Group Health Plan

GHP
A Coventry Health Care Plan

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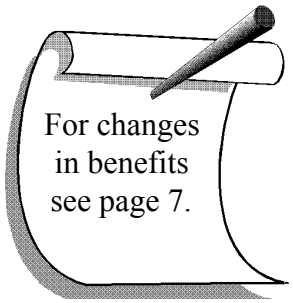
2001

A Health Maintenance Organization



Serving: Greater St. Louis and 17 Illinois Counties

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

Enrollment codes for this Plan:

MM1 Self Only
MM2 Self and Family

SPECIAL NOTICE: This plan has reduced its service area. The following Illinois counties have been dropped from GHP's service area: Jackson, Perry, Randolph & Union. For Instructions please see "How we change for 2001" on page 7.

Authorized for distribution by the:

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

FEHB
Federal Employees
Health Benefits Program

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Table of Contents

Introduction

Group Health Plan
111 Corporate Office Drive
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Earth City, MO 63045

This brochure describes the benefits of Group Health Plan under its contract (CS1930) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) 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 premiums with each plan annually. Benefit changes are effective January 1, 2001, and are shown 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" means Group 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, 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 not have to submit claim forms or pay bills. You only pay the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans 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, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Who provides my healthcare

Group Health Plan is an IPA model Health Maintenance Organization (HMO). Your care is provided by the primary care doctor you select. Adults may select either an internal medicine doctor, a family practice doctor, or general practice doctor as a Primary Care Physician. For children, you may choose a pediatrician or family practice doctor.

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. See "How you get care" section for services that you can receive without a referral from your primary care doctor. Due to Illinois law, Illinois residents may select a "Woman's Principal Health Care Provider" in addition to a Primary Care Physician. A "Woman's Principal Health Care Provider" is a physician licensed to practice medicine in all its branches and specializing in obstetrics and gynecology or family practice. A Woman's Principal Health Care Provider may be seen for care without a referral from a Primary Care Physician. You may select a Woman's Principal Health Care Provider upon initial enrollment or at any other time. Selecting a Woman's Principal Health Care Provider is optional.

The Plan's provider directory lists primary care doctors (generally family practitioners, pediatricians, and internists), with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by call the Member Service Department at 1-800-755-3901; You can also find out if your doctor participates with this Plan by checking directly with the provider or by calling us at the above number.

If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients.

Should you decide to enroll in the Plan, you will be asked to select a primary care doctor for you and each family member. Plan personnel are available to help you select a doctor. Members may change their doctor selection at any time, except when the member is hospitalized or undergoing certain types of treatment. Changes received before the 15th of the month will become effective on the first of the following month. This may be done by calling Member Service at 1-800-755-3901.

Facts about this HMO plan *(Continued)*

Patient 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 your health plan, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

Group Health Plan is in compliance with the state requirements of Missouri and Illinois. In addition, GHP has had a comprehensive system in place to identify and prevent medical errors and to ensure that all providers credentialed are competent. Through the Quality Improvement Program, medical errors and other adverse events are monitored to identify patterns of preventable events and events related to individual network providers. Patterns or individual cases are investigated and action is taken to make improvements.

If you want more information about us, call 1-800-743-3901, or write to 111 Corporate Office Drive, Suite 400 / Earth City, MO 63045. You may also contact us by fax at 314/506-1712 or visit our website at www.ghp.com.

Service Area

To enroll with us, you must live or work in our service area. This is where our providers practice. Our service area is: the Metropolitan St. Louis area. Specifically:

St. Louis City and the **Missouri** counties of Crawford, Franklin, Gasconade, Jefferson, Lincoln, St. Charles, Ste. Genevieve, and Warren.

The **Illinois** counties of Calhoun, Christian, Clinton, Cole, Franklin, Jersey, Johnson, Macoupin, Madison, Menard, Monroe, Montgomery, Morgan, Saline, Sangamon, St. Clair, and Williamson.

Ordinarily, you must get your care from providers who contract with us. If you receive care 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 placed a 20 outpatient visit limit on mental health and substance abuse services that was not on services to treat physical illness, injury, or disease. Outpatient office visits will be $10 per visit.

- 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 1-800-755-3901, or checking our website, www.ghp.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 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 60.8% for Self Only or 45.9% for Self and Family.

- Prescription drug copayments will now be $8 for generic formulary, $15 for name brand formulary, and $30 for a non-formulary drug. Previously, the copays were $7 for generic and $12 for brand name drugs. Please see page 29 for prescription benefits.

- Preventative Dental benefit copayment is now $10 per office visit instead of no member copay per visit.

- We have dropped our HMO Group Reciprocity benefit.

SPECIAL NOTICE

We have dropped the following Illinois counties from our service area: Jackson, Perry, Randolph, and Union. Members living in these counties are strongly advised to select a new health plan during Open Season. If you do not select a new health plan, you will be required to use plan providers in our remaining service area. Active members (employees) should contact their personnel office. Retirees should follow instructions in the open season package mailed to you or call the Office of Personnel Management Retirement Information office at 1-888-767-6738.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-755-3901.

Where you get covered care

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

•Plan providers

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. All providers must go through our Credentialing process. The elements verified include state license, DEA certificate to administer drugs, board certification, work history, clinical privileges at the admitting hospital, education and training and malpractice insurance coverage. In addition, the practitioner's history of federal or state sanctions and malpractice claims are investigated using state and federal sources. These are all verified by going to the original source. All credentials are verified using the primary source.

We list Plan providers in the provider directory, which we update periodically. There is an alphabetical index in the back of the provider directory if you are looking for a specific provider.

•Plan facilities

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

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. You may select an internal medicine doctor, a general practice doctor, or a family practice doctor for your Primary Care Physician. Children may designate a Pediatrician for their Primary Care Physician.

•Primary care

The role of the Primary Care Physician is to function as your health advisor and advocate. Together, you and your Primary Care Physician decide what your health care will be. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

•Specialty care

Your primary care physician will refer you to a specialist for needed care. However, there are 4 circumstances in which you do not need a referral.

- Women can self-refer to any participating OB/GYN for an annual well-woman exam.
- Women can self-refer to any participating OB/GYN for pregnancy.
- Members can self-refer to any participating Primary Eye Care provider for an annual eye exam.
- Members can self-refer to GHP's Behavioral Health Line for and Mental Health/Alcohol and Substance Abuse benefits.

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 will work with the Plan and the specialist to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

- 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. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

  •• terminate our contract with your specialist for other than cause; or

  •• drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or

  •• reduce our service area and you enroll in another FEHB Plan,

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

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

• Hospital care

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

If you are in the hospital when your enrollment in our Plan begins, call our Precertification Department immediately at 1-800-546-4603. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, 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 Precertification. Your physician must obtain precertification for services such as but not limited to: inpatient admissions, skilled nursing or rehabilitation admissions, transplants, outpatient surgeries, dialysis, certain outpatient diagnostics, cardiac rehabilitation, pulmonary rehabilitation, ancillary services, pain management, infertility services, pregnancy, self-injectable drugs, botox, visudyne, chiropractic manipulations, speech therapy, and observation hospital stays.

Section 4. Your costs for covered services

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

• Copayments

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

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

• Deductible

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

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. We do not have coinsurance.

Your out-of-pocket maximum for copayments

After your copayments total $4,700 per person or $11,740 per family enrollment in any calendar year, you do not have to pay any more for covered services.

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 47 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800-755-3901 or at our website at www.ghp.com.

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You Pay
Diagnostic and treatment services	
Professional services of physicians • Office visits • Second surgical opinion	$10 per office visit
Professional services of physicians • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment	Nothing
• At home	Nothing
House calls will be provided within the service area if in the judgement of the Plan doctor such care is necessary and appropriate.	
Not covered: • *Physical examinations and immunizations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel*	*All charges.*
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing

Preventive care, adult	You Pay
Routine screenings, such as: • Blood Pressure • Total Blood Cholesterol – once every five years, ages 17 on up • Colorectal Cancer Screening, including •• Fecal occult blood test	Nothing
•• Sigmoidoscopy, screening – every five years starting at age 50	Nothing
• Prostate Specific Antigen (PSA test)- one annually for men age 40 and older	Nothing
• Routine pap test	Nothing
Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing
Not covered:Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	$10 per office visit
Preventive care, children	
Childhood immunizations recommended by the American Academy of Pediatrics	$10 per office visit
• Examinations, such as: •• Eye exams to determine the need for vision correction. •• Ear exams to determine the need for hearing correction •• Examinations done on the day of immunizations	$10 per office visit
• Well-child care charges for routine examinations, immunizations and care (through age 22)	
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care which includes one routine ultrasound • Delivery • Postnatal care	$10 for initial office visit only

Maternity Care *(Continued)*	**You Pay**
Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; your physician should precertify for you. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$10 for initial office visit only
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*
Family planning	
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs) • Oral Contraceptives (see section 5f. Prescription Drugs)	$10 per office visit
Not covered: Reversal of voluntary surgical sterilization	*All charges*
Infertility services	
Diagnosis and treatment of infertility, such as: Artificial insemination: •• *intrauterine insemination (IUI)* *covered for up to 6 cycles per lifetime*	$10 per office visit
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* •• *in vitro fertilization (IVF)* *Intracytoplasmic sperm injection (ICSI)* •• Gamete and Zygote intrafallopian transfer *(GIFT & ZIFT)* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Storage of eggs, sperm, and embryo* • *Fertility Drugs* • *Selective reduction*	*All charges.*

Allergy care	You pay
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
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 22. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Growth hormone therapy (GHT) Note: – We will only cover GHT when we preauthorize the treatment. Call 1-800-546-4603 for preauthorization. Ask if GHT is authorized before you begin treatment. If we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	$10 per office visit if done in physician's office; otherwise you pay nothing.
Rehabilitative therapies	
Physical therapy, Occupational therapy and Speech therapy -- • 60 visits per condition for the combined services of each of the following: •• qualified physical therapists; •• speech therapists; and •• occupational therapists. Note: Therapy is provided on an inpatient or outpatient basis when significant improvement can be expected and progress is achieved. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 36 sessions	Nothing
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Speech Therapy of developmental delays*	*All charges.*
Hearing services (testing, treatment, and supplies)	
• Hearing testing	$10 per office visit
Not covered: • *Hearing aids ,and the testing and examinations for hearing aids*	*All charges.*

Vision services (testing, treatment, and supplies)	You pay
• Annual eye exam -Includes exam for refraction to get a prescription for eyeglasses or contacts.	$10 per office visit
• Initial placement of corrective contact lenses or eyeglasses are covered for diagnosis of pseudophakia or aphakia (surgical removal of natural lens of the eye). Note: Surgery must be performed by GHP.	Nothing
Not covered: • *Corrective glasses and frames or contact lenses (including the fitting of the lenses)* • *Eye exercises (orthoptics)* • *Radial keratotomy and other refractive surgery such as LASIK*	*All charges.*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$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; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*
Orthopedic and prosthetic devices	
• Artificial limbs (initial placement only after diagnosis is made) • External lenses following cataract removal – initial placement only • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5 (c) for payment information. See 5(b) for coverage of the surgery to insert the device.	$10 per office visit if done in doctor's office; otherwise you pay nothing
Not covered: • *Orthopedic, diabetic and corrective shoes* • *Arch supports* • *Corrective orthopedic appliances for treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, Jobst stockings, support hose, and other supportive devices*	*All charges.*

Orthopedic and prosthetic devices *(Continued)*	**You pay**
• *Prosthetic replacements* • *Testicular Implants All charges.*	*All Charges*
Durable medical equipment (DME)	
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Hospital beds; • Ostomy supplies; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; • Insulin pumps; and • Oxygen therapy Note: Your physician will arrange coverage for durable medical with GHP and plan provider.	Nothing
Not covered: • *Non durable medical supplies such as c-pap masks, foley catheters, dressings and leg bags* • *Repairs and Replacement of purchased equipment*	*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. Home Health Aide is covered when medically necessary. • Services include intravenous therapy.	Nothing
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.* • *Custodial care*	*All charges.*

Alternative treatments	You Pay
• Chiropractic services for acute episode-spinal manipulations are covered when obtained by a Plan provider and referred by PCP. • Biofeedback - when all other conservative measures have been exhausted.	$10 per office visit
Not covered: • *Chiropractic services other than spinal manipulations* • *Naturopathic services* • *Hypnotherapy* • *Acupuncture*	*All charges.*
Educational classes and programs	
Coverage is limited to: • Diabetes self-management Living with Diabetes is an education-based program supervised by a Certified Diabetes Educator. The program is coordinated through GHP's Complex Case Management Department and is directed at members who have diabetes. The program includes educational materials, quarterly newsletters, NurseAccess's 24-hour telephone access to a Registered Nurse for urgent care, self-care guidelines, periodic health postcard reminders (for foot exams, retinal eye exams, cholesterol testing and long-term blood sugar tests), and referrals to group and individual educational programs/support groups provided by hospitals and home health agencies. • Healthy Basics for Healthy Babies To help promote a healthy pregnancy, GHP has developed a Healthy Basics for a Healthy Baby program for its expectant members. Healthy Basics encourages prenatal care and a healthy lifestyle, provides educational material, and identifies pregnancies that may be of greater than average risk. Healthy Basics is a free enhancement to the regular obstetrical care mothers receive during pregnancy. Expectant members are enrolled in Healthy Basics when GHP is notified of the pregnancy.	Nothing

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- 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.)
- YOU MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

IMPORTANT

Benefit Descriptions	You Pay
Surgical procedures	
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity – when Plan criteria is met • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information. • Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a). • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$10 per office visit for outpatient: nothing for inpatient treatment.
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.* • *Replacement of Penile prosthesis*	*All charges.*

Reconstructive surgery	You Pay
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: •• the condition produced a major effect on the member's appearance and •• the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: •• Surgery to produce a symmetrical appearance on the other breast; •• Treatment of any physical complications, such as lymphedemas; •• Breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$10 per office visit: Nothing for inpatient services
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation* • *Scar Revision*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$10 per office visit: Nothing for inpatient services
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as root canals, extractions, periodontal membrane, gingiva, and alveolar bone)* • *dental care involved in the treatment of TMJ*	*All charges.*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • 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 if the donor has no other coverage for this service.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered* • *Hair Transplants* • *Non human organs*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing
Not covered: • *Anesthesia for dental procedures*	*All Charges*

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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible.
- 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 Section 5(a) or (b).

IMPORTANT

Benefit Descriptions	You Pay
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, extended care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*

Outpatient hospital or ambulatory surgical center	You Pay
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service	$10 copayment per office visit
Not covered: • *Storage of blood donated before surgery* • *Designated Donor Fees*	*All charges*
Extended care benefits/skilled nursing care facility benefits	
Covered for up to 45 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan.	Nothing
Not covered: custodial care	*All charges*
Hospice care	
Inpatient and Home care when authorized and approved by Plan	Nothing
Not covered: • *private duty nursing* • *homemaker services*	*All charges*
Ambulance	
Local professional ambulance service when medically appropriate	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

If you are in an emergency situation, please call your primary care doctor or the plan at 1-800-580-9733. In medical emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911-telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 48 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized in a non-Plan facility, the Plan should be notified by you or a family member within 48 hours unless it is not reasonably possible to do so. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

The Plan or your primary care physician in conjunction with the Plan must approve follow-up care recommended by non-Plan providers. Normally, you will be required to return to the Plan's service area for follow up care.

The copayment for an Emergency Room visit is $50. The $50 copayment is waived if you are admitted.

Benefit Description	You pay
Emergency within our service area	
Emergency care at a doctor's office	$10 per office visit
• Emergency care at an urgent care center • Emergency care at a hospital, including doctors' services	$50 per visit Waived if admitted to hospital
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office	$10 per office visit
• Emergency care at an urgent care center • Emergency care at a hospital, including doctors' services	$50 per visit Waived if admitted to hospital
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges.*
Ambulance	
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	Nothing

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

IMPORTANT

Parity

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

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

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 copayment per office visit
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment.	Nothing
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Mental health and substance abuse benefits *(Continued)*	
Preauthorization	To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes: Please call GHP's Behavioral Health Line at 1-877-227-3520 to access mental health and substance abuse services. GHP's Behavioral Health Line provides 24-hour access for these benefits. The Behavioral Health Line will be able to help you identify participating providers and initiate referral procedures.
Special transitional benefit	If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following condition: • If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause. If this 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 and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.
Limitation	We may limit your benefits if you do not follow your treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- 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

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

- **Who can write your prescription.** A licensed Plan physician must write the prescription.
- **Where you can obtain them.** You may fill your prescription at a participating retail pharmacy, by mail, or a participating 90-day pharmacy if it is maintenance medication.
- **We use a formulary.** A drug formulary is a list of drugs available for coverage under the Plan. The purpose of the formulary is to assist physicians in prescribing cost effective, quality drug therapy for members. Drugs from all therapeutic groups are available on the drug formulary. The formulary has a mandatory generic policy when there is a generic medication that has been proven by the FDA to be the equivalent of the brand name. If a member or physician prefers the name brand or non-formulary drug when a generic is available, the member will be charged the difference in cost plus the copayment. Since there is a copayment for non-formulary drugs, there will no longer be exceptions to the formulary. If a doctor prescribes a non-formulary drug, you can go back to the doctor and ask them to prescribe something from the formulary, or pay the higher copayment.
- **These are the dispensing limitations.** Participating retail pharmacies will dispense a 30-day supply or 100-unit supply of medication (whichever is less) for the following copayments: $8 for generic, $15 for name brand, $30 non formulary. Prescriptions dispensed as a unit (such as 1 box, 1 tube, 1 inhaler) will have a copayment per unit. GHP's 90-day pharmacies and mail order program will dispense a 90-day supply (when the prescription is written for 90-days) for 2 copayments. Some prior approval drugs such as Imitrex have limited dosage amounts. Please have your doctor call for prior approval. If a generic is available, you will pay the difference in cost, plus name brand or non-formulary copayment. If there is no generic equivalent available, you will pay brand name copayment.
- **When you have to file a claim.** You would only have to file a claim if you were out of our Service area and unable to use one of the National chains participating in the Plan in an Emergency situation. In this case, please submit an itemized bill to GHP with an explanation and we will reimburse you all but your copayment.

Prescription drug benefits begin on the next page.

Benefit Description	You pay
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: • Drugs for which a prescription is required by law • Full range of FDA-approved drugs, prescriptions, and devices for birth control • Insulin, with a copay charge applied to each vial • Disposable needles and syringes needed for injecting insulin and covered prescribed medication • Blood glucose test strips for insulin dependent members • Intravenous fluids and medication for home use are covered under Medical and Surgical Benefits. **Limited benefits:** Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits. You pay a $15 copayment, up to the dosage limits and all charges thereafter. Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.	You pay $8 copayment for generic formulary drug. You pay $15 copayment for name brand formulary with no generic equivalent. For name brand drugs with generic equivalent, you pay $15 copay plus the difference between the retail cost of the name brand drug and the generic equivalent. You pay $30 copayment for non-formulary drug. For non-formulary drug with a generic equivalent, you pay a $30 copay plus the difference between the retail cost of the brand name and the generic equivalent. Note: If there is no generic equivalent available, you will pay the brand name copay.
Not covered: • *Drugs available without a prescription or for which a non prescription equivalent is available* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Vitamins and nutritional substances that can be purchased without a prescription* • *Medical supplies such as dressings and antiseptics* • *Fertility drugs* • *Diabetic supplies, except for needles, syringes, lancets and blood glucose test strips* • *Drugs for cosmetic purposes* • *Drugs to enhance athletic performance* • *Smoking cessation drugs and medication, including nicotine* • *Patches* • *Drugs for weight loss* • *Refills for prescriptions resulting from loss or theft* • *Prescription drugs for travel* • *Special packaging required for drugs dispensed in nursing homes*	*All Charges*

Section 5 (g). Special Features

Feature	Description
24 hour nurse line	GHP's NurseAccess line is available 24 hours a day, seven days a week, to provide medical information. NurseAccess is staffed by Registered Nurses with a minimum of five years experience in patient care. NurseAccess may be reached toll-free at 1-800-580-9733.
High risk pregnancies	To help promote a healthy pregnancy, GHP has developed a Healthy Basics for a Healthy Baby program for its expectant members. Healthy Basics encourages prenatal care and a healthy lifestyle, provides educational material, and identifies pregnancies that may be of greater than average risk. Healthy Basics is a free enhancement to the regular obstetrical care mothers receive during pregnancy. Expectant members are enrolled in Healthy Basics when GHP is notified of the pregnancy.
Joint Replacement Program	Members who are being precertified for surgery are educated in hopes of the following: Increase knowledge about their surgery and postoperative care through recovery to decrease anxiety; Reduce length of stay for joint replacement member; and support preoperative teaching programs.
Centers of excellence for transplants	Group Health plan utilizes the United Resource Network ("URN") to provide our members with access to nationally recognized transplant programs. These programs are "Centers of Excellence" offering our members quality transplant services. The URN network provides an opportunity for our members to have access to some of the nation's leading transplant centers.

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit	You pay
Restorative services and supplies necessary to promptly repair (within 2 days) but not replace sound natural teeth. The need for these services must result from an accidental injury.	Nothing
Dental benefits	
What is covered: The following preventive and diagnostic dental services are provided by participating Plan dentists. Services are limited to one visit per 6 months per member. • Oral examination and X-rays as necessary • Dental prophylaxis (cleaning) • Topical application of fluoride	$10 per office visit
Not covered: Other dental services not shown 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.

MEDICARE PREPAID PLAN ENROLLMENT:

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare without payment of an FEHB premium. As indicated on page 29, certain annuitants and former spouses who are covered by both Medicare Parts A and B and FEHB may elect to drop their FEHB coverage and later reenroll in FEHB. Contact your retirement system for information on changing your FEHB enrollment. Contact us at 314/506-1525 for information on the Medicare prepaid plan and the cost of that enrollment.

ADDITIONAL DENTAL BENEFITS:

In addition to the preventative dental benefits included in the FEHB package, Group Health Plan is offering the following at no additional cost:

- A discount on any major or minor restorative care provided by general dentists listed in our directory.
- Please see Fee schedule with Provider Directory.

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 *What Services Require Our Prior Approval* on page 10.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- 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 not have to file claims. Just present your identification card and pay your copayment.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-800-755-3901.

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

Submit your claims to: **Group Health Plan**
P.O. Box 7474
London, KY 40742-7374

Prescription drugs

You will not have to file claims when using participating pharmacy providers. In emergency situations submit itemized bill.

Submit your claims to: **Group Health Plan**
111 Corporate Office Drive, Suite 400
Earth City, MO 63045
Attention: Pharmacy Department

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. Write to us at: 111 Corporate Office Drive, Suite 400, Earth City, MO 63045 You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: 111 Corporate Office Drive, Suite 400, Earth City, MO 63045; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, D.C. 20044-0436. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim. 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.

The disputed claims process *(Continued)*

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 preuthorization/prior approval, then call us at 1-800-743-3901 and we will expedite our review; or

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division III at 202/606-0737 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.

•What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

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

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

• The Original Medicare Plan

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

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

We will waive the copayments when you have Medicare part B.

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

Please note, if your Plan physician does not participate in Medicare, you will have to file a claim with Medicare

Coordinating benefits with other coverage *(Continued)*

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

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

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 1-800-755-3901 or visit the our website at www.ghp.com.

We waive some costs when you have Medicare -- When Medicare is the primary payer, we will waive some out-of-pocket costs, as follows: specialist copayments, coinsurance, and deductibles.

Medical services and supplies provided by physicians and other health care professionals. If you are enrolled in Medicare Part B, we will waive precertification and referral guidelines, specialist copayments, coinsurance, and deductibles.

- **Medicare managed care plan**

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

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do waive any of our copayments for your FEHB coverage.

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.

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.

Coordinating benefits with other coverage *(Continued)*

TRICARE

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

Workers' Compensation

We do not cover services that:

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

Once OWCP or 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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 12.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 12.

Covered services

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

Custodial care

Care that is primarily for the purpose of helping the plan member with activities of daily living or meeting personal needs and can be provided safely and reasonably by people without professional skills or training. Examples of custodial care include rest cures, respite care and home care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12.

Experimental or investigational services

A drug device,treatment, therapy,procedure,service or supply of any kind whatsoever (a "Service") that:

1) cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at that time of use or proposed use, or
2) is the subject of a current investigational new drug or new device application on file with the FDA
3) In the predominant opinion of experts, as expressed in the published authoritative literature, that usage should be substantially confined to research settings or that further research is needed inorder to define safety, toxicity, efficacy or effectiveness of that Service compared with conventional alternatives.

Group health coverage

A corporation, partnership, union or other entity that is eligible for group coverage under State or Federal laws; and which enters into Agreement with the Plan to offer coverage to Employees and their eligible dependents.

Medical necessity

Services which are provided for the diagnosis or care and treatment of medical condition; Appropriate and necessary for the symptoms, diagnosis or treatment of that condition; Rendered within standards of generally accepted medical practice; Not primarily for the convenience of You, Your family, or a Provider; and Perfomed in the most appropriate setting or manner for treating Your condition, as determined by the Medical Director.

Us/We

Us and we refer to Group 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.

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)*

Your medical and claims records are confidential

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

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

When you retire

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

When you lose benefits

•When FEHB coverage ends

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

•• Your enrollment ends, unless you cancel your enrollment, or

•• You are a family member no longer eligible for coverage.

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

•Spouse equity coverage

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

•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)*

•Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Inspector General Advisory

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-800-755-3901 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE--202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

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

Index

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

Summary of benefits for the Group 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.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $10 specialist	13-19
Services provided by a hospital: • Inpatient • Outpatient	Nothing per admission $10 copay	23-24
Emergency benefits: • In-area ..... • Out-of-area	$50 per emergency room visit, waived if admitted to hospital. $50 per emergency room visit, waived if admitted to hospital.	25-26
Mental health and substance abuse treatment	Regular cost sharing.	27-28
Prescription drugs.....	$8 generic $15 name brand $30 non formulary Copayment is per 30-day supplyand applies to each unit (i.e. box, tube, vial, inhaler).	29-30
Dental Care.....	Preventative Dental Care: $10 copayment Accidental Injury: Nothing	32
Vision Care	Annual Eye exam is covered for $10 copayment.	17
Protection against catastrophic costs ..... (your out-of-pocket maximum)	Nothing after $4,700/Self Only or $11,740/Family enrollment per year Some costs do not count toward this protection	11

2001 Rate Information for
Group Health Plan, Inc.

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
Greater St. Louis and 17 Illinois Counties							
Self Only	**MM1**	**$86.59**	**$40.99**	**$187.61**	**$88.81**	**$102.22**	**$25.36**
Self and Family	**MM2**	**$195.82**	**$81.04**	**$424.28**	**$175.58**	**$231.17**	**$45.69**