The George Washington University Health Plan 2001

http://www.gwhealthplan.com

A Health Maintenance Organization

Serving: Northern Virginia, Maryland and Washington, D.C.

Enrollment in this Plan is limited; see page 6 for requirements.

This Plan has Commendable Accreditation from the NCQA.
See the 2001 Guide for more information on NCQA

Enrollment codes for this Plan:

E51 Self Only
E52 Self and Family

Special notice: Our service area no longer includes the Maryland county of Cecil, the Virginia city of Winchester, and the Virginia counties of Frederick and Warren. If you live or work in one of these counties and do not work or live within our remaining service area, you should choose another health plan during open season. Please see page 6 for a description of our service area for 2001.

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Introduction

The George Washington University Health Plan
4550 Montgomery Avenue
Suite 800
Bethesda, MD 20814

This brochure describes the benefits of The George Washington University Health Plan under our contract (CS 1764) 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 on page 7. 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" and "us" means The George Washington University Health Plan.

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 HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

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

When you receive services from Plan providers, you will rarely have to submit claim forms or pay bills. You only pay the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans 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.

How we pay providers

We contract with individual physicians, medical groups, hospitals, and other providers to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you are only responsible for your copayments or coinsurance. For emergency care from non-Plan providers, we will pay reasonable charges, minus your copayment or coinsurance.

We pay the physicians we contract with using either the discounted fee-for-service or capitation methods. **We do not use bonuses or withholds.** During calendar year 1999, we paid 93.3% of Plan physicians using the discounted fee-for-service method. This means that, through a contractual agreement with the physician, we pay a reduced (or discounted) fee for each patient visit, medical procedure or service. In the same year, we paid 6.7% of contracted physicians using the capitation method. Under this type of contractual agreement, we pay a fixed amount every month for each member who chose that physician to be his/her doctor. We pay the same amount every month, whether the member receives services or not.

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 our health plan, its 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.

- The George Washington University Health Plan is a not-for-profit organization owned by The George Washington University.
- The Plan was organized under the District of Columbia Non-Profit Corporation Act on May 16, 1972.
- We are licensed in three jurisdictions: the District of Columbia, the State of Maryland and the Commonwealth of Virginia. We renewed our health maintenance organization (HMO) license in the District of Columbia on April 15, 2000; in Maryland on December 1, 1999; and in Virginia on July 1, 2000. The George Washington University Health Plan has been federally qualified since 1979 under the Federal HMO Act of 1973.

If you want more information about us, call 301-941-2021 or 1-800-333-GWHP, or write to The George Washington University Health Plan, 4550 Montgomery Avenue, Suite 800, Bethesda, MD 20814. You may also contact us by fax at 301-941-2093 or on our website at www.gwhealthplan.com.

Service Area

Effective January 1, 2001, our service area no longer includes the Maryland county of Cecil, the Virginia city of Winchester, and the Virginia counties of Frederick and Warren.

To enroll in this Plan, you must live in or work in our service area. Our service area is:

1. All of the **District of Columbia**;
2. **Virginia**
   - Cities of Alexandria, Fairfax, Falls Church, Fredericksburg, Manassas, and Manassas Park,
   - Counties of Arlington, Fairfax, Fauquier, Loudoun, Prince William, Spotsylvania, and Stafford; and
3. **Maryland**
   - City of Baltimore,
   - Counties of Anne Arundel, Baltimore, Calvert, Carroll, Charles, Frederick, Harford, Howard, Montgomery, Prince George's, St. Mary's and Washington.

You must get your care from providers in our service area who contract with us. Outside our service area, we will pay only for emergency care. We will not pay for any other health care services.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the 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 services from providers in our Plan network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we only covered acute services and we placed higher patient cost sharing on some mental health and substance abuse services than we did on services to treat physical illness.
- 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 Member Services at 301-941-2021 or 1-800-333-GWHP, or checking our website, www.gwhealthplan.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 the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care 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 5.1% for Self Only or decrease by 0.3% for Self and Family.

Service Area

- Our service area no longer includes the Maryland county of Cecil, the Virginia city of Winchester, and the Virginia counties of Frederick and Warren.

Dental Benefits

- Our dental benefits have changed to an open-access dental benefit. You may visit any Plan dentist whenever necessary. You do not have to select a primary dentist and you are not limited to one dentist per family. You do not need a referral for specialty dental care. You now have access to hundreds of additional dentists throughout the service area.
- The new plan provides comprehensive dental services while emphasizing preventive care. Most preventive and diagnostic services are covered at no cost to you and **we eliminated the $5.00 sterilization fee for office visits.** Please note that member payments for non-preventive dental services have increased. Your dentist can charge you up to the maximum allowable amount shown in *Section 5. (h)* for non-preventive dental services.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when we receive your enrollment. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (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 call Member Services at 301-941-2021 or 1-800-333-GWHP.

When you receive your ID card, look it over carefully. If it contains any incorrect information, call Member Services immediately at 301-941-2021 or 1-800-333-GWHP to request a new one. When you receive the new card, destroy the old one. If your card is lost or stolen, call us to request a replacement.

Never let anyone else use your ID card.

Where you get covered care

You must get care from "Plan providers" and "Plan facilities," except in an emergency. When you use Plan providers and facilities, you will only pay copayments, deductibles, and/or coinsurance, and you will rarely have to file claims.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential all Plan providers according to national standards. Our network includes some of the top doctors in our service area.

Our *Directory of Participating Providers* lists physicians and other health care providers, their locations, phone numbers and languages spoken in the office. The *Directory* also shows whether a primary care physician is accepting new patients. (Generally, if you are switching plans but keeping the same primary care physician, you are not considered a new patient.) The *Directory* is updated periodically. You can call Member Services at 301-941-2021 or 1-800-333-GWHP to request the most recent *Directory* or you can look at the list on our website, www.gwhealthplan.com.

- **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 *Directory of Participating Providers*, which we update periodically.

What you must do

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. Your primary care physician refers you for most specialty care and services when necessary and makes arrangements if you need to be hospitalized.

After you look at the *Directory of Participating Providers* or check the list of providers on our website, you must select a primary care physician for yourself and each enrolled family member. You can let us know which primary care physician(s) you want by filling out and mailing the Physician

Selection Form in your enrollment packet or by calling Member Services at 301-941-2021 or 1-800-333-GWHP. If you do not choose a primary care physician, we will choose one for you. You may request to change our selection at any time.

If you would like more information about our physicians, please call Member Services at 301-941-2021 or 1-800-333-GWHP.

• Primary care

Your primary care physician can be a Family Practice, Internal Medicine or Pediatric physician. Each family member can choose a different primary care physician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

NOTE: If you select a primary care physician who is one of The George Washington University Medical Faculty Associates (GWU-MFA) physicians located at 2150 Pennsylvania Avenue, NW, Washington, DC, you will be referred only to specialty care providers who are part of the GWU-MFA. If you select a GWU-MFA primary care physician and you need to be hospitalized, you will be admitted to The George Washington University Hospital.

If you want to change your primary care physician or if your primary care physician leaves the Plan, call us. We will help you select a new one. If we receive your change request by the 15th of the month, the change will become effective by the first of the following month. If we receive your change request after the 15th, the change will become effective the first of the month after the next month. For example: If we receive your request on August 10th, 2001, the change will become effective on September 1, 2001; if we receive your request on August 16, 2001, the change will become effective on October 1, 2001. We may make an exception to this policy under special circumstances.

You must continue to use your current primary care physician until the change is effective. If you receive medical care from the new physician prior to the effective date of the change, you will have to pay for the services.

• Specialty care

You must always get a referral for specialty care from your primary care physician except in the following cases:

- In an emergency
- For obstetrical (maternity) and gynecological care (including annual checkups)
- For your annual routine eye examination
- For mental health/substance abuse treatment services
- When you have already received a referral authorizing long-term specialty treatment

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician, together with your specialist and our Medical Management Department, will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. They will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval from us beforehand). Examples of chronic,

complex or serious medical conditions are kidney failure, cancer and diabetes.

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. Even if you selected the same primary care physician you had before you enrolled in this Plan, you must get a referral from the primary care physician to continue specialty care under this Plan. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. If you are under active treatment, you may receive approval to obtain services from your current specialist until we can make arrangements for another specialist to treat you.
- 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 FEHB 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 Medical Management Department immediately at 301-941-2023. 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 hospital benefit of the hospitalized person.

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process *prior authorization*. Your physician is responsible for obtaining prior authorization. We may deny payment to a provider for failing to obtain prior authorization when necessary. **We do not hold you responsible for the payment as long as you have seen your primary care physician or a Plan provider your primary care physician referred you to for care.**

Your physician must obtain prior authorization directly from us for the following services:

- Any service by a non-participating provider
- Any admission to a hospital, skilled nursing facility or other facility
- Any inpatient or outpatient surgical procedure
- Occupational, speech or cardiac rehabilitation therapy
- Inpatient skilled nursing care in a facility
- MRIs (knee, brain, or spine)
- Infertility treatment or procedures
- Durable medical equipment, orthopedic and prosthetic devices (purchase and rental)
- Home health services
- Hospice care
- Certain procedures conducted in the office
- Certain prescription drugs
- Travel outside the service area after the 35th week of pregnancy

Before seeking mental health and substance abuse treatment, you must obtain prior authorization from American Psych Systems (APS) at 1-888-571-0213. You do not need a referral from your primary care physician. **If you fail to call for prior authorization, we will not pay for the mental health/substance abuse services.**

Section 4. Your costs for covered services

You must share the cost of some services.

You are responsible for:

- **Copayment**

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

Example: When you see your primary care physician, you pay a copayment of $10 per office visit.

- **Deductible**

A deductible is a fixed expense you must incur each calendar year for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- We have separate deductibles for:
  - Durable medical equipment, orthopedic and prosthetic devices combined – $100 per member per calendar year
  - Prescription drugs – $35 per member per calendar year

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

- **Coinsurance**

Coinsurance is the percentage of our negotiated fee that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: In our Plan, you pay 50% of our allowance for infertility services.

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

After your copayments total $650 per Self Only or $1,500 per Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments, deductibles and coinsurance for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments, deductibles and coinsurance for these services:

- Prescription drugs
- Durable medical equipment, orthopedic and prosthetic devices
- Infertility services
- Dental benefits

Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

Section 5. Benefits — OVERVIEW

(See page 7 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 claim forms, claim filing advice, or more information about our benefits, contact us at 301-941-2021 (TTY 301-941-2004) or 1-800-333-GWHP, or at our website at www.gwhealthplan.com.

(a) Medical services and supplies provided by physicians and other health care professionals 14-21

- Diagnostic and treatment services
- Lab, X-ray, and other diagnostic tests
- Preventive care, adult
- Preventive care, children
- Maternity care
- Family planning
- Infertility services
- Allergy care
- Treatment therapies
- Rehabilitative therapies
- Hearing services (testing, treatment, and supplies)
- Vision services (testing, treatment, and supplies)
- Foot care
- Orthopedic and prosthetic devices
- Durable medical equipment (DME)
- Home health services
- Alternative treatments
- Educational classes and programs

(b) Surgical and anesthesia services provided by physicians and other health care professionals 22-24

- Surgical procedures
- Reconstructive surgery
- Oral and maxillofacial surgery
- Organ/tissue transplants
- Anesthesia

(c) Services provided by a hospital or other facility, and ambulance services 25-27

- Inpatient hospital
- Outpatient hospital or ambulatory surgical center
- Extended care benefits/skilled nursing care facility benefits
- Hospice care
- Ambulance

(d) Emergency services..28-29

- Medical emergency
- Ambulance

(e) Mental health and substance abuse benefits..30-31

(f) Prescription drug benefits..32-33

(g) Special features..34

- FirstHelp 24-hour nurse line
- High risk pregnancy support and education
- TTY service for deaf and hearing impaired members
- Disease management

(h) Dental benefits 35-40

(i) Non-FEHB benefits available to Plan members 41

Summary of benefits 55

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:	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 physicians must provide or arrange your care. • We do not have a calendar year deductible for most medical services. We have a $100 calendar year deductible per member for durable medical equipment, orthopedic and prosthetic devices (combined) and a $35 calendar year deductible per member on prescription drugs. These deductibles do not count toward the annual out-of-pocket maximum amount. • 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.	

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians including office medical consultations and second surgical opinions • In physician's office **Note:** You do not need a referral from your primary care physician to see a Plan gynecologist or obstetrician.	$10 per office visit
• In an urgent care center	$10 per office visit
• During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a "Self and Family" enrollment	Nothing
• At home – when your Plan physician considers it medically necessary	$10 per visit
Not covered: • *Physical examinations such as those required for continuing employment or insurance, attending school or camp, or for travel* • *Immunizations for travel* • *Routine podiatry services* • *Acupuncture, naturopathy and hypnotherapy*	*All charges*
Lab, X–ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-screening pap tests • Pathology • X-rays • Non-screening mammograms • Ultrasound • Electrocardiogram and EEG	Nothing (included in office visit copay)
• CT scans and MRIs	$10 per office visit

Preventive care, adult	**You pay**
Vision and glaucoma – comprehensive screening every two to three years between the ages of 19 and 60. Annually beginning at age 61. Increasing frequency for high-risk individuals.	$10 per office visit
Routine screenings, such as: • Cholesterol – once every five years, beginning at age 21 • Colorectal Cancer Screening, including •• Fecal occult blood test – annually beginning at age 50, AND •• Sigmoidoscopy with digital rectal exam – every five years starting at age 50, OR •• Colonoscopy with digital rectal exam – every ten years starting at age 50, OR •• Double contrast barium enema with digital rectal exam – every 5-10 years starting at age 50 • Prostate specific antigen (PSA test) – one annually for men age 50 and older • Clinical testicular exam – every three years between ages 18 and 39; annually beginning at age 40 • Pelvic exam – every one to three years between ages 18 and 39; annually beginning at age 40 • Routine pap test – annually beginning at age 18 (under age 18 if sexually active) • Mammogram •• from age 35 through 39, one during this five year period •• from age 40 through 64, one every calendar year •• from age 65 and older, one every two consecutive calendar years	Nothing (included in office visit copay)
Not covered: • *Physical exams such as those required for obtaining or continuing employment or insurance, attending schools or camp, or travel.*	*All charges*
Routine Immunizations, including: • Tetanus-diphtheria (Td) – if not given during childhood, •• first dose •• second dose four to six weeks after the first dose •• third dose six to twelve months after the second dose •• booster shot every ten years • Influenza (flu) – annually in the Fall starting at age 50. Also recommended for those under age 50, if at high risk for complications • Hepatitis A and B – recommended for those at high risk • Measles, Mumps, Rubella (MMR) – recommended for all persons born after 1956 who were not previously immunized • Varicella (chicken pox) – recommended for adults who have not previously had chicken pox or were not previously vaccinated • Pneumococcal – recommended once for all persons age 65 and older. Also recommended for those under age 65 if at high risk for complications. Repeat dose may be given five years later to those at highest risk.	Nothing
Not covered: • *Immunizations for travel*	*All charges*

Preventive care, children	You pay
• Newborn exam, well-baby/well-child care (through age 6), including routine examinations and immunizations • Childhood immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control, the American Academy of Pediatrics and the American Academy of Family Physicians	Nothing
• Well-child care, age 7 and older, including routine examinations and immunizations	$10 per office visit
Not covered: • *Physical examinations such as those required for obtaining or continuing employment or insurance, attending schools or camp, or for travel* • *Immunizations for travel*	*All charges*
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care **Note:** Here are some things to keep in mind: • You do not need a referral from your primary care physician to see a Plan OB/GYN for obstetrical care. • You may remain in the hospital up to 48 hours after an uncomplicated regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • If you request early discharge from the hospital, we will cover one visit by a nurse to your home. (See *Section 5. (a) – Home health services*.) • 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 the infant is enrolled under a "Self and Family" enrollment. • Women may use participating Plan-certified nurse midwives under the supervision of a participating physician. • We pay hospitalization and surgeon services (delivery) the same as for any other illness or injury. See *Sections 5. (b)* and 5. *(c)*. • If it is absolutely necessary for you to travel outside the service area after the 35th week of pregnancy, your obstetrician must obtain prior authorization from us.	$10 for the first office visit, then nothing
Not covered: • *Normal, full-term delivery of a baby outside our service area without prior authorization* • *Maternity care after coverage in this Plan has ended, if enrollment is terminated during pregnancy*	*All charges*
Family planning	
• Voluntary sterilization and family planning services • Surgically implanted contraceptives, such as Norplant • Injectable contraceptive drugs • Intrauterine devices (IUDs)	$10 per office visit

Family planning – Continued on next page

Family planning *(Continued)*	**You pay**
Not covered: • *Reversal of voluntary surgical sterilization* • *Procedures, services, drugs, 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* • *Genetic counseling*	*All charges*
Infertility services	
Diagnosis and treatment of infertility, as well as the following types of artificial insemination: • Intravaginal insemination (IVI) • Intracervical insemination (ICI) • Intrauterine insemination (IUI)	50% of our Plan allowance **Note:** Payment does not count toward meeting your annual out-of-pocket maximum
Not covered: • *Fertility drugs* • *Other assisted reproductive technology (ART) procedures, such as in vitro fertilization, embryo transfer, GIFT and ZIFT* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of sperm storage* • *Reversal of voluntary, surgically-induced sterility*	*All charges*
Allergy care	
• Allergy tests • Allergy treatment, including injections	$10 per office visit
• Allergy serum	Nothing
Not covered: • *Provocative food testing, sublingual allergy desensitization and RAST*	*All charges*
Treatment therapies	
• 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 • Intravenous (IV)/Infusion Therapy – home IV and antibiotic therapy	Nothing
Not covered: • *Medical food, nutritional substances, tube and enteral feedings, except intravenous hyperalimentation* • *Sleep therapy* • *Biofeedback* • *Acupuncture* • *Naturopathic services* • *Hypnotherapy* • *Other alternative therapies*	*All charges*

Rehabilitative therapies	You pay
Short term physical, occupational, and speech therapy on an inpatient or outpatient basis. • Up to 90 days per condition for the services of each of the following Plan providers: •• physical therapists •• speech therapists •• occupational therapists **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. We provide coverage only if significant improvement can be expected within 90 days.	$10 per office visit or Nothing if performed during an approved hospital admission
• Cardiac therapy – provided on an inpatient or outpatient basis following a heart transplant, bypass surgery, or myocardial infarction. No visit limits.	$10 per office visit
Not covered: • *Long-term habilitative or rehabilitative therapy* • *Exercise programs*	*All charges*
Hearing services (testing, treatment, and supplies)	
• Routine testing • Hearing testing for children through age 17 to determine the need for hearing correction	$10 per office visit
Not covered: • *Hearing aids, internal and external hearing devices* • *Testing and examinations for hearing aids, internal and external hearing devices* • *All other hearing testing*	*All charges*
Vision services (testing, treatment, and supplies)	
• Routine annual eye examination • Eye exam for children through age 17 to determine the need for vision correction **Note:** You do not need a referral from your primary care physician to see a participating optometrist or ophthalmologist for your annual eye examination. **Note:** Diagnosis and treatment of diseases of the eye are covered in this section under *Diagnostic and treatment services.*	$10 per office visit
Not covered: • *Frames, lenses, and other eyewear* • *Contact lenses, including special contact lenses used in the treatment of certain eye diseases, and their fitting* • *Visual training exercises* • *Radial keratotomy, LASIK surgery or any eye surgery solely for the purpose of correcting refractive defects such as nearsightedness (myopia), farsightedness (hyperopia) and astigmatism (blurring)*	*All charges*

Foot care	**You pay**
Foot care (podiatry) services are covered when related to an underlying medical condition such as diabetes See *Orthopedic and prosthetic devices* below for information on podiatric shoe inserts (orthotics).	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or dislocation (subluxation) of the foot, unless the treatment is by open cutting surgery*	*All charges*
Orthopedic and prosthetic devices	
Rental or purchase (at our option) of devices prescribed by your Plan physician and prior authorized by us. Includes: • Orthopedic devices such as braces, crutches, canes and walkers • Prosthetic devices such as artificial limbs and ocular lenses following cataract removal • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy **Note:** We will only cover the repair or replacement of orthopedic and prosthetic devices when growth makes it necessary. Limited to one replacement. **Note:** We only cover specific items. Call Member Services at (301) 941-2021 or 1-800-333-GWHP for a copy of the list of covered items.	$100 calendar year deductible per member, plus 50% of the remainder of our Plan allowance **Note:** Payment does not count toward your annual out-of-pocket maximum. **Note:** The deductible may be combined with the deductible for durable medical equipment.
• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, ocular lenses following cataract removal, and surgically implanted breast implant following mastectomy. **Note:** We cover internal prosthetic devices as surgical benefits. See *Section 5. (b)* for coverage of the surgery to insert the device.	Nothing
Not covered: • *Devices for which there is a non-prescription equivalent available* • *Wigs and other hair prostheses* • *Orthopedic and corrective shoes* • *Foot orthotics and arch supports* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Repair, replacement and duplication of orthopedic and prosthetic devices, except as noted above* • *Other orthopedic and prosthetic devices that are not on our list of covered items*	*All charges*

Durable medical equipment (DME)	**You pay**
Rental or purchase (at our option) of durable medical equipment prescribed by your physician and prior authorized by us. Equipment must be able to withstand repeated use, primarily serve a medical purpose, and be appropriate for use in your home. Includes such items as: • Hospital beds • Oxygen equipment and oxygen for home use • Non-motorized wheelchairs **Note:** We cover only specific items. Call Member Services at 301-941-2021 or 1-800-333-GWHP for a copy of the list of covered items. **Note:** Members with diabetes may obtain one of two types of glucose monitors at no cost. Call Disease Management at 301-941-2160 for information about how to order.	$100 calendar year deductible per member, plus 50% of the remainder of our Plan allowance **Note:** Payment does not count toward your annual out-of-pocket maximum amount. **Note:** The deductible may be combined with the deductible for orthopedic and prosthetic devices.
Not covered: • *Devices for which there is a non-prescription equivalent available* • *Insulin pumps* • *Hearing aids* • *Repair, replacement and duplication of DME items* • *Motorized wheel chairs and carts/scooters* • *Vehicles* • *Other durable medical equipment that is not on our list of covered items*	*All charges*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. Services include administration of intravenous fluids and medications prescribed by a Plan physician. **Note:** Your physician must receive prior authorization from us in order for us to cover your care. **Note:** We and your physician will periodically review your treatment plan for continuing appropriateness and need. **Note:** If you request early discharge from your maternity hospital stay, we will cover one visit by a nurse to your home. **Note:** We only cover home health aides when they are part of an approved home health care team.	$10 per visit
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All charges*

Alternative treatments	You pay
• Chiropractic services are covered for up to 20 visits per condition per calendar year if significant improvement can be expected within 20 visits.	$8 per office visit for the first 5 visits; $14 per office visit for the 6th through 20th visit; $20 per office visit for all visits thereafter. **Note:** The $20 office visit copay applies if you have had two or more conditions during the calendar year and have already received a combined total of 20 visits during the calendar year.
Not covered: • *Acupuncture* • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Sleep therapy* • *Any alternative therapy not shown as covered*	*All charges*
Educational classes and programs	
Coverage is limited to: • Diabetes nutritional counseling, when coordinated through our Medical Management Department	Nothing
Not covered: • *Health education classes not listed above*	*All charges*

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

I M P O R T A N T

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 physicians must provide or arrange your care.
- We do not have a calendar year deductible for most medical services. We have a $100 calendar year deductible per member for durable medical equipment, orthopedic and prosthetic devices (combined) and a $35 calendar year deductible per member on prescription drugs. These deductibles do not count toward the annual out-of-pocket maximum amount.
- 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 in *Section 5. (c)* for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR ANY INPATIENT OR OUTPATIENT SURGICAL PROCEDURE.** Please refer to the prior authorization information shown in *Section 3* to be sure which services require prior authorization.

I M P O R T A N T

Benefit Description	You pay
Surgical procedures	
Medically necessary medical or surgical care such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Endoscopy procedures • Biopsy procedures • Correction of congenital anomalies (see *Reconstructive surgery in this section*) • 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 and meet medical guidelines • Insertion of internal prosthetic devices such as pacemakers and artificial joints. See *Section 5. (a) – Orthopedic and prosthetic devices* for device coverage information. • Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs). **Note:** Devices are covered under *Section 5. (f) – Prescription drug benefits*. • Treatment of burns	Nothing if performed during an approved hospital admission or $10 per office visit if performed in a Plan physician's office
Not covered: • *Reversal of voluntary sterilization* • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance*	*All charges*

Reconstructive surgery	You pay
• Surgery to correct a congenital or functional defect • Surgery to correct a condition caused by accident, injury or surgery 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 • 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 *Section 5. (a) – Orthopedic and 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.	Nothing if performed during an approved hospital admission or $10 per office visit if performed in a Plan physician's office
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures provided for non-dental surgical and hospitalization procedures for congenital defects and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses, including but not limited to: • Treatment of fractures of the jaw or facial bones • Excision of tumors and cysts when done as independent procedures • Surgical correction of cleft lip and cleft palate	Nothing if performed during an approved hospital admission or $10 per office visit if performed in a Plan physician's office or urgent care center
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, including any dental care involved in the treatment of temperomandibular joint (TMJ) pain dysfunction syndrome*	*All charges*

Organ/tissue transplants	**You pay**
Limited to: • Cornea • Heart • Heart/lung • Kidney • Liver • Lung: Single and Double • Pancreas • Pancreas/Kidney • 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 **Note:** We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: • *Transplants not listed as covered* • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs*	*All charges*
Anesthesia	
Professional services provided in: • Hospital (inpatient) • Hospital (outpatient) • Outpatient surgery facility • Skilled nursing facility	Nothing
Professional services provided in: • Physician's office	$10 per office visit

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

I M P O R T A N T

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.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility, except in an emergency.
- We do not have a calendar year deductible for most medical services. We have a $100 calendar year deductible per member for durable medical equipment, orthopedic and prosthetic devices (combined) and a $35 calendar year deductible per member on prescription drugs. These deductibles do not count toward the annual out-of-pocket maximum amount.
- 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 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 covered in *Sections 5. (a)* and *5. (b)*.
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR ANY INPATIENT OR OUTPATIENT HOSPITAL OR FACILITY ADMISSION.** Please refer to *Section 3* to be sure which services require prior authorization.

I M P O R T A N T

Benefit Description	You pay
Inpatient hospital	
All medically necessary services are covered, including: • Semiprivate room accommodations • Specialized care accommodations, such as intensive care or cardiac care units • Private room when Plan physician determines it is medically necessary • General nursing care • Private duty nursing care when Plan physician determines it is medically necessary • 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. **Note:** We cover hospitalization for certain dental procedures only when a participating physician determines it is required for reasons totally unrelated to the dental procedure. We will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease. The need for anesthesia by itself is not a condition for hospitalization.	Nothing

Inpatient hospital – Continued on next page

Inpatient hospital *(Continued)*	**You pay**
Other covered hospital services and supplies, such as: • Pre-admission testing • Operating, recovery, maternity, and other treatment rooms • Anesthetics and anesthesia services • Prescribed drugs and medicines and their administration • Diagnostic laboratory tests, X-rays and pathology services • Administration of blood, blood products and other biologicals • Blood products and blood derivatives • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Treatment and rehabilitative therapies	Nothing
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Private room and private nursing care, except as described above* • *Whole blood and concentrated red blood cells* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds*	*All charges*
Outpatient hospital or ambulatory surgical center	
All medically necessary services are covered, including: • Pre-surgical testing • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines and their administration • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood products and other biologicals • Blood products and blood derivatives • Dressings, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics and anesthesia service **Note:** We cover hospitalization for certain dental procedures only when a participating physician determines it is required for reasons totally unrelated to the dental procedure. We will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease. The need for anesthesia by itself is not a condition for hospitalization.	Nothing
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Private nursing care* • *Whole blood and concentrated red blood cells* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds*	*All charges*

Extended care benefits/skilled nursing care facility benefits	**You pay**
We cover extended care for up to 90 days per calendar year when full-time skilled nursing care is medically necessary and we approve the confinement: • Bed and board • General nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the extended care/skilled nursing facility when prescribed by a Plan physician	Nothing
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Private nursing care* • *Whole blood and concentrated red blood cells* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds*	*All charges*
Hospice care	
We cover supportive care in the home or hospice facility to manage symptoms of a terminally ill member. Services are provided under the direction of a Plan physician who certifies that the member is in the terminal state of illness, with a life expectancy of approximately six months or less. Services include: • Inpatient and outpatient care • Family counseling	Nothing
Not covered: • *Private-duty nursing* • *Homemaker services*	*All charges*
Ambulance	
We cover ground ambulance transportation when ordered or authorized by us.	Nothing

Section 5. (d) Emergency services/accidents

I M P O R T A N T	**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. • We do not have a calendar year deductible for most medical services. We have a $100 calendar year deductible per member for durable medical equipment, orthopedic and prosthetic devices (combined) and a $35 calendar year deductible per member on prescription drugs. These deductibles do not count toward the annual out-of-pocket maximum amount. • 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.	I M P O R T A N T

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:

1. Call your primary care physician.
2. If you cannot reach your primary care physician, call GW FirstHelp for assistance at 1-800-667-2571.
3. If a delay in reaching your primary care physician would result in death, disability or significant jeopardy to your condition, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify us.
4. If you are hospitalized due to the emergency, the hospital or your physician must notify our Medical Management Department at 301-941-2023 or 1-800-333-GWHP **and** you or a family member should call Member Services at 301-941-2021 or 1-800-333-GWHP within 24 hours or on the first working day following your admission, unless it is not reasonably possible to notify us within that time. It is your responsibility to ensure that we are notified promptly.
5. If you are hospitalized in a non-Plan facility, and we believe your care can be better provided in a Plan facility, we will arrange to transfer you when medically feasible and we will cover any ambulance charges.
6. We must approve all follow-up care recommended by non-Plan providers or it must be provided by Plan providers. Your physician must call our Medical Management Department in advance at 301-941-2023 or 1-800-333-GWHP to request authorization.

Note: We pay reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

Emergency services/accidents – Continued on next page

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center	$10 per office visit
• Emergency care as an outpatient at a hospital or free-standing emergency room, including doctors' services	$50 per visit (waived if you are admitted)
Not covered: • *Elective care or non-emergency care*	*All charges*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center	$10 per office visit
• Emergency care as an outpatient at a hospital or free-standing emergency room, including doctors' services	$50 per visit (waived if you are admitted)
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside of the service area if the need for the care could have been foreseen before leaving the service area* • *Normal full-term delivery of a baby outside the service area without prior authorization* • *Cost of medical evacuation from any foreign country or distant areas of the United States. (Members who wish to protect themselves from this expense are advised to purchase travel insurance.)*	*All charges*
Ambulance	
We cover ground ambulance service when medically appropriate. See *Section 5. (c)* for non-emergency ambulance service.	Nothing
Not covered: • *Air ambulance* • *Cost of medical evacuation from any foreign country or distant areas of the United States. (Members who wish to protect themselves from this expense are advised to purchase travel insurance.)*	*All charges*

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

I M P O R T A N T

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.
- We do not have a calendar year deductible for most medical services. We have a $100 calendar year deductible per member for durable medical equipment, orthopedic and prosthetic devices (combined) and a $35 calendar year deductible per member on prescription drugs. These deductibles do not count toward the annual out-of-pocket maximum amount.
- 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 PRIOR AUTHORIZATION FOR THESE SERVICES FROM AMERICAN PSYCH SYSTEMS BEFORE YOU SEEK MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.** See the instructions after the benefit description below.

I M P O R T A N T

Benefit Description	You pay
Mental health and substance abuse benefits	
Diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan approved by the American Psych Systems (APS) Mental Health Administrator. 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 office visit or Nothing if performed during an approved inpatient admission
• Diagnostic tests	Nothing (included in office visit copay)
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing

Mental health and substance abuse benefits – Continued on next page

Mental health and substance abuse benefits *(Continued)*	You pay
Not covered: • *Services not prior authorized by the APS Mental Health Administrator* • *Services provided by a government, community or employer program, even if recommended by a participating provider* • *Psychiatric or psychological examinations, testing or treatments for purposes of school evaluations, marriage, adoption, medical research, obtaining or maintaining employment, a license, insurance or other official document, or solely relating to forensic evaluation, judicial or administrative proceedings* • *Psychiatric evaluation or therapy on court order or as a condition of parole or probation unless determined by the Mental Health Administrator to be medically necessary and appropriate* • *Services for enrollees who are consciously and deliberately non-compliant with recommended treatment, when such non-compliance is not a direct result of psychiatric illness* • *Services and treatments provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health Administrator as medically necessary* • *Intelligence, IQ, aptitude, ability, interest or any other psychological testing not medically necessary to determine the appropriate treatment of a psychiatric condition* • *Services that are custodial in nature* • *All charges if the member does not complete substance abuse treatment program*	*All charges*

Prior authorization

To be eligible to receive these benefits you must follow your treatment plan and the following prior authorization process:

Before you seek mental health or substance abuse treatment, you must call the American Psych Systems (APS) Mental Health Administrator at 1-888-571-0213. The APS Mental Health Administrator will assess the services you need, the professional best suited to treat you, the progress of your treatment and the need for additional (continuing) care.

Special transitional benefit

When a mental health or substance abuse professional provider is treating you under our Plan as of January 1, 2001, you may be eligible for continued coverage with your provider for up to 90 days if the provider currently treating you leaves the plan at our request for other than cause.

If this condition 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. The transitional period will last for up to 90 days from the date you receive notice of the change. You may receive this notice prior to January 1, 2001, and the 90-day period begins with receipt of the notice.

Limitation

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

How to submit claims

Submit claims to: APS – Claims Department
P.O. Box 1246
Rockville, MD 20849

Section 5. (f) Prescription drug benefits

I M P O R T A N T

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.
- We do not have a calendar year deductible for most medical services. We have a $100 calendar year deductible per member on durable medical equipment, orthopedic and prosthetic devices (combined) and a $35 calendar year deductible per member on prescription drugs. These deductibles do not count toward the annual out-of-pocket maximum amount.
- **Your physician must request prior authorization from us in writing before he/she can prescribe certain drugs for you.** The request must be based on a medical reason that you need the drug. Our authorization is good for the remainder of the calendar year or a specified time period, whichever is less.
- 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.

I M P O R T A N T

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

- **Who can write your prescription.** A Plan physician or Plan dentist must write the prescription.
- **Where you can obtain them.** You may fill your prescription at a Plan pharmacy or order maintenance medication by mail from PharmaCare. For information about how to get started in the mail order program, call 1-800-777-1023.

  If you need to fill a prescription while you are outside of our service area, you can go to one of PharmaCare's national network pharmacies. You will pay only the unpaid portion of your deductible and/or copayment. Call 1-800-237-6184 to find the nearest participating national network pharmacy.

  In an emergency while you are outside of our service area, you may purchase your medication at a non-Plan pharmacy. You must pay for the medication and request reimbursement from PharmaCare. Be sure to keep all receipts and information describing the cost, the prescribing physician and the date purchased. Submit all requests for reimbursement within 60 days from the date of purchase. See *Section 7 – Filing a claim for covered services*.
- **We use a formulary.** Plan providers prescribe drugs in accordance with our formulary. Our formulary lists medications that we have reviewed and approved to be included for coverage. We choose formulary medications based on their effectiveness in treating certain conditions and on other criteria.

  We divide our formulary into three categories: *Tier I, Tier II and Tier III*. Tier I includes generic drugs. Tier II includes preferred brand name drugs. Tier III includes non-preferred brand name drugs.

  Our Pharmacy and Therapeutics (P&T) Committee periodically reviews the formulary. The P&T Committee includes Plan doctors and pharmacists who meet quarterly to review the clinical, quality and economic effectiveness of medications. We assign drugs to different tiers based on their findings. You may obtain a copy of the formulary from Member Services or contact the Pharmacy Coordinator at 301-941-2094 to see if a specific drug is included on the formulary.
- **These are the dispensing limitations.** Plan pharmacies dispense drugs in prescription units or refills. One prescription unit or refill is defined as up to a 30-day supply. Drugs for maintenance purposes may be ordered and dispensed for up to a 90-day supply for two copayments. We have a list of specific formulary drugs that are dispensed as maintenance drugs. You can purchase maintenance drugs at Plan retail pharmacies or from PharmaCare's mail order program.

  Plan pharmacies will fill your prescription with a generic equivalent, when one is available, unless your physician specifically requests a name brand drug. Every drug does not have a generic equivalent. Your copay will be based on whether you receive a Tier I, Tier II, or Tier III drug.

Prescription drug benefits – Continued on next page

- **When you have to file a claim.** Send a brief explanation of the reason you are requesting reimbursement with a PharmaCare Drug Reimbursement Form and the pharmacy receipt (not a register receipt) to:

  Pharmacare
P.O. Box 519
25 Blackstone Valley Place
Lincoln, RI 02865

Benefit Description	You pay
Note: The $35 prescription drug calendar year deductible per member applies to all benefits in this Section.	
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • FDA-approved drugs for which a prescription is required by federal or state law • Contraceptive drugs (e.g., oral) and devices (e.g., diaphragms) approved by the FDA for use as contraceptives • Insulin • Disposable needles and syringes needed to inject covered medication • Diabetic supplies, including glucometer supplies, for insulin-dependent diabetics are covered when purchased for the glucometers we provide free to our diabetic members • Growth hormones are covered only when medically necessary and appropriate to treat an illness and if authorized as part of a treatment plan provided to and approved by our Medical Management Department • Drugs for sexual dysfunction have dispensing limitations. Contact Member Services for details. • Chemotherapy drugs – oral **Note:** Implantable and injectible contraceptive devices, such as Norplant, IUDs, and Depo Provera, are covered as part of an office visit. There is no additional charge for the drug or device. See *Section 5. (a) – Family planning*. **Note:** Injectible chemotherapy drugs are covered as part of an office visit. There is no additional charge for the drug. See *Section 5. (a) – Treatment therapies*.	For each prescription unit or refill up to a 30-day supply: $5 for Tier I drugs $15 for Tier II drugs $25 for Tier III drugs For up to a 90-day supply of maintenance drugs: $10 for Tier I drugs $30 for Tier II drugs $50 for Tier III drugs **Note:** Your copay will never exceed the price of the drug. **Note:** If a generic equivalent is not available, you still pay the applicable brand name copay.
Not covered: • *Drugs available without a prescription or for which there is a non-prescription equivalent available* • *Drugs obtained at a non-participating pharmacy, except in an emergency while you are outside our service area* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Medical supplies such as dressings and antiseptics* • *Smoking cessation drugs and medications, including nicotine patches* • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs for infertility* • *Drugs to induce weight loss (anorexients)*	*All charges*

Section 5. (g) Special Features

Feature	Description
FirstHelp 24-hour nurse line	For urgent health concerns you may call 1-800-667-2571 and talk with a registered nurse. The nurse will advise you how to take care of minor injuries and illnesses, whether your doctor can best treat your problem, or whether you need to go to the emergency room. The FirstHelp line is available 24 hours a day, 7 days a week.
High risk pregnancies	For support and education during your pregnancy, we offer *Next Generation Babies*, a free program that can help you deliver a healthy, full-term baby. You can register as soon as you learn you are pregnant. When you register by the 16th week of pregnancy, you receive a welcome package including colorful books and materials. After delivery and one postnatal visit, a congratulatory gift is yours. Call 301-907-3566.
TTY Service for deaf and hearing impaired members	TTY phone number – 301-941-2004
Disease Management	We offer a support and education program that helps members with chronic health problems learn how to be healthier through better management of a disease. The disease management program currently helps members with asthma, diabetes, high cholesterol, congestive heart failure and high blood pressure. Call 301-941-2160.

Section 5. (h) Dental benefits

	Here are some important things to keep in mind about these benefits:	
IMPORTANT	• 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 dentists must provide or arrange your care. • We do not have a calendar year deductible or a benefit maximum for dental benefits. We have a $100 calendar year deductible per member on durable medical equipment, orthopedic and prosthetic devices (combined) and a $35 calendar year deductible per member on prescription drugs. These deductibles do not count toward your annual out-of-pocket maximum amount on medical services. • We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below. • Be sure to read *Section 4 – Your costs for covered services* for valuable information about how cost sharing works. Also read *Section 9* about coordinating benefits with other coverage, including with Medicare.	**IMPORTANT**

Accidental injury benefit

We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury from an external force (not chewing). You pay a $10 copay for each visit to a dentist; you pay $50 if you are treated in the emergency room.

Dental benefits

We contract with Dental Benefit Providers (DBP) to administer dental benefits for our members. Dentists contracted by DBP provide services. We cover comprehensive dental care services when provided by participating DBP dentists in our service area. This dental benefit plan emphasizes prevention, with most preventive and diagnostic dental services covered at no cost. There are no deductibles, and no benefit maximums. You do not need to submit claim forms unless you receive out-of-area emergency care.

You will be automatically enrolled in this dental program when you enroll in the GW Health Plan. You do not have to fill out additional paperwork. You will receive a separate identification card from DBP.

You do not need to select a primary dentist. You may obtain services at any Plan dentist and you do not need a referral to visit a participating specialty dentist. Each enrolled family member can visit different Plan dentists. Before your appointment, you should verify that a dentist still participates with this Plan by calling DBP Customer Service toll-free at 1-877-502-6037. We do not cover services provided by non-Plan dentists. You may obtain a new *Directory of Participating Dentists* from the GW Health Plan Member Services Department.

You must give at least 24 hours notice to cancel a dental appointment, or you may have to pay a broken appointment charge of up to $15 per half-hour scheduled.

In-Area Emergency Services: If an emergency results in acute pain or a condition requiring immediate treatment, you should contact a participating dentist to obtain services. A $25 surcharge will be applied for emergency dental services provided during non-business hours.

Out-of-Area Emergency Services: If an emergency results in acute pain or a condition requiring immediate treatment and you are more than 50 miles from home, you may seek care from any general dentist. Coverage is limited to emergency services necessary to stabilize your condition, when not related to an accidental injury. DBP will reimburse you for the difference between the out-of-network dentist's charge and your in-network copayment, up to a maximum of $50 per occurrence. You pay your copayment and any remaining charges. You must submit a claim for reimbursement, with the itemized bill, to DBP. Claims should be sent to: Dental Benefit Providers, Attn: Claims Department, P.O. Box 30640, Bethesda, MD 20824-0640.

Dental benefits – Continued on next page

If you have questions about your dental coverage, call DBP Customer Service at 1-877-502-6037. Representatives are available to help you Monday through Thursday from 8:30 a.m. until 8:00 p.m., and Friday from 9:00 a.m. until 8:00 p.m. EST. After you are enrolled in this Plan, you may choose the Interactive Voice Response (IVR) System option. The automated IVR System provides you with an easy-to-use means of obtaining eligibility and provider information. The IVR System is available 24 hours a day, 7 days a week.

The following services are covered when provided by participating dentists. **The "you pay up to" column shows the MAXIMUM amount you will be charged for a given service.**

Dental Benefits	You pay up to
ADA Code # and Description of Services	
Diagnostic	
00110 Initial oral examination	Nothing
00120 Periodic oral examination (once every 6 mos.)	Nothing
00140 Limited oral evaluation - problem focused	Nothing
00150 Comprehensive oral evaluation	Nothing
00210 Intraoral – complete series incl. bitewings (once every 36 mos.)	Nothing
00220 Intraoral – periapical – first film	Nothing
00230 Intraoral – each additional film	Nothing
00240 Intraoral – occlusal film	Nothing
00270 Bitewing – single film	Nothing
00272 Bitewing – 2 films	Nothing
00273 Bitewing – 3 films	Nothing
00274 Bitewings – 4 films	Nothing
00330 Panoramic film (once every 36 mos.)	Nothing
00460 Pulp vitality tests	Nothing
00470 Diagnostic casts	Nothing
Preventive	
01110 Prophylaxis (cleaning) – Adult (once every 6 mos.)	Nothing
01120 Prophylaxis (cleaning) – Child (once every 6 mos.)	Nothing
01201 Topical fluoride, including prophylaxis, age <14, (once every 6 mos.)	Nothing
01203 Topical fluoride, excluding prophylaxis, age <14 (once every 6 mos.)	Nothing
01205 Topical fluoride, excluding prophylaxis, age (14 (once every 6 mos.)	Nothing
01330 Oral hygiene instruction	Nothing
01351 Sealant – per tooth to age 16	$28.00
01510 Space maintainer – fixed unilateral	$162.00
01515 Space maintainer – fixed bilateral	$273.00
01520 Space maintainer – removable unilateral	$214.00
01525 Space maintainer – removable bilateral	$289.00
01550 Recementation of space maintainer	$33.00
Restorative	
02110 Amalgam – one surface, primary	$54.00
02120 Amalgam – 2 surfaces, primary	$70.00
02130 Amalgam – 3 surfaces, primary	$87.00
02131 Amalgam – 4 or more surfaces, primary	$107.00
02140 Amalgam – one surface, permanent	$61.00
02150 Amalgam – 2 surfaces – permanent	$79.00
02160 Amalgam – 3 surfaces, permanent	$98.00
02161 Amalgam – 4 or more surfaces, permanent	$116.00
02330 Resin – one surface, anterior	$76.00
02331 Resin – 2 surfaces, anterior	$97.00
02332 Resin – 3 surfaces, anterior	$121.00
02335 Resin – more than 3 surfaces or involving incisal angle anterior	$133.00
02380 Resin – one surface, posterior primary	$69.00
02381 Resin – 2 surfaces, posterior primary	$90.00
02382 Resin – 3 or more surfaces, posterior primary	$112.00
02385 Resin – one surface, posterior permanent	$82.00
02386 Resin – 2 surfaces, posterior permanent	$113.00
02387 Resin – three or more surfaces, posterior permanent	$139.00
02510 Inlay – metallic one surface	$393.00
02520 Inlay – metallic 2 surfaces	$445.00

Dental benefits – Continued on next page

Dental Benefits *(Continued)*	**You pay up to**
Restorative (continued)	
02530 Inlay – metallic 3 or more surfaces	$538.00
02543 Onlays – metallic – three surfaces	$575.00
02544 Onlays – metallic – four or more surfaces	$620.00
02610 Inlay – porcelain/ceramic one surface	$463.00
02620 Inlay – porcelain/ceramic 2 surfaces	$476.00
02630 Inlay – porcelain/ceramic 3 surfaces	$536.00
02640 Onlay – porcelain/ceramic per tooth	$205.00
02650 Inlay – composition/resin one surface (lab procedure)	$404.00
02651 Inlay – composition/resin 2 surfaces (lab procedure)	$412.00
02652 Inlay – composition/resin 3 or more surfaces (lab)	$460.00
02710 Crown – resin (laboratory)	$209.00
02740 Crown – porcelain/ceramic substrate	$624.00
02750 Crown – porcelain fused to high noble metal	$628.00
02751 Crown – porcelain fused to predominantly base metal	$537.00
02752 Crown – porcelain fused to noble metal	$576.00
02790 Crown – full cast high noble metal	$591.00
02791 Crown – full cast predominantly base metal	$531.00
02792 Crown – full cast noble metal	$543.00
02810 Crowns – 3/4 metallic	$633.00
02910 Recement inlay	$49.00
02920 Recement crown	$49.00
02930 Prefabricated stainless steel crown primary tooth	$129.00
02931 Prefabricated stainless steel crown permanent tooth	$133.00
02932 Prefabricated resin crown	$143.00
02940 Sedative fillings	$47.00
02950 Crown buildup (substructure) including pins	$124.00
02951 Pin retention – per tooth in addition to restoration	$23.00
02952 Cast post & core in addition to crown	$199.00
02954 Prefabricated post & core in addition to crown	$168.00
02962 Labial veneer – laboratory (bonding)	$484.00
02970 Temporary crown (fractured tooth)	$110.00
02980 Crown repair	$102.00
Endodontics	
03110 Pulp cap – direct, excluding final restoration	$37.00
03120 Pulp cap – indirect, excluding final restoration	$30.00
03220 Therapeutic pulpotomy excluding final restoration	$84.00
03310 Root canal therapy – anterior, excluding final restoration	$386.00
03320 Root canal therapy – bicuspid, excluding final restoration	$461.00
03330 Root canal therapy – molar, excluding final restoration	$603.00
03346 Retreatment of previous root canal therapy – anterior	$465.00
03347 Retreatment of previous root canal therapy – bicuspid	$545.00
03348 Retreatment of previous root canal therapy – molar	$668.00
03410 Apicoectomy/periradicular surgery – anterior	$401.00
03421 Apicoectomy/periradicular surgery – bicuspid first root	$454.00
03425 Apicoectomy/periradicular surgery – molar first root	$488.00
03426 Apicoectomy/periradicular surgery – molar, each add'l root	$175.00
03430 Retrograde filling – per root	$109.00
03450 Root amputation – per root	$265.00
03920 Hemisection (incl. any root removal but without root canal therapy)	$221.00
03960 Bleaching of discolored tooth	$189.00
Periodontics	
04210 Gingivectomy/gingivoplasty – per quadrant (once in 36 mos.)	$222.00
04211 Ginvivectomy/gingivoplasty – per tooth (once in 36 mos.)	$77.00
04220 Gingival curettage, surgical – per quadrant – by report (once in 36 mos.)	$108.00
04240 Gingival flap, including root planing – per quadrant (once in 36 mos.)	$300.00
04249 Crown lengthening – hard/soft tissue – by report	$325.00
04250 Muco-gingival surgery – per quadrant	$332.00
04260 Osseous surgery including flap entry & closure	$570.00
04261 Osseous graft (once in 36 mos. per quadrant)	$217.00
04262 Osseous graft, multiple (once in 36 mos. per quadrant)	$248.00
04268 Guided tissue regeneration, including surgical re-entry by report	$319.00

Dental benefits – Continued on next page

Dental Benefits *(Continued)*	You pay up to
Periodontics (continued)	
04270 Pedicle soft tissue graft procedure	$404.00
04271 Free soft tissue graft and donor site	$431.00
04273 Subepithelial connective tissue graft	$321.00
04320 Provisional Splinting – intracoronal	$115.00
04321 Provisional Splinting – extracoronal	$106.00
04341 Periodontal scaling & root planing – per quadrant (once every 24 mos.)	$114.00
04355 Full mouth debridement before comprehensive treatment (once every 36 mos.)	$68.00
04910 Periodontal maintenance following active therapy	$71.00
Prosthetics Removable	
05110 Complete denture – upper	$725.00
05120 Complete denture – lower	$725.00
05130 Immediate denture – upper	$789.00
05140 Immediate denture – lower	$789.00
05211 Upper partial denture resin base including clasps	$614.00
05212 Lower partial denture resin base including clasps	$614.00
05213 Upper partial denture metallic base/resin saddle including clasps	$863.00
05214 Lower partial denture metallic base/resin saddle including clasps	$863.00
05281 Removable unilateral partial denture metallic base, cast clasp	$459.00
05410 Adjust denture – complete or partial, upper or lower	$43.00
05411 Adjust complete denture – lower	$43.00
05510 Repair broken complete denture base	$82.00
05520 Replace missing/broken teeth complete denture per tooth	$69.00
05610 Repair acrylic saddle or base	$82.00
05620 Repair cast framework	$93.00
05630 Repair/replace broken clasp	$100.00
05640 Replace broken teeth – per tooth	$72.00
05650 Add tooth to existing partial denture	$93.00
05660 Add clasp to existing partial denture	$113.00
05710 Rebase denture – complete or partial upper or lower	$271.00
05730 Reline denture – complete or partial, upper or lower (once in 12 mos. beginning 6 mos. following insertion)	$151.00
05750 Reline denture – complete or partial, laboratory	$236.00
05820 Interim partial denture – upper or lower	$290.00
05850 Tissue conditioning – maxillary	$78.00
05851 Tissue conditioning – mandibular	$78.00
Prosthetics Fixed	
06210 Pontic – cast high noble metal	$582.00
06211 Pontic – cast predominantly base metal	$537.00
06212 Pontic – cast noble metal	$546.00
06240 Pontic – porcelain fused to high noble metal	$615.00
06241 Pontic – porcelain fused to predominantly base metal	$527.00
06242 Pontic – porcelain fused to noble metal	$566.00
06520 Inlay – metallic 2 surfaces	$445.00
06530 Inlay – metallic 3 or more surfaces	$538.00
06545 Retainer – cast metal for acid etch bridge	$230.00
06750 Crown – porcelain fused to high noble metal	$628.00
06751 Crown – porcelain fused to predominantly base metal	$537.00
06752 Crown – porcelain fused to noble metal	$576.00
06780 Crown – 3/4 cast high noble metal	$565.00
06790 Crown – full cast high noble metal	$591.00
06791 Crown – full cast predominantly base metal	$531.00
06792 Crown – full cast noble metal	$543.00
06930 Recement bridge	$69.00
Oral Surgery	
07110 Single tooth	$69.00
07120 Each additional tooth	$64.00
07130 Root removal – exposed roots	$87.00
07210 Surgial removal of erupted tooth	$133.00
07220 Removal of impacted tooth – soft tissue	$170.00

Dental benefits – Continued on next page

Dental Benefits *(Continued)*	**You pay up to**
Oral Surgery (continued)	
07230 Removal of impacted tooth – partially bony	$228.00
07240 Removal of impacted tooth – completely bony	$268.00
07241 Removal of impacted tooth – completely bony with unusual surgical complications	$342.00
07250 Surgical removal of residual tooth roots (cutting procedure)	$136.00
07260 Oroantral fistula closure	$302.00
07270 Tooth reimplantation	$181.00
07280 Surgical exposure of impacted or unerupted tooth – orthodontic	$284.00
07281 Surgical exposure of impacted or unerupted tooth – aid eruption	$208.00
07285 Biopsy of oral tissue – hard	$151.00
07286 Biopsy of oral tissue – soft	$144.00
07291 Transseptal fiberotomy	$37.00
07310 Alveoloplasty in conjunction with extraction, per quadrant	$108.00
07320 Alveoloplasty not in conjunction with extraction, per quadrant	$146.00
07410 Radical excision – lesion to 1.25 cm	$171.00
07420 Radical excision – lesion over 1.25 cm	$258.00
07430 Excise benign tumor/lesion to 1.25 cm	$199.00
07431 Excise benign tumor/lesion over 1.25 cm	$299.00
07450 Remove odontic cyst/tumor/lesion to 1.25cm	$189.00
07451 Remove odontic cyst/tumor/lesion over 1.25 cm	$307.00
07460 Remove nonodontic cyst/tumor/lesion to 1.25 cm	$216.00
07470 Remove exotosis-maxilla or mandible	$271.00
07510 Incision & drainage of abscess – intraoral soft tissue	$84.00
07520 Incision & drainage of abscess – extraoral soft tissue	$168.00
07530 Removal of foreign body, skin, subcutaneous alveolar tissue	$90.00
07550 Sequestrectomy for osteomyelitis	$293.00
07910 Suture simple wounds up to 5 cm	$47.00
07911 Suture complex wounds up to 5 cm	$48.00
07960 Frenulectomy (frenectomy or frenotomy) – separate procedure	$207.00
07970 Excision of hyperplastic tissue – per arch	$166.00
07971 Excision of pericoronal gingiva	$95.00
Orthodontics	
08010 Limited Ortho. Treatment – primary dentition	$700.00
08020 Limited Ortho. Treatment – transitional dentition	$700.00
08030 Limited Ortho. Treatment – adolescent dentition	$750.00
08040 Limited Ortho. Treatment – adult dentition	$900.00
08050 Interceptive – primary dentition	$1,250.00
08060 Interceptive – transitional dentition	$1,450.00
08070 Othodontia, comprehensive – transitional	$2,400.00
08080 Orthodontia, comprehensive – adolescent	$2,400.00
08090 Orthodontia, comprehensive – adult	$2,600.00
08210 Removable appliance therapy (6 mos.)	$526.00
08220 Fixed appliance therapy (6 mos.)	$618.00
08660 Pre-orthodontic treatment visit	$176.00
Additional Procedures	
09110 Palliative (emergency) treatment of dental pain, minor procedures	$47.00
09220 General anesthesia – first 30 mins.	$186.00
09221 General anesthesia – each additional 15 mins.	$68.00
09230 Analgesia	$24.00
09240 Intravenous sedation	$177.00
09310 Consultation – per session (consultation by Specialist or prior authorized second opinion by Dental Plan)	$40.00
09910 Application of desensitizing medication	$22.00
09940 Occlusal guards by report	$292.00
09951 Occlusal adjustment – limited (fewer than 12 teeth)	$52.00
09952 Occlusal adjustment –complete	$254.00
09980 Sterilization surcharge	Nothing

Dental benefits – Continued on next page

Dental Benefits *(Continued)*	**You pay up to**
What is not covered • *Services provided by a non-Plan dentist, except in an out-of-area emergency* • *Procedures performed in a hospital or non-dental setting, except as described above* • *Procedures which are cosmetic, elective, experimental or investigative in nature* • *Dental implants* • *Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue. See Section 5. (b) – Oral and maxillofacial surgery.* • *Procedures involving treatment of malignant or benign neoplasm, cysts, or other pathology, except excisional removal* • *Procedures involving treatment of congenital malformations. See Section 5. (b) – Surgical procedures.* • *Replacement of partial dentures, fixed bridgework or crowns previously provided within 60 months after placement and before member has been enrolled in this Plan for 12 continuous months (includes retainers, habit appliances, any fixed or removable interceptive orthodontic appliances)* • *Replacement of missing natural teeth lost prior to enrollment in this Plan until member has been enrolled in this Plan for 12 continuous months* • *Services related to the temporomandibular joint (TMJ), either bilateral or unilateral* • *Broken appointment charges* • *Services of pediatric dentists* • *Charges for second opinions and treatment by second opinion dentist, unless prior authorized by DBP* • *Expenses for dental procedures and orthodontia begun prior to enrollment in this Plan* • *Fixed or removable prosthodontic restoration procedures for complete mouth rehabilitation or reconstruction* • *Attachments to conventional removable prostheses or fixed bridgework (includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the constructions of a prosthesis of this nature)* • *Procedures related to the reconstruction of correct vertical dimension of occlusion* • *Occlusal guards, except for control of habitual grinding* • *Laboratory tests performed in tissues as a result of biopsy. See Section 5. (a) – Lab, X-ray and other diagnostic tests.* • *Other dental services not listed as covered*	*All charges*

Section 5. (i) 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.

- **Discounts at the GWU Medical Center – Center for Integrative Medicine.** We give you access to services at The George Washington University Medical Center – Center for Integrative Medicine (GWUMC-CIM). The GWUMC-CIM is staffed by highly trained practitioners who offer programs in alternative and complementary medicine, including acupuncture, body work, guided imagery, massage therapy and more. *These services are not covered under your contract, but if you wish to use them, you will receive a 20 percent discount off the normal full charge for each service at the GWUMC-CIM.*

- **Discounts at Health Clubs.** Members are eligible for discounted membership fees for a variety of health and fitness clubs located throughout the metropolitan area. You do not pay any additional premium for this service. You pay the discounted membership fee directly to the fitness center. Look under "Health Clubs" in the *Directory of Participating Providers*, on our website, or call Member Services at 301-941-2021 or 1-800-333-GWHP for a list of participating centers.

- **Discounts on Eyeglasses and Contact Lenses.** Members may obtain discounts on the purchase of eyeglasses, contact lenses and certain other non-covered services when purchased through participating optometrists and opticians. A list of participating optometrists and opticians is located in the *Directory of Participating Providers.*

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 and we agree,** as discussed under *Section 3 – Services requiring our prior approval* on page 11.

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see *Section 5. (d) – Emergency services/accidents*);
- 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 devices;
- 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, drugs, 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 rarely have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call Member Services at 301-941-2021 or 1-800-333-GWHP or contact us through our website, www.gwhealthplan.com.

When you must file a claim—such as for out-of-area care—submit it on 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 of physician or facility that provided the service or supply;
- Dates the member received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- If applicable, 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: The GW Health Plan
Attn: Claims Department
4550 Montgomery Avenue
Suite 800
Bethesda, MD 20814

Prescription drugs

In the rare event when a Plan pharmacy is unable to process your prescription by computer, or if you have to purchase prescription drugs at a non-Plan pharmacy in an emergency, you may request reimbursement. Send the following information with your request:

- Brief explanation of the reason you are requesting reimbursement.
- PharmaCare Drug Reimbursement Form available in your new member packet or from PharmaCare Customer Service at 1-800-777-1023.
- Pharmacy receipt (not a register receipt)

Submit your claims to: PharmaCare
P.O. Box 519
25 Blackstone Valley Place
Lincoln, RI 02865

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 covered 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 prior authorization:

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: The GW Health Plan, Attn: Manager, Complaints and Appeals, 4550 Montgomery Avenue, Suite 800, Bethesda, MD 20814; 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	When we need additional information, you or your provider must send the information so that we receive it within 60 days. 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.
4	If your appeal is denied at the first level review, we will give you the opportunity to participate in a grievance hearing attended by members of our management staff who were not involved in prior decisions about your appeal. You may attend the grievance hearing in person, or by phone, or you may send a personal representative. You will receive written notification of our decision following both steps in the appeals process. If you do not agree with our decision at the grievance hearing, 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 3, P.O. Box 436, Washington, DC 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;

Disputed claims process – Continued on next page

- 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.

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 prior authorization, then call us at 301-941-2021 or 1-800-333-GWHP (for medical services) or American Psych Systems at 1-888-571-0213 (for mental health and substance abuse services) and we will expedite our review to provide you with a decision in one day; or

(b) We denied your initial request for care or prior authorization, 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 3 at 202-606-0755 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 have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary 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. **You must use our Plan providers and follow the rules in this brochure for us to cover your care. We will not pay for services that are not covered benefits under this Plan.**

• 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 managed care plan" 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 to go 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 and use our Plan providers for us to cover your care. We do not waive copayments, deductibles, coinsurance, or any rules that you must follow for us to cover your care.

Coordinating benefits – Continued on next page

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	✓	
b) Or, 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,		
a) And are an annuitant	✓	
b) And are an active employee		✓

Note: If your Plan physician does not participate with Medicare, you will have to file a claim with Medicare.

Coordinating benefits – Continued on next page

Claims process

When your physician participates with both Medicare and us, you probably will never have to file a claim 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 claim 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 Member Services at 301-941-2021 or 1-800-333-GWHP.

• 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) available 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, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles.

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 managed care plan's 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 members, 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

Coordinating benefits – Continued on next page

- 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 in accordance with your plan benefits.

If you do not seek damages, you must agree to let us try. This is called subrogation. If you need more information, contact Member Services at 301-941-2021 or 1-800-333-GWHP 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 to the provider when you receive covered services.

Coinsurance

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

Covered services

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

Custodial care

Custodial care is 1) non-health related services, such as assistance with activities of daily living or 2) health-related services which do not contribute to a cure, such as care provided during a period when a patient's medical condition is not changing or 3) services which do not need to be adminstered by a trained medical person. Examples of custodial care include, but are not limited to: washing and bathing, feeding, changing bed linens, turning, transferring (e.g., from bed to chair), and assisting with medications that could be self-administered.

Deductible

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

Experimental or investigational services

Experimental and investigational or unproven products, procedures, drugs and supplies include those which are: 1) in a testing stage or in field trials on animals or human beings; 2) have not received the required final federal regulatory approval for commercial distribution for the specific purposes and methods of use; 3) with respect to prescription drugs, have not been approved by the U.S. Food and Drug Administration as safe and effective treatment for a particular illness or condition except as described; 4) are not in accordance with generally accepted standards of medical practice; or, 5) have not yet been shown to be consistently effective in diagnosing or creating a condition. The fact that an experimental, investigational or unproven product, procedure, drug or supply is the only available treatment for a particular condition, does not mean that we will cover it. A product, procedure, drug or supply is considered *investigational* if it is not yet being used in a clinical trial. It is considered *experimental* if it has moved from investigational to the clinical trial state where numbers of humans have agreed to participate.

Our Medical Director determines what products, procedures, drugs and supplies are experimental or investigational based on the findings of a committee made up of community physicians, our staff and experts in the field. The committee periodically reviews published literature and other presentations to make an informed decision.

Group health coverage

Usually an insurance plan in which a number of employees of one employer and their eligible dependents are insured under a single policy or contract issued to the employer.

Definitions – Continued on next page

Medical necessity

Services or supplies provided by a physician, hospital or other health care provider to diagnose or treat an illness, injury or medical condition that this Plan's Medical Director determines are:

- Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition
- Provided for the diagnosis or direct care and treatment of the condition
- Consistent with the benefits we cover
- Performed in the most cost-effective setting or manner appropriate to treat the medical condition
- Not primarily for cosmetic pruposes
- Not primarily custodial care (including domiciliary and institutional care)
- Not provided primarily for the convenience of the member, the attending or consulting physician, or another health care provider.

This definition relates only to coverage and differs from the way in which a physician may practice medicine. The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness or mental illness, does not mean it is a medically necessary covered benefit.

With the exception of hospice care, non-acute and/or custodial care and treatment provided to a patient when there is no reasonable expectation of improvement or recovery, as determined by our Medical Director, is not considered medically necessary.

Plan allowance

Plan allowance is the maximum costs we use to determine our payment to providers and your coinsurance for covered services under this contract. The Plan allowance is continuously revised and subject to change.

Us/We

Us and we refer to The George Washington University Health Plan.

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.

Note: 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.

FEHB facts – Continued on next page

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;
- OPM, when reviewing a disputed claim or defending litigation about a claim; or
- Custodial parents for the claims of covered dependent children under their care.

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 (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.

• 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.

FEHB facts – Continued on next page

- **Converting to individual coverage**

You may convert to an 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 **301-907-3515** 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 they try to obtain services for a person who is not an eligible family member, or are no longer enrolled in the Plan and try to obtain benefits. Your agency may also take administrative action against you.

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

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Summary of benefits for The George Washington University 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.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to a calendar year deductible.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office • Gynecological and obstetrical care – no referral required • Preventive care, adult and children age 7 and over	Office visit copay: $10 primary care; $10 specialist	14 14 15
• Preventive care, children until age 7	Nothing	16
Services provided by a hospital: • Inpatient • Outpatient	Nothing	25-26 26
Emergency benefits: • In-area • Out-of-area	$50 per visit; waived if admitted $50 per visit; waived if admitted	29 29
Mental health and substance abuse treatment – no referral required	Regular cost sharing.	30-31
Prescription drugs*: • Up to a 30-day supply at Plan retail pharmacy • Up to a 90-day supply of maintenance drugs by mail order or at a Plan pharmacy	$35 calendar year deductible per member and $5 generic/$15 name brand preferred/ $25 name brand non-preferred $10 generic/$30 name brand preferred/ $50 name brand non-preferred	32-33
Dental Care: • Routine and preventive care • Minor and major restorative care	Nothing Up to the maximum	35-40
Vision Care: • Diagnosis and treatment of diseases of the eye • Annual routine eye exam – no referral required	$10 specialist office visit copay	18
Special features: FirstHelp 24-hour urgent care advice line; Next Generation Babies pregnancy support and education; Disease Management programs for members with chronic health problems; TTY phone number for hearing impaired members	Nothing	34
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $650/Self Only or $1,500/Family enrollment per year Some costs do not count toward this protection	12

2001 Rate Information for
The George Washington University 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 and 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	**E51**	**$76.83**	**$25.61**	**$166.46**	**$55.49**	**$90.92**	**$11.52**
Self and Family	**E52**	**$188.26**	**$62.75**	**$407.90**	**$135.96**	**$222.77**	**$28.24**