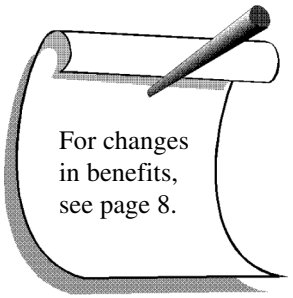
Group Health Plan

GHP
A Coventry Health Care Plan

http://www.ghp.com

2002

A Health Maintenance Organization



Serving: Greater St. Louis and 17 Illinois Counties

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.

Enrollment codes for this Plan:

MM1 Self Only
MM2 Self and Family

SPECIAL NOTICE: Effective January 1, 2001 Group Health Plan acquired Health Partners of the Midwest. Current members of Health Partners of the Midwest who do not elect another plan will automatically be enrolled with Group Health Plan effective January 1, 2002. See "How we change for 2002"on page 8.

FEHB
Federal Employees
Health Benefits Program

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Table of Contents

Introduction

Group Health Plan
111 Corporate Office Drive
Suite 400
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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2002, and are shown on page 8. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; "we" means Group Health Plan (GHP).
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, DC 20415-3650

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 800/755-3901 and explain the situation.
- If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

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.

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 calling the Member Services 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.

Your Rights

OPM requires that all FEHB Plans to provide certain information to their FEHB members. 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, Coventry 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 1-800-755-3901, or write to 111 Corporate Office Drive, Suite 400 / Earth City, MO 63045. You may also contact us by fax at 314/506-1959 or visit our website at www.ghp.com.

Service Area

- To enroll in this Plan, you must live in 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 out of our service area unless the services have prior plan approval.

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 2002

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to this Plan

- Your share of the non-Postal premium will increase by 25.1% for Self Only or 21.8% for Self and Family.
- We no longer limit total blood cholesterol tests to certain age groups.
- We now cover routine screening for chlamydial infection.
- We increased speech therapy benefits by removing the requirement that services must be required to restore functional speech.
- We now cover certain intestinal transplants.
- We changed the address for sending disputed claims to OPM.
- The Office visit copay for a specialist increases to $20 per visit (Primary Care physician visits remain at $10)
- Each inpatient hospital admission requires a $100 copay
- Each outpatient surgery requires a $50 copay
- Each Skilled Nursing facility admission requires a $100 copay with a 30-day maximum
- Physical, occupational and cardiac rehabilitation therapies require a 20% coinsurance
- Speech therapy requires a 20% coinsurance
- Home health care requires a 20% coinsurance
- Hospice care requires a 20% coinsurance
- Each ambulance transport requires a 20% coinsurance
- Durable medical equipment requires a 20% coinsurance
- Orthotic and prosthetic devices require a 20% coinsurance in addition to the specialist office visit copay
- The prescription drug copayment increases to $20 for name brand formulary and $35 for a non-formulary drugs
- The preventive dental benefit is eliminated

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 to get covered care

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**

Your primary care physician can be a family practitioner, general practitioner, internal medicine, doctor of osteopath (D.O.) or pedicatrician. 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. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. 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 any 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, facility, pharmacy, etc., when you receive services.

  Example: When you see your primary care physician you pay a copayment of $10 per office visit. When you see a participating specialist you pay a copayment of $20 per office visit.

- **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.

  Example: In our plan, you pay 20% of our allowance for durable medical equipment.

Your out-of-pocket maximum for copayments and coinsurance

After your copayments and/or coinsurance total $1,000 per person or $2,000 per family enrollment in any calendar year, you do not have to pay any more for covered services except for prescription drug 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 8 for how our benefits changed this year and page 55 for a benefits summary.)

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

IMPORTAN

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 • In physician's office	$10 per visit to primary care physician $20 per visit to specialist
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion	$10 per visit to primary care physician $20 per visit to specialist
At home House calls will be provided within the service area if in the judgement of the Plan doctor such care is necessary and appropriate.	$10 per visit to primary care physician $20 per visit to specialist
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 if you receive these services during your office visit; otherwise, $10 per visit to primary care physician $20 per visit to specialist
Preventive care, adult	
Routine screenings, such as: •Total Blood Cholesterol – once every three years •Colorectal Cancer Screening, including • Fecal occult blood test • Sigmoidoscopy, screening – every five years starting at age 50	$10 per visit to primary care physician $20 per visit to specialist
•Prostate Specific Antigen (PSA test)- one annually for men age 40 and older	$10 per visit to primary care physician $20 per visit to specialist
•Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnosis and Treatment*, above.	$10 per visit to primary care physician or ob/gyn
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	$10 per visit to primary care physician or ob/gyn
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, ages19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	$10 per visit to primary care physician $20 per visit to specialist

Preventive care, children	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per visit to primary care physician

• Well-child care charges for routine examinations, immunizations and care (through age 22)
• Examinations, such as:
  • Eye exams through age 17 to determine the need for vision correction.
  • Ear exams through age 17 to determine the need for hearing correction
  • Examinations done on the day of immunizations
	$10 per visit to primary care physician

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care which includes one routine ultrasound • Delivery • Postnatal care 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	
A broad range of voluntary family planning services, limited to: • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms NOTE: We cover oral contraceptives under the prescription drug benefit	$10 per visit to primary care physician $20 per visit to specialist
Not covered: *Reversal of voluntary surgical sterilization*	*All charges.*

Infertility services	You pay

Diagnosis and treatment of infertility, such as:
• Artificial insemination:
  • *intravaginal insemination (IVI)*
  • *intracervical insemination (ICI)*
  • *intrauterine insemination (IUI)*
covered for up to 6 cycles per lifetime
	$10 per visit to primary care physician
	$20 per visit to specialist

Not covered:
• *Assisted reproductive technology (ART) procedures, such as:*
  • *in vitro fertilization (IVF)*
  • *intracytoplasmic sperm injection (ICSI)*
  • *embryo transfer,Gamete (GIFT) and Zygote (ZIFT)*
  • *Zygote transfer*
• *Services and supplies related to excluded ART procedures*
• *Cost of donor sperm*
• *Cost of donor egg*
• *Storage of eggs, sperm, and embryo*
• *Fertility Drugs*
• *Selective reduction*
	All charges.

Allergy care	
Testing and treatment Allergy injection	$10 per visit to primary care physician $20 per visit to specialist
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 25. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. 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 visit to primary care physician $20 per visit to specialist

Physical and occupational therapies	You pay

• 60 visits per condition for the combined services of each of the following:
  • qualified physical therapists;
  • occupational therapists.
Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.
Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 36 sessions
	20% coinsurance for therapies done in the office or outpatient basis
	
	No coinsurance or copay for therapies done during a covered inpatient admission.

Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges.*

Speech therapy	
• 20 visits or two consecutive months (whichever is greater) Note: Covered in situations where it is medically necessary.	20% coinsurance for therapy done in the office or outpatient basis No coinsurance or copay for therapies done during a covered inpatient admission.
Not covered: • *Speech therapy services that are not medically necessary*	*All charges.*
Hearing services (testing, treatment, and supplies)	
• Hearing testing	$10 per visit to primary care physician $20 per visit to specialist
Not covered: • *Hearing aids, 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 visit to primary care physician $20 per visit to specialist
• 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: a) You must be a GHP member at the time of surgery and at the time the initial post-surgical contact lenses or eyeglasses are obtained. b) See *Preventive care, children* for eye exams for children	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 visit to primary care physician $20 per visit to specialist
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	**You pay**
• 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. • Corrective orthopedic appliances for treatment of temporomandibular joint (TMJ) pain dysfunction syndrome	$10 per visit to primary care physician $20 per visit to specialist 20% coinsurance for orthotic or prosthetic device *Note: Office visit copay is in addition to the 20% coinsurance for the device, whether billed separately or together.*
Not covered: • *Orthopedic, diabetic and corrective shoes* • *Arch supports* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, Jobst stockings, support hose, and other supportive devices* • *Prosthetic replacements* • *Testicular Implants*	*All charges.*

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Hospital beds; • 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.	20% coinsurance
Not covered: • *Non durable medical supplies such a 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.	20% coinsurance
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges.*

Chiropractic	
• Chiropractic services for acute episode-spinal manipulations are covered when obtained by a Plan provider and referred by PCP	$10 per visit to primary care physician $20 per visit to specialist
Not covered: • *Chiropractic services other than spinal manipulations*	*All charges.*
Alternative treatments	
• Biofeedback - when all other conservative measures have been exhausted.	$10 per visit to primary care physician $20 per visit to specialist
Not covered: • *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, 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
Not covered: • *Weight loss programs*	*All Charges.*

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.)
- YOUR PHYSICIAN 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 Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • 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 and prosthetic devices for device coverage information.	$10 in primary care physician office $20 in specialist office $50 for outpatient surgery

Surgical procedures continued on next page.

Surgical procedures *(Continued)*	**You pay**
• Voluntary sterilization • 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 in primary care physician office $20 in specialist office $50 for outpatient surgery
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.* • *Replacement of Penile prosthesis*	*All charges*
Reconstructive surgery	
• 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 in primary care physician office $20 in specialist office $50 for outpatient surgery
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. • Non-dental treatment of Temporomandibular (TMJ) joint pain dysfunction syndrome	$10 in primary care physician office $20 in specialist office $50 for outpatient surgery
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 • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas. 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

Organ/Tissue Transplants continued on next page

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	**You pay**
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 Sections 5(a) or (b).
- YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS. Please refer to Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$100 per admission

Inpatient hospital continued on next page.

Inpatient hospital (Continued)	You pay
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	$100 per admission
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, 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	
• 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	$50 per outpatient surgery visit
Not covered: • *Storage of blood donated before surgery* • *Designated Donor Fees*	*All charges*
Extended care benefits/skilled nursing care facility benefits	**You pay**
Covered for up to 30 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.	$100 per admission
Not covered: Custodial Care	*All charges*

Hospice care	
Inpatient and Home care when authorized and approved by Plan	20% coinsurance
Not covered: • *private duty nursing* • *homemaker services*	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate	20% coinsurance

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. 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 $75. The $75 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 visit to primary care physician $20 per visit to specialist
• Emergency care at an urgent care center	$75 per visit
• Emergency care at a hospital, including doctors' services	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 visit to primary care physician $20 per visit to specialist
• Emergency care at an urgent care center	$75 per visit
• Emergency care at a hospital, including doctors' services	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.	20% coinsurance

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

IMPORTANT

When you get 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 any other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per visit to primary care physician $20 per visit to specialist

Mental health and substance abuse benefits - Continued on next page

Mental health and substance abuse benefits *(Continued)*	**You pay**
• Diagnostic tests	Nothing
• Services provided by a 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.	$100 per admission
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.*

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow 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.

Limitation

We may limit your benefits if you do not obtain a 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 or 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, $20 for name brand, $35 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 difference in cost, plus name brand or non-formulary copayment. If there is no generic equivalent available, member will pay brand name copayment
- **Why use generic drugs?** To reduce your out-of-pocket expenses! A generic drug is the chemical equivalent of a corresponding brand name drug. Generic drugs are less expensive than brand name drugs; therefore, you may reduce your out-of-pocket costs by choosing to use a generic drug.
- **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 except those listed as *Not covered* • 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. • Growth hormone **Limited benefits:** Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits. You pay a $20 copayment, up to the dosage limits and all charges thereafter.	You pay $8 copayment per generic formulary drug. You pay $20 copayment per name brand formulary with no generic equivalent. For name brand drugs with generic equivalent, you pay $20 copay plus the difference between the retail cost of the name brand drug and its generic equivalent. You pay $35 copayment per non-formulary drug. For non-formulary drug with a generic equivalent, you pay a $35 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 still have to 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
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
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.	$10 per visit to primary care physician $20 per visit to specialist

Dental Benefits

We have no other dental benefits offered as part of this medical plan.

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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 in Section 9, 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 1-800-533-0362, or for the hearing impaired 1-877-231-0573, for information on the Medicare prepaid plan and the cost of that enrollment.

VOLUNTARY DENTAL PROGRAM:

With your continued or new enrollment with GHP for 2002, you have the opportunity to select a low-cost Voluntary Dental program offered by CompDent. Highlights of the benefits available with this plan are as follows:

→ No waiting periods
→ No deductible
→ No benefit maximum
→ No claims to file
→ Oral evaulations at **no charge**
→ Xrays at **no charge**
→ Cleanings – Once every 6 months at **no charge**
→ Basic and major services
→ 25% discount for specialty services including orthodontia
→ Additional discounted services for pharmacy, contact lenses, glasses and hearing needs

COST PER MONTH → Employee Only: $ 5.78 Employee + Family: $12.86

If you choose to enroll in this value-added benefit, the cost for single coverage or family coverage will be automatically deducted from your checking account on a monthly basis, or you may pay on an annual basis by using a major credit card. Participation is voluntary so you will not be automatically enrolled in this program.

Additional information including dentist directory, benefit schedule, enrollment application, member services phone number and more can be found in the CompDent packet located inside the GHP enrollment packet.

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 .**

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 or coinsurance.

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 of the 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 7374
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 3, 1900 E Street, NW. Washington, D.C. 20415-3630.

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 include 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 or from the year in which you were denied precertification or prior approval. 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 1-800-755-3901 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 3 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 Commissioner's 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. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information .
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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 (Part A or Part B)

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

When you are enrolled in Original Medicare along with this plan, 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 the Original Medicare Plan 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, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

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

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

- 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 the Original Medicare Plan -- When Original Medicare is the primary payer, we will waive some out-of-pocket costs, as follows: Specialist copayments and coinsurance.

- 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 and coinsurance.

• Medicare managed care plan

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan -- 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 provide all the benefits that Original Medicare covers. 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 or coinsurance 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 or coinsurance. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in 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.

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

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 illness 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 care. 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.

Coinsurance

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

Copayment

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

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 joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

Your medical and claims records are confidential

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

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

When you retire

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

When you lose benefits

•When FEHB coverage ends

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

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

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

• Spouse equity coverage

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

•Temporary continuation of coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

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

Enrolling in TCC. 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. It explains what you have to do to enroll.

•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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), is aFederal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group 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.

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program.. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked question. It highlights HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and haves information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG*!
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.

I'm healthy. I won't need long term care. Or, will I?

- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. LTC insurance can supplement care provided by family members, reducing the burden you place on them.
- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. Many people now consider long term care insurance to be vital to their financial and retirement planning.

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8- hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. Long term care insurance can protect your savings.

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. Long term care insurance can provide choices of care and preserve your independence.

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

NOTES

Summary of benefits for the Group Health Plan - 2002

- **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; $20 specialist	14
Services provided by a hospital:		
• Inpatient	$100 per admission copay	27
• Outpatient	$50 per outpatient surgery	28
Emergency benefits:		
• In-area	$75 per emergency room visit, waived if admitted to hospital.	31
• Out-of-area	$75 per emergency room visit, waived if admitted to hospital.	31
Mental health and substance abuse treatment	Regular cost sharing.	32
Prescription drugs	$8 generic $20 name brand $35 non formulary Copayment is per 30-day supply and applies to each unit (i.e. box, tube, vial, inhaler).	34
Dental Care	No dental benefit	37
Vision Care	Annual Eye exam is covered for $10 primary care; $20 specialist	19
Special features Flex Benefits option, High risk pregnancies, Joint replacement program,Centers of excellence for transplants		36
Protection against catastrophic costs (your out-of-pocket maximum).....	Nothing after $1,000/Self Only or $2000/Family enrollment per year Some costs do not count toward this protection	12

2002 Rate Information for
GROUP 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, 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 who are not career postal employees. 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
High Option Self Only	MM1	$97.86	$51.26	$212.03	$111.06	$115.52	$33.60
High Option Self and Family	MM2	$223.41	$98.68	$484.06	$213.80	$263.75	$58.34