatment is a treatment that has not been tested in human beings; or that is being tested but has not yet been approved for general use; or that is subject to review or approval by an Institutional Review Board.

Investigational treatment includes, but is not limited to, services or supplies which are under study or in a clinical trial to evaluate their toxicity, safety and efficiency for a particular diagnosis or set of indications.

Clinical trials include, but are not limited to, controlled experiments having a clinical event as an outcome measurement involving persons having a specific disease or health condition; or involving the administration of different study treatments in a parallel treatment design done to evaluate the efficacy and safety of a test measurement. Clinical trials include Phase I, Phase II, and Phase III studies. Clinical trials also include randomized trials or studies.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. We determine our allowance as follows:

The Plan allowance is the fee schedule or negotiated rate that GHI uses as payment in full for covered services rendered by participating providers.

Us/We

Us and we refer to Group Health Incorporated

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you *A Guide to Federal Employees Health Benefits Plans,* brochures for other plans, and other materials you need to make an informed decision about:

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

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

When benefits and premiums start

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

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions
- OPM and the General Accounting Office when conducting audits
- Individuals involved in bona fide medical research or education that does not disclose your identity or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

When you retire

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

When you lose benefits

- When FEHB coverage ends

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

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

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

- Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

- Temporary Continuation Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire.

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

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

· Converting to individual coverage

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

••Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay your premium, you cannot convert

••You decided not to receive coverage under TCC or the spouse equity law; or

••You are not eligible for coverage under TCC or the spouse equity law.

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at (888) 456-3728 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE—(202) 418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

NOTES:

Summary of benefits for the GHI Health Plan - 2001

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

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	$10 per visit for a Participating Provider. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for a non-participating provider.	11
Services provided by a hospital: • Inpatient • Outpatient	Nothing Note: $25 deductible per referral for ambulatory laboratory test and diagnostic X-rays when referred and rendered.	26 27
Emergency benefits: • In-area • Out-of-area	$25 per hospital emergency room visit or urgent care center visit and charges that exceed the Plan's emergency fee schedule. $25 plus 20% of charges per hospital emergency room visit or urgent care center visit for non-participating facilities.	29 29
Mental health and substance abuse treatment	Regular cost sharing.	31
Prescription drugs prescribed by a doctor and obtained at a participating pharmacy Mandatory Mail	$5 copay for generic drugs; $15 copay per prescription unit or refill for name brand drugs listed on the preferred prescription drug formulary, and $30 copay per prescription unit or refill for a name brand drug not listed on the preferred prescription drug formulary. For mail-order maintenance you pay a $10 copay for generics and a $30 copay for name brand. All maintenance medications must be sent to Merck Medco Rx Services. Two refills per prescription will be allowed at any local "preferred" TelePAID pharmacy.	33
Dental Care	Nothing for preventive services provided by Participating Providers. For non-participating providers, you pay any difference between GHI's fee schedule and the billed amount.	36
Vision Care	One refraction annually. Lenses (annually) and frames (every two years). Nothing to Participating Vision Centers.	17
Special features: Large Case Management, High Risk Pregnancies, Centers of Excellence for Transplants/Heart/Surgery/etc., Travel Benefits/Services Overseas		35
Point of Service benefits – Yes		38
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $5,000 per person per year Some costs do not count toward this protection	9

2001 Rate Information for GHI Health Plan

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses; for Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	801	$86.59	$30.60	$187.61	$66.30	$102.22	$14.97
Self and Family	802	$195.82	$97.14	$424.28	$210.47	$231.17	$61.79