GHI HMO

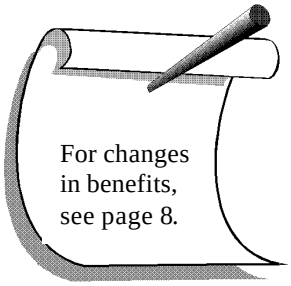
http://www.ghihmo.com

2002

A Health Maintenance Organization

Serving: Albany – Capital District Area, New York's Hudson Valley, New York City Area

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



This Plan has new health plan accreditation from NCQA. See the 2002 Guide for more information on accreditation.

Enrollment codes for this Plan:

Albany – Capital District, Hudson Valley Area
X41 Self Only
X42 Self and Family

New York City Area
6V1 Self Only
6V2 Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

FEHB
Federal Employees
Health Benefits Program

RI 73-591

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Introduction

GHI HMO Select, Inc.
25 Barbarosa Lane
Kingston, NY 12401

This brochure describes the benefits of GHI HMO under our contract (CS2655) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002 and changes are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plan's 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 GHI HMO.

- 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 us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us 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 1-877-244-4466 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 and coinsurance 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 health care?

GHI HMO Select, an individual practice prepayment plan, is a New York State certified, for-profit community-sponsored, primary care network model Health Maintenance Organization (HMO).

GHI HMO Select organizes preventative and routine health care as well as needed services for serious illness or injury. Care and coverage is provided by approximately one thousand seven hundred and eighty nine (1,789) individually affiliated primary care doctors, seventy two (72) area hospital, eleven thousand two hundred and fifty two (11,252) local specialist.

GHI HMO Select administrative offices are located at 25 Barbarosa Lane and 120 Wood Road, Kingston, NY 12401; and at 80 Wolf Road, Albany, NY 12205. Affiliated primary care doctors, specialists and other health care providers are conveniently located throughout the service area.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence - GHI HMO Select, Inc. is a subsidiary of GHI, the largest, not-for-profit health services corporation operating state-wide in New York, and has been operating in 25 counties of NYS since July 1999.
- Company profit status - GHI HMO Select, Inc. is a for-profit HMO.
- Drug Formulary - GHI HMO offers an open drug formulary.
- Percentage of Board Certified Physicians - 86% of GHI HMO physicians are Board Certified.

If you want more information about us, call 1-877-244-4466, or write to GHI HMO, Customer Service, 120 Wood Road, Kingston, NY 12401. You may also contact us by fax at (845) 334-8950 or visit our website at http://www.ghihmo.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:

Albany – Capital District Area: Albany, Broome, Columbia, Delaware , Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties.

Hudson Valley Area: Dutchess, Orange, Otsego, Putnam, Rockland, , Sullivan, and Ulster Counties.

New York City Area: Bronx, Brooklyn, Manhattan, Queens, and Westchester.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will only pay for emergency care benefits. 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 should 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 the Open Enrollment 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.

Program-wide changes

- We changed the address for sending disputed claims to OPM. (Section 8)

Changes to this Plan

- Your share of the non-Postal premium will increase by 9.8% for Self Only or 14.5% for Self and Family for Code X4. Your share will decrease by 50.4% for Self Only or 27.5% for Self and Family for Code 6V.
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- You pay $10 for generic, $20 for preferred brand and $30 for non-preferred brand for prescription drugs at a retail pharmacy. The retail co-pay applies to a 30-day supply. You pay $20 for generic, $40 for preferred brand and $50 for non-preferred brand for maintenance medications prescription drugs using mail-order. The mail order copay covers up to a 90-day supply for maintenance medication.

  If a brand drug is selected and there is a generic equivalent available you pay the brand co-pay and the difference in price between the generic and brand drug.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or 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 1-877-244-4466.

Where you get covered care

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

- **Plan providers**

Plan providers are physicians, including primary care physicians and specialists and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The directory is divided alphabetically by county. Primary Care Physicians are listed first, Specialty Care Physicians are listed second and all other providers (ancillary) are listed third under each county. The list is also on our website www.ghihmo.com.

- **Plan facilities**

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

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. Primary care physicians are listed in our provider directory and also on our web site. You may also call our Customer Service Department (1-877-244-4466) and they may assist you in selecting a provider near your home or office.

- **Primary care**

Your primary care physician can be a family practitioner, internist or pediatrician. 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, you may see your OB/GYN twice a year without a referral and a participating optometrist for a routine vision exam annually without a referral.

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 specialists 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 customer service department immediately at 1-877-244-4466. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

These provisions apply only to the hospital 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 percertification. Your physician must obtain prior authorization from the GHI HMO Medical Director. These services may include but are not limited to:

a. Specialist Referrals
b. Ambulatory Surgery
c. Hospital/Nursing Home admissions and any care rendered during stay
d. Physical Therapy and Cardiac Rehabilitation
e. Home Care and Hospice
f. Durable Medical Equipment over $250 and all Orthotics
g. Non-Participating Providers
h. Member requests for experimental or investigative health care services.
i. Mental Health and Substance Abuse (MH/SA)

GHI HMO may request supporting documentation from your provider to substantiate Medical Necessity of the requested service. All inpatient admissions are reviewed to evaluate that the services are covered services, Medically Necessary and being rendered at the appropriate level of care.

You have the right to designate a representative for utilization review. GHI HMO will notify you and your provider, by phone and in writing for prospective, concurrent and retrospective utilization review decisions. If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing
2. Refer to specific brochure wording in explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Arrange for a health care provider to give you the service; or
4. Ask for more information

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

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 and when you go in the hospital, you pay nothing.
· **Deductible**	We do not have a deductible
· **Coinsurance**	Coinsurance is the percentage of our negotiated that you must pay for your care. Example: In our plan you pay 50% of our allowance for infertility services. Also, you pay 20% for durable medical equipment up to a maximum of $1500 per person, per year.
Your catastrophic protection out-of-pocket maximum for deductibles, coinsurnace, and copayments	We do not have an catastrophic protection out-of-pocket maximum.

Section 5. Benefits – OVERVIEW

(See page 8 for how our benefits changed this year and page 60 for a benefits summary.)

NOTE: This benefits section is divided broken 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 following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at *1-877-2GH-IHMO or 1-877-244-4466* or at our website at www.ghihmo.com

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

IMPORTANT

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

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

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Physical examinations • Routine eye exams • Chiropractic services (with referral from PCP)	$10 per office visit
• Routine cervical Cytology (PAP smear) • Well Baby and Well Child Care visits (including immunizations) • Mammogram Exam	Nothing
Professional services of physicians • In an urgent care center • Office medical consultations • Second surgical opinion	$10 per office visit
• During a hospital stay • In a skilled nursing facility / 120 day limit	Nothing

Diagnostic and treatment services -- Continued on next page

Diagnostic and treatment services *(Continued)*	**You pay**
At Home	Nothing
Not covered: • *Routine foot care and foot orthotics* • *Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel* • *Long-term rehabilitative therapy* • *Homemaker services*	*All Charges* .
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	Nothing if you receive these services during your office visit; otherwise, $10 per office visit
• CAT Scans/MRI • X-ray	$10 copay
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 Prostate Specific Antigen (PSA test) - one annually for men age 40 and older	$10 per office visit
Routine pap test Note: The pap test is covered if the office visit is on the same day the office copay still applies; see *Diagnosis and Treatment* on page 15.	$10 per office visit

Preventive care, adult *(continued)*	**You pay**
Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 and older, one every calendar year	Nothing
Not covered: Physical exams 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 office visit
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Examinations, such as: – Eye exams through age 19 to determine the need for vision correction. – Ear exams through age 19 to determine the need for hearing correction by a primary care physician	$10 per office visit
– Examinations done on the day of immunizations (under age 22) – Well-child care charges for routine examinations, immunizations and care (under age 22)	Nothing

Maternity Care	You Pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 10 for other circumstances, such as extended stays for you or your baby. • 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).	Initial $10 copay, subsequent pre and post natal care you pay nothing
Not covered: Routine sonograms to determine fetal 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 office visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling,	*All charges.*

Infertility services	
Diagnosis of infertility	$10 per office visit
Treatment of Infertility, such as: • Artificial insemination – *intravaginal insemination (IVI)* – *intracervical insemination (ICI)* – *intrauterine insemination (IUI)*	50% of charges
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete GIFT and zygote ZIFT* - *Zygote transfer* • *Services and supplies related to excluded ART procedures* • *Fertility Drugs* • *Cost of donor sperm* • *Cost of donor egg*	*All charges.*
Allergy care	
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*
Diabetic Supplies and Equipment	
Blood glucose monitors, data management systems, test strips for glucose monitoring, insulin, injection aids, cartridges for legally blind, syringes, insulin pumps, insulin infusion devices, oral agents for controlling blood sugar	$10 copay for supplies

Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page xx. • Respiratory and inhalation therapy– Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	Nothing
• 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 or have your physician 1 877-2GH-IHMO or 1 877-244-4466 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. This benefit is provided under our Prescription Drug Benefits. See *Services requiring our prior approval* in Section 3.	$10 copay for prescriptions
Not covered: • *Treatment for experimental or investigational procedure* • *Therapy necessary for transsexual surgery*	*All charges.*

Physical and occupational therapies	You pay
• Up to two consecutive months per condition if significant improvement can be expected within two months for the following services: ••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. Physical and occupational therapy is provided on an inpatient or outpatient basis for up to two consecutive months per condition if significant improvement can be expected within two months; you pay $10 copay per outpatient visit. Speech therapy is limited to treatment if certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 30 visits within 60 days.	$10 per office visit $10 per outpatient visit Nothing per visit during covered inpatient admission
Not covered: • *Long term rehabilitative therapy* • *Exercise programs*	*All charges.*
Speech therapy	
• Up to two consecutive months per condition when medically necessary.	$10 per office visit
Hearing services (testing, treatment, and supplies)	
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per office visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges.*

Vision services (testing, treatment, and supplies)	You pay
• Eye exam to determine the need for vision correction (see preventive care) • Annual eye refractions Note: See preventive care, children for eye exam	$10 per office visit
Not covered: • *Eyeglasses or contact lences* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges. .*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose • 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 non-dental treatment of temporomandibular joint (TMJ) paid dysfunction syndrome.	20% coinsurance to a maximum of $1,500 per person, per calendar year.

Orthopedic and prosthetic devices (*Continued)*	
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All charges.*
Durable medical equipment (DME)	
Rental or purchase, as determined by GHI HMO, 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; • standard wheelchairs; • apnea monitors; • nebulizers; • crutches and; • walkers; Note: Call us at 1-877-244-4466 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment and will tell you more about this service when you call.	20% coinsurance to a maximum benefit $1,500 per person, per calendar year.
Not covered: • *Motorized wheel chairs* • *Hearing aids*	*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.), or other Home Health Care Agency personnel licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	Nothing

Home health services *(Continued)*	
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home health care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges.*
Chiropractic	
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application • Chiropractic services when authorized by PCP	$10 per office visit
Alternative treatments	
Not covered: • ***Acupuncture services*** • ***Naturopathic services*** • ***Hypnotherapy*** • ***Biofeedback***	*All charges.*
Educational classes and programs	
No Benefit	

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 facility (i.e. hospital, surgical center, etc).
- YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require prior authorization and identify which surgeries require prior authorization .

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 -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • 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 per office visit; nothing for hospital visits
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*

Reconstructive surgery	You pay
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: – the condition produced a major effect on the member's appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.	$10 per office visit; nothing for hospital visits
• 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	See above.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Temporanmandibular Joint treatment (TMJ) • Other surgical procedures that do not involve the teeth or their supporting structures.	$10 per office visit
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome*.	*All charges.*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogenic (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 • National Transplant Program (NTP) – GHI HMO will cover transplants approved as safe and effective for a specific disease by the Federal Drug Administration (FDA) or National Institute of Health or which GHI HMO's Medical Director determines is medically necessary, appropriate and advisable on a case-by-case basis. GHI HMO will cover the medical and hospital services, and related organ acquisition costs. Eligibility for transplants shall be determined solely by GHI HMO's Medical Director upon recommendation of an Enrollee's Primary Care Physician. Eligibility for transplants mu st be approved in advance of surgery by GHI HMO's Medical Director. Additionally, all transplants must be performed at hospitals specifically approved and designated by GHI HMO to perform these procedures. Specialty physician experts from our designated centers of excellence will provide clinical review and support to the Medical Director's decision. Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*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

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.
- 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 PRIOR AUTHORIZATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require prior authorization 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 • special duty nursing and private rooms during inpatient hospitalization when medically necessary and approved by GHI HMO Medical Director NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing

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	Nothing
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 NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment if in connection with an accidental injury to sound natural teeth within twelve (12) months of the accident, or in the judgement of GHI HMO's Medical Director, a hazardous concurrent medical condition requires hospitalization. Hospital care is only available when a medical condition necessitates such care. We do not cover the dental procedures.	Nothing
Not covered: blood and blood derivatives not replaced by the member	*All charges*

Extended care benefits/skilled nursing care facility benefits	You pay
Skilled nursing facility (SNF): Limited to 120 days per person per calendar year : • Bed, board and general nursing care • Drugs, biologicals, supplied and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by your plan doctor.	Nothing
Not covered: custodial care	*All charges*
Hospice care	
Supportive and palliative care for the terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care and family counseling. Benefits are limited to 210 days; bereavement counseling services are covered up to five (5) days.	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

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

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

IMPORTANT

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in a condition 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. These conditions would be defined as **urgent care**. 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:

Emergencies within our service area:

In the event of a medical emergency you should seek immediate medical treatment at the nearest emergency facility anywhere in the world whether or not they participate with GHI HMO. You do not need prior approval by GHI HMO or your PCP to receive emergency treatment. However, you or a family member must contact your PCP, unless it not reasonably possible to do so. If you are unable to contact your PCP, please call GHI HMO at 1-877-244-4466. It is your PCP's responsibility to contact GHI HMO with this information. All emergency room visits that do not result in a hospital admission will require emergency room $35 copay.

Urgent care is defined as a sudden onset of illness or accident that does not require acute care treatment and would not result in a several disability. Examples of conditions we do not consider to be emergencies are but are not limited to: head colds, influenza, tension headaches, toothaches, minor cuts and bruises, muscle strain, hemorrhoids and intoxication. You must contact your PCP prior to obtaining care. Your PCP will provide care for your situation, arrange for you to receive care in a GHI HMO affiliated facility or refer you to the nearest emergency room. You will be responsible for the full cost of the visit if you do not contact your PCP. If referred to the emergency room by PCP, you will pay a $35 copay. If you are unable to reach your PCP, please call GHI HMO at 1-877-244-4466.

Emergencies outside our service area:

If you are out of the GHI HMO Service Area, your PCP or the on-call physician to authorize your care at the nearest emergency facility as appropriate. It is your responsibility or that of a family member to contact your PCP prior to receiving non-emergency care, unless it was not reasonably possible to do so.

Section 5 (d). Emergency services/accidents

Your membership care instructs physicians and hospitals outside the GHI HMO Service Area to send all claims for services rendered directly to GHI HMO. However, if the emergency care you receive is relatively minor in cost, you may be asked to pay for services rendered. In these cases, keep all receipts and bills (indicating the provider's name, date of service, procedures performed, amount charged and amount paid) and present them along with an explanation to GHI HMO's Customer Service department for review and appropriate reimbursement. GHI HMO, Customer Service, 120 Wood Road, PO Box 4443, Kingston, NY 12401

If you were admitted to the hospital from the Emergency Room the $35 day copay is waived. Follow-up care after an emergency must be provided with a participating GHI HMO provider. Care provided by a non-participating provider will not be covered for follow-up visits.

What is an accidental injury? An accidental injury is a bodily injury sustained solely through violent, external, and accidental means, such as broken bones, animal bites, and poisonings. We do cover dental care for accidental injury to sound natural teeth only.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center	$10 per office visit
Emergency care as an outpatient at a hospital, including doctors' services Note: copay waived if admitted to the hospital.	$35 copay
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center	$10 per office visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: copay waived if admitted to the hospital	$35 copay
Emergency outside our service area	
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*	*All charges.*
Ambulance	
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	Nothing
Not covered: air ambulance unless medically necessary and approved by GHI HMO's Medical Director	*All charges.*

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

IMPORTANT

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

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. Here are some important things to keep in mind about these benefits:
- 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 includes services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, nurse, or clinical social workers. • Medication Management	$10 per office visit

Mental health and substance abuse benefits (*Continued*)	**You Pay**
• Diagnostic test • Lab work	Nothing
• X-rays	$10 per office visit
• Services provided by a hospital or other facility • Services in approved alternative care settings such as: - partial hospitalization - residential treatment - full-day hospitalization - facility based intensive outpatient treatment	Nothing
Not covered in the network: The same exclusions contained in this brochure that apply to other benefits apply to these mental health and substance abuse benefits, unless the services are included in a treatment plan that we approve. *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.*

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

Preauthorization

To be eligible to receive these benefits you must follow your treatment plan and all of our network authorization processes.

Merit Behavioral Health Care an affiliate of Magellan Behavioral Health has been contracted to manage your behavioral health benefits. In order to access your benefits, please call the Merit Behavioral Health Care toll free number at 1-800-836-2256. You will be connected to a customer service representative who will be able to assist you in identifying a behavioral health care provider in your area or to verify if your current provider is a participating provider in the Behavioral Health network.

If participating, the customer service representative will verify benefits/eligibility and an authorization for treatment will be sent out to your provider. They will continue to follow their contractual obligations and submit treatment plan reports for continued authorization. The treatment reports will be reviewed by a New York State licensed clinician to determine if the treatment you are receiving meets medical necessity criteria for the level of care and the intensity of treatment you are receiving.

If non-participating, the customer service representative will either offer you a provider participating in the network that specializes in your area of need or will offer to forward a treatment report to you. You will be responsible for your provider completing the forms in their entirety and returning them to the address provided. The treatment reports will be reviewed by a New York State licensed clinician to determine if the treatment you are receiving meets medical necessity criteria for the level of care and the intensity of treatment you are receiving.

Treatment will not be interrupted if the licensed clinician reviewer finds your treatment to be needed and appropriately provided. At that point, your non-participating provider will be required to sign an ad hoc agreement, which will allow you to continue in treatment. Your non-participating provider will be required to accept contracted rates. They will be required to follow all the same contract requirements as a participating provider.

Inpatient and alternative levels of care, which are more intense, than routine outpatient therapy must be called in by using the same toll free number. New York State licensed staff is available 24 hours a day, 7 days a week, 365 days a year.

Participating provider directories can be obtained by calling the Customer Service department at GHI HMO Select at 1-877-244-4466 or view the directory on our website www.ghihmo.com.

How to submit claims

There are no claim forms. You must work through participating providers. In the event you are in the transitional period, you must notify the Plan and have the provider contact the Plan. If you have mistakenly received a bill for covered services or your provider needs to contact GHI HMO, please contact customer service at 1-877-244-4466. Mail billing statements to GHI HMO, Attn: Claims, PO BOX 4332, Kingston, NY 12402.

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.
- *There are no deductibles.*
- Your prescription drug program provides coverage for some drugs only if they are prescribed for certain uses. For this reason, some medications must receive Prior Authorization before they can be covered by your benefit plan. If the prescribed medications require Prior Authorization, please contact or have your provider contact the GHI HMO Medical Management Department at 1-877-244-4466 for approval. If your medication is not approved for coverage under your Plan, you will be responsible for paying the full cost of the drug. Below is a partial list of those medications needing prior authorization.
- *Tretinoin Topical (Retin-A) for Age >35*
- *COX-II Inhibitors (Celebrex/Vioxx)*
- *Onychomycosis therapy (Sporanox)*
- *Growth Hormones*
- *Interferons*
- *Galtiramer Acetate*
- *Alglucerase*
- 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 Plan physician, PCP or Specialist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at any participating pharmacy within the Merck Medco network, or by mail for maintenance medications. The Merck Medco network pharmacies are identified as participating in PAID PRESCRIPTIONS. Merck Medco has over 55,000 pharmacies in its network. Some of these pharmacies are CVS, Eckerd, Walgreen's. Rite Aid, PriceChopper and many others.You may also obtain maintenance medications through the mail. To find the participating pharmcy nearest to you, visit Merck Medco at www.merck-medco.com. You can use the interactive pharmacy locator online or call your toll-free 1 800 473-3455 Merck-Medco Member Services to use the voice-activated Pharmacy Locator System.

  · **Retail Pharmacy –** Original prescriptions and refills. The supply amount will be a 30 day supply for each prescription.

  · **Mail Order Prescriptions –** Maintenance Medications refills may be obtained through this benefit. The supply amount will be up to a 90 day consecutive supply for each prescription.

Note: Certain controlled substances and several other prescribed medications maybe subject to other dispensing limitations (e.g quantities dispensed) and the professional judgement of the pharmacist. Federal Law prohibits the return of dispensed controlled substances.

- **We use a formulary.** Your prescription drug program includes a open "formulary" feature. A formulary is a list of commonly prescribed medications that are preferred based on their clinical effectiveness and opportunities to help contain your Plan's costs. There are approximately 1132 drugs on the formulary. The list includes products manufactured by most major pharmaceutical manufacturers, including Merck & Co., Inc. By asking your doctor to prescribe formulary medications, you can help control rising health care costs while maintaining high-quality care. Use of a formulary drug is, voluntary; there is no financial penalty if your physician does not prescribe a formulary drug. Sometimes your physician may prescribe a medication when a formulary preferred brand or generic alternative drug is available, including in some cases, a prescription to be dispensed as written. As part of your prescription drug Plan, the pharmacist may discuss with your physician whether and alternative drug listed on the formulary might be appropriate for you. If your physician agrees, your prescription will be filled with the alternative drug. A confirmation will be sent to you and your physician explaining the change. Let your physician know if you have any questions about a change in prescription. Your physician always makes the final decision on your medication and you can always choose to keep the original prescription.

- **These are the dispensing limitations.** Prescriptions obtained in retail pharmacies are filled with a thirty (30) consecutive day supply. You pay $10 for generic, $20 for preferred brand and $30 for non-preferred brand for prescription drugs at a retail pharmacy. The retail co-pay applies to a 30-day supply. You pay $20 for generic, $40 for brand, $50 for non-preferred brand for maintenance medications prescription drugs through using mail-order. The mail order copay covers up to a 90-day supply for maintenance medication. A member shall pay the lesser of the copay charge if the medication is less than the copay amount. If a prescription refill is submitted prior to either the 30 day or 90 day limit, the medication will not be filled until the appropriate length of time has lapsed. Medications needing prior authorization must be submitted to Medical Affairs for approval. All medications are subject to the same rigid US Food and Drug Administration (FDA) standards for quality, strength and purity.

- **Why use generic drugs?** Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your plan less money than a name-brand drug.

When you have to file a claim. You would only file a claim for a prescription if you have paid for your prescriptions. This can happen if you need to fill a prescription out-of-area, if your name does not appear in the pharmacies database, etc. You may have to pay for the prescription and the Plan will reimburse you the expense. Submit a completed claim form to PAID Prescriptions. The prescription receipt must be attached to the form. To obtain claim forms, visit the Merck/Medco website at www.merck-medco.com or call member services. Pharmacy claim forms are also available by calling GHI HMO's Customer Service Department at 1-877-2GH-IHMO or 1 877-244-4466. You are responsible for 100% of the price of the prescription at the time of purchase when using a non-participating pharmacy. You will be reimbursed usually within 21 days from the date your claim form is received.

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
The following drug categories are available for dispensing through Merck Medco Rx Services. For a complete formulary listing call 1-877-244-4466 (GHI HMO) or Merck Medco at 1-800-445-9709. • Anti-infectives • Cardiovascular • Endocrine • Gastrointestinal • Psychotherapeutics • NSAIDS (Pain relievers) • Respiratory	Retail Pharmacy: $10 co pay - generic $20 co pay – preferred brand $30 co pay – non-preferred brand (30-day supply) Mail Order: $20 co pay – generic $40 co pay – preferred brand $50 co pay – non-preferred brand (90-day supply for maintenance medications
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan retail pharmacy will be dispensed for up to a 34-day supply or 100 unit supply, whichever is less, 240 milligrams of liquid (8 oz.); 60 grams of ointment, creams or topical preparation; or one commercially prepared unit (i.e. one inhaler, one vial ophthalmic medication or insulin). • Contraceptive drugs and devices • Insulin • Disposable needles and syringes for the administration of covered medications • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. – Prescription drugs for diet or weight control including anorexic agent – Drugs utilized for treatment of sexual dysfuntion are limited to 6 doses per month – Prescription drugs not obtained at a GHI HMO participating pharmacy or Mail Order Pharmacy – Initial prescriptions or refills in excess of a 34 consecutive day supply or one month's cycle of any oral contraceptive drug (Mail order available for up to a 90 day supply) – Drugs related to non-covered medical services – OTC drugs – Contraceptive devices such as condoms and spermacidal agents – Drugs not approved by the FDA – Medications for cosmetic purposes only	Retail Pharmacy: $10 co pay - generic $20 co pay – preferred brand $30 co pay – non-preferred brand (30-day supply) Mail Order: $20 co pay – generic $40 co pay – preferred brand $50 co pay – non-preferred brand (90-day supply for maintenance medications)

Covered medications and supplies *(continued)*	**You pay**
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs {plan specific}* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines*	*All Charges*

Section 5 (g). Special features

Feature	Description
Services for deaf and hearing impaired	We provide a TDD Line for the deaf and hearing impaired, 1-877-208-7920
Centers of excellence for transplants/heart surgery/etc	Life Trac – National Ancillary providers for organ transplants utilizing 31 Centers of Excellence throughout the United States
PHIP - Personal Health Improvement Program	GHI HMO is now offering the Personal Health Improvement Program (PHIP) to our members. PHIP is a behavioral medicine intervention for the following types of patients: (1) those with stress related illnesses such as headaches, back pain, fatigue, insomnia, and gastrointestinal discomfort. (2) those learning to deal with a chronic disease such as multiple sclerosis, fibromyalgia and diabetes. (3) patients whose mood (anxiety, depression, etc.) seems to influence their physical health. PHIP is based on the mind-body theory that mood and physical health are closely correlated. It helps patients reduce suffering and the symptoms of chronic illnesses by allowing participants to become aware of how their bodily reactions are related to behavioral patterns, including coping styles. By making such connections, participants learn to adopt new behaviors that will relieve their pain or discomfort. The program consists of six weekly two hour classes led by a trained facilitator. The classes consist of a combination of group discussion and specific exercises designed to help participants become aware of their own reactions to daily life. Participants are provided with a workbook and home-study questions, as well as audiotape to guide them through an awareness exercise that they are asked to do daily.

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.
- GHI HMO does not provide dental benefits.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit	You Pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. The services must be provided within 12 months of the injury.	Nothing

Dental benefits

We have no other dental benefits.

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 Service Require Prior Authorization* on page 11.**

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;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services related to the professional fee for treatment of cavities and extractions, care of gums or bones supporting the teeth, orthodontia, false teeth, odontoma (tumors that are of dental origin and comprised of hard dental tissue), or any other dental services.

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, Hospital & Drug 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 1-877-244-4466.

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 following 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: **GHI HMO Claims Department**
PO Box 4141
Kingston, NY 12401

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.

If a claim is denied, you will receive notice of the decision, including reasons for the denial and the provisions of the contract on which the denial was based. If you disagree with the plans decision, you may request reconsideration in accordance with the disputed claims procedure described on page

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: GHI HMO, 120 Wood Road, Kingston, NY 12401; 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.

The Disputed Claims Process (*Continued*)

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 fromyou 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 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 preauthorization/prior approval, then call us at 1-877-244-4466 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 Commissioners' guidelines.

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

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

· What is Medicare

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. 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 and arranged by your Plan PCP.

(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		✓

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 is you need to do something about filing your claims, call us at 1-877-244-4466 or visit our website at www.ghihmo.com.

· **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 of 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 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, 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 and enroll in Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Mediare 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

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

If you do not seek damages you must agree to let us try. This is called subrogation. You must assist us in receiving our excess payment, for example, by completing and filing claim forms with other Health Plans and endorsing checks over to us. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 13.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 13

Covered services

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

Custodial care

Any service which can be learned and provided by an average individual who does not have medical training. Examples of Custodial Care include:

a. Assistance in meeting activities of daily living such as feeding, dressing and personal hygiene;
b. Administration of oral medications, routine changing of dressing, or preparation of special diets;
c. Assistance in walking or getting out of bed;
d. Child care necessitated by the incapacity of a parent; or
e. Respite Care

Experimental or Investigational services

Any drug, device or medical treatment or procedure is experimental or investigational:

- If the drug or device has not been approved by the Food and Drug Administration (FDA)
- If reliable evidence, (reports in respected medical and scientific literature) shows that the opinion of experts is that further study is needed to decide how a drug, device or medical treatments or procedures compares with the standard method of treatment or diagnosis.

Medical necessity

Medically necessary health care services are those necessary to preserve and maintain an Enrollee's health in accordance with acceptable standards of medical practice and received in an appropriate setting. The GHI HMO Medical Director shall determine whether a particular health care service rendered to an Enrollee is Medical Necessary for the purpose of determining whether such health care services are covered services and not for the purpose of practicing medicine or determining a course of treatment, which course is to be determined by the Participating Physician.

Plan allowance

The plan allowance is a fee negotiated between the providers of service and the plan. These agreed upon fees are considered to be payment in full for services rendered by all participating providers. Your coinsurance (50% for infertility services, and 20% for durable medical equipment) will be applied to these negotiated fees.

Us/We	Us and we refer to GHI HMO
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.

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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 a Federal 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. These highlight 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 have 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.
- 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.*

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

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half 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.

Summary of benefits for the GHI HMO – 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; $10 specialist	15
Services provided by a hospital: • Inpatient..... • Outpatient..... • Lab ..... • X-Ray.....	Nothing $10 copay	30
Emergency benefits: • In-area ..... • Out-of-area	$35 per office visit $35 per office visit	33
Mental health and substance abuse treatment.....	Regular cost sharing.	34
Prescription drugs.....	$10 copay for retail $20 copay for mail order	37
Dental Care	Accidental injury to sound natural teeth only. You pay nothing	42
Vision Care	One refraction annually. You pay $10 copay per office visit	22
Special features: • Services for deaf and hearing impaired • Centers of Excellence for transplans/heart surgeries • PHIP – Personal Health Improvement Project		41
Protection against catastrophic costs (your out-of-pocket maximum)	Your out-of-pocket expenses for benefits under this Plan are limited to the stated copayments which are required for few benefits	

NOTES:

2002 Rate Information for
GHI HMO Select, Inc.

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses, 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
Bronx/Brooklyn/Manhattan/Queens/Westchester							
Self Only	6V1	$96.14	$32.05	$208.31	$69.44	$113.77	$14.42
Self and Family	6V2	$223.41	$98.91	$484.06	$214.30	$263.75	$58.57
Albany/Broome/Columbia/Delaware/Dutchess/Fulton/Greene/Montgomery/Orange/Otsego/Putnam/Rensselaer/ Rockland/Saratoga/Schenectday/Schoharie/Sullivan/Ulster/Warrren/Washington							
Self Only	X41	$85.67	$28.56	$185.63	$61.87	$101.38	$12.85
Self and Family	X42	$220.87	$73.62	$478.55	$159.51	$261.36	$33.13