The George Washington University Health Plan

1999

A Health Maintenance Organization

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

Enrollment in this Plan is limited; see page 9 for requirements.

High Option

Enrollment Code:

E51 Self only
E52 Self and family

Standard Option

Enrollment Code:

E54 Self only
E55 Self and family

Visit the OPM website at **http://www.opm.gov/insure**

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United States Office of Personnel Management

Federal Employees Health Benefits Program

RI 73-046

The George Washington University Health Plan, Inc.

The George Washington University Health Plan, Inc., 4550 Montgomery Avenue, Bethesda, Maryland 20814, has entered into a contract (CS 1764) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called the Plan.

This brochure is the official statement of benefits on which you can rely. A person enrolled in the Plan is entitled to the benefits stated in this brochure. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1999, and are shown on page 24 of this brochure.

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Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits, or increase the amount of FEHB benefits, is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital or pharmacy, charged your plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation—sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at 301-941-2000 and explain the situation.
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202-418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, D.C. 20415

The inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

General Information

Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confidential and will be used only: 1) by the Plan and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education.

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. **As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor except in the case of emergency as described on pages 15-16.** If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See *If you are hospitalized* on page 4.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

General Information *continued*

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about: when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan; if you changed plans or plan options, see *If you are a new member* above. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers, except for emergency benefits.
- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions, including divorces, of covered family members to the Plan promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. **Before** you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

You may also remain enrolled in this Plan when you join a Medicare prepaid plan.

Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800-638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she generally will be eligible for a free 31-day extension of coverage. The employee or family member also may be eligible for one of the following:

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date, and coverage may not exceed the 18 or 36 month period noted above.

Notification and election requirements

Separating employees – Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

Children – You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.

General Information *continued*

Former spouses – You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices are available—or chosen—when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Certificate of Creditable Coverage

Under Federal law, if you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan Coverage from the last FEHB Plan to cover you. This certificate, along with any certificates you receive from other FEHB plans you may have been enrolled in, may reduce or eliminate the length of time a preexisting condition clause can be applied to you by a new non-FEHB insurer. If you do not receive a certificate automatically, you must be given one on request.

Facts about this Plan

This Plan is a comprehensive medical plan, sometimes called a health maintenance organization (HMO). When you enroll in an HMO, you are joining an organized system of health care that arranges in advance with specific doctors, hospitals and other providers to give care to members and pays the providers directly for their services. Benefits are available only from Plan providers except during a medical emergency. **Members are required to select a personal doctor from among participating Plan primary care doctors.** Services of a specialty care doctor can only be received by referral from the selected primary care doctor except for obstetrical and gynecological services and for an annual routine eye examination, which a member may obtain directly from a Plan specialist. There are no claim forms when Plan doctors are used.

Your decision to join an HMO should be based on your preference for the plan's benefits and delivery system, not because a particular provider is in the plan's network. You cannot change plans because a provider leaves the HMO.

Because the Plan provides or arranges your care and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan places great emphasis on preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness.

Information you have a right to know

All carriers in the FEHB Program must provide certain information to you. If you did not receive information about this Plan, you can obtain it by calling the Carrier at 301-941-2000 or you may write the Carrier at 4550 Montgomery Avenue, Suite 800, Bethesda, Maryland 20814. You may also contact the Carrier by fax at 301-941-2093.

Information that must be made available to you includes:

- Disenrollment rates for 1997.
- Compliance with State and Federal licensing or certification requirements and the dates met. If noncompliant, the reason for noncompliance.
- Accreditations by recognized accrediting agencies and the dates received.
- Carrier's type of corporate form and years in existence.
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

About this Plan

The George Washington University Health Plan, Inc. ("Plan") is a wholly-owned, non-public subsidiary of The George Washington University, a federally chartered corporation. The Plan was organized under the District of Columbia Non-Profit Corporation Act on May 16, 1972, and is currently in good standing.

In October 1997, the Plan received one-year accreditation by the National Committee for Quality Assurance (NCQA), an independent, non-profit organization that accredits managed care organizations. One-year accreditation is granted to plans that have well-established quality improvement programs and meet most NCQA standards.

The Plan covers comprehensive health care in three (3) state jurisdictions plus coverage for federal employees within the Plan's service area. The Plan renewed its health maintenance organization ("HMO") license in Virginia on July 1, 1998, and in Maryland on December 1, 1997. These licenses renew annually. The Plan recently obtained an HMO license in the District of Columbia effective April 14, 1998, under the District's new HMO Act (previously, HMOs were not required to be licensed in the District). The Plan also has been a federally-qualified HMO since 1979, which qualification stays in effect unless withdrawn. None of the above-referenced jurisdictions require a certification process.

How to Obtain Medical Records

Under its current contracts with providers, the Plan permits a member to obtain a copy of his or her medical record for a nominal fee, not to exceed $.50 per page. This member access includes the right to review the medical record.

Who provides care to Plan members?

Care is provided by physicians who are part of an independent network practicing in the Plan's service area. All of the physicians who participate in the network are credentialed and have met rigorous screening standards established by the Plan. At the core of the physician network are faculty members of The George Washington University School of Medicine and Health Sciences who practice at six health care centers.

Plan members must select a primary care physician who is either a family practitioner, internist or pediatrician. The primary care doctor is responsible for managing the member's medical care, including referrals to specialists and hospital admissions. Each family member may select a different primary care physician. Members who select a primary care physician affiliated with the GW Medical Faculty Associates at the downtown Ambulatory Care Center located at 2150 Pennsylvania Avenue, NW, Washington, DC, will be referred only to specialists who are also affiliated with that center. For additional information on provider groups, please call Member Services at 301-941-2021.

Role of a primary care doctor

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. The goal is to establish a relationship between the member and his or her primary care physician that promotes continuity of care. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization.

Services of other providers are covered only when you have been referred by your primary care doctor, with the following exceptions: for Plan obstetrical and gynecological appointments and for a routine annual eye examination.

Choosing your doctor

The Plan's provider directory lists primary care doctors (family practitioners, pediatricians, and internists), with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Member Services Department at 301-941-2021; you can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. **Important note: When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider, cannot be guaranteed.**

Should you decide to enroll in the Plan, you must select a primary care physician by completing the Physician Selection Form or calling the Plan. Until a primary care physician is selected, only emergency and prescription services will be available. When you select a primary care doctor, an identification card will be issued specifying the primary care doctor.

To change your primary care doctor, please contact Member Services at 301-941-2021. Failure to use your designated primary care doctor may result in your being billed for services or having your claim denied for payment.

If you are receiving services from a doctor who leaves the Plan, the Plan will pay for covered services until the Plan can arrange with you for you to be seen by another participating doctor.

Referrals for specialty care

You must always contact your primary care doctor for a referral before seeing any other doctor or obtaining special services, with the following exceptions: in an emergency; when obtaining gynecological or obstetrical care; for your annual routine eye examination; or, when a primary care doctor has designated another doctor to see patients when he or she is unavailable. Referral to a participating specialist is given at the primary care doctor's discretion.

The primary care doctor will give specific instructions to the specialist as to what services are authorized. If additional services or visits are suggested by the specialist, you must first check with your primary care doctor. Do not go to the specialist unless your primary care doctor has provided a referral. You must obtain a referral form and take it to your specialist at the time of your appointment. All follow-up care must be provided or arranged by the primary care doctor

If you have a chronic, complex, or serious medical condition that causes you to see a Plan specialist frequently, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct access visits with that specialist. The treatment plan will permit you to visit your specialist without the need to obtain further referrals. Examples of a referral for a chronic, complex, or serious medical condition would be for dialysis or chemotherapy.

Authorizations

The Plan will cover services only when they are medically necessary to prevent, diagnose or treat your illness or condition. Your Plan doctor must obtain the Plan's determination of medical necessity before you may be hospitalized, receive outpatient surgery, be referred for specialty care or obtain follow-up care from a non-Plan provider or medical facility (except in a medical emergency).

For new members

If you are already under the care of a specialist who is a Plan participant, you must still obtain a referral from a Plan primary care doctor for the care to be covered by the Plan. If the doctor who originally referred you prior to your joining this Plan is now your primary care doctor, you need only call to explain that you now belong to this Plan and ask that a referral form be sent to the specialist for your next appointment.

If you are selecting a new primary care doctor, you must schedule an appointment so the primary care doctor can decide whether to treat the condition directly or refer you back to the specialist.

Hospital care

If you require hospitalization, your primary care doctor or authorized specialist will make the necessary arrangements and continue to supervise your care.

Out-of-pocket maximum

Copayments are required for a few benefits. However, copayments will not be required for the remainder of the calendar year after your out-of-pocket maximum total is reached. The Plan has established a maximum amount of $650 per Self only enrollment and $1,500 per Self and Family enrollment per calendar year under the High Option plan and a maximum amount of $1,000 per Self only enrollment and $2,500 per Self and Family enrollment per calendar year under the Standard Option plan. The copayment maximums do not include costs of prescription drugs, dental benefits, infertility services, durable medical equipment (DME), or orthopedic and prosthetic devices.

You should maintain accurate records of the copayments made, as it is your responsibility to determine when the copayment maximum is reached. You are assured a predictable maximum in out-of-pocket costs for covered health and medical needs. Copayments are due when service is rendered, except for emergency care.

Deductible carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible will be covered by your old plan if they are for care you got in January **before** the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Submit claims promptly

When you are required to submit a claim to this Plan for covered expenses, submit your claim within 60 days of the date of service. The Plan will not pay benefits for claims submitted later than December 31 of the calendar year following the year in which the expense was incurred, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Experimental/ investigational determinations

The Plan evaluates new treatments, procedures, devices, and drugs based on recommendations of a committee composed of practicing community physicians, GW Health Plan staff and experts in the field under review. The committee reviews literature and presentations to determine whether proposed technologies are medically effective and applicable to the membership. If the committee determines the technology would be beneficial to Plan members, a recommendation will be made to consider coverage of the technology. The Medical Director will consider requests for coverage of new technologies for members with an urgent need.

Other considerations

Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you will be able to accept treatment or procedures that may be recommended by Plan providers.

The Plan's Service Area

The service area for this Plan, where Plan providers and facilities are located, is described below. You must live or work in the service area to enroll in this Plan.

The service area for this Plan includes the following areas:

The **District of Columbia**, the **Virginia** cities of Alexandria, Fairfax, Falls Church, Fredericksburg, Manassas, Manassas Park, and Winchester, as well as the **Virginia** counties of Arlington, Fairfax, Fauquier, Frederick, Loudoun, Prince William, Spotsylvania, Stafford, and Warren, the **Maryland** city of Baltimore, and the **Maryland** counties of Anne Arundel, Baltimore, Calvert, Carroll, Cecil, Charles, Frederick, Harford, Howard, Montgomery, Prince Georges, St. Mary's and Washington.

Benefits for care obtained outside the service area are limited to emergency services, as described on page 16.

If you or a covered family member move outside the service area, or you no longer work in the service area, you may enroll in another approved plan. It is not necessary to wait until you move or for the open enrollment season to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. Plan physicians may charge a $25.00 fee for broken appointments, if the member does not give 24-hour advance notice of cancellation. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan.** This brochure is the official statement of benefits on which you can rely.

Circumstances beyond Plan control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

Arbitration of claims

Any claim asserted by or on behalf of any Plan enrollee for any personal injury, including but not limited to any claim for physical, mental or emotional injuries or death arising out of the alleged negligent rendition of or failure to render any services (commonly referred to as medical malpractice) under this contract must be submitted to binding arbitration. This arbitration provision applies to any such claim asserted on or after January 1, 1995, regardless of when the alleged rendition of or failure to render services occurred. Such arbitration shall be conducted pursuant to the Rules of the American Arbitration Association for arbitrating health claims. For purposes of this arbitration clause only, "claim" shall be any demand for money or other relief against any person or entity who is alleged to have been negligent or liable for medical malpractice in providing any health care services under this Plan.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Plan and complete all necessary documents and authorizations requested by the Plan.

Medicare

If you or a covered family member is enrolled in this Plan and Medicare Part A and/or Part B, the Plan will coordinate benefits according to Medicare's determination of which coverage is primary. However, this Plan will not cover services, except those for emergencies, unless you use Plan providers. You must tell your Plan that you or your family member is eligible for Medicare. Generally, that is all you will need to do, unless your Plan tells you that you need to file a Medicare claim.

Group health insurance and automobile insurance

This coordination of benefits (double coverage) provision applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Plan.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan.

One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

General Limitations

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of a prepaid plan, special limitations on your CHAMPUS coverage apply; your primary provider must authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities, and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name.

If you need more information about subrogation, the Plan will provide you with its subrogation procedures.

General Exclusions

All benefits are subject to the limitations and exclusions in this brochure. Although a specific service may be listed as a benefit, it will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness or condition as discussed under *Authorizations* on page 8. The following are excluded:

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see *Emergency Benefits*) or eligible self-referred services;
- Expenses incurred while not covered by this Plan;
- Services furnished or billed by a provider or facility barred from the FEHB Program;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Procedures, treatments, drugs or devices that are experimental or investigational;
- Procedures, services, drugs and supplies related to sex transformations; and
- Procedures, services, drugs and 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.

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits, subject to applicable copayments.

High Option – You pay nothing for office visits to your primary care doctor, for specialty care visits, allergy testing, MRI or CAT scan tests, outpatient surgery performed at a hospital or ambulatory surgical center, or for home health visits.

Standard Option – You pay a $10 office visit copayment for primary care visits and allergy treatment (e.g., allergy injection); **you pay** a $20 copayment for specialty care visits and home health visits, allergy testing and for each MRI or CAT scan test. **You pay** nothing for prenatal office visits and well-child visits through age 6. **You pay** a $50 copayment per visit for outpatient surgery performed at a hospital or ambulatory surgical center.

The following services are included:

- Preventive care, including well-baby care and periodic check-ups
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters
- Self-referral to Plan doctors for gynecological care. **You pay** nothing under the High Option; **you pay** a $10 office visit copayment under the Standard Option for your annual gynecological (well-woman) examination; **you pay** a $20 copayment under the Standard Option for all other gynecological visits.
- Self-referral to Plan doctors for obstetrical (maternity) care. Women may use Plan certified nurse midwives under the supervision of a physician or other qualified provider as credentialed by the Plan. **You pay** nothing under the High or Standard Option for prenatal or postnatal office visits.
- Self-referral to Plan doctors for routine annual eye examination. **You pay** nothing under the High Option; **you pay** a $20 copayment for each office visit under the Standard Option.
- Consultations by specialists if referred by your primary care physician
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. The mother, at her option, may remain in the hospital up to 48 hours after an uncomplicated regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of the infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including test and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints
- Cornea, heart, heart/lung, single and double lung, pancreas, pancreas/kidney, kidney and liver transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer, multiple myeloma, epithelial ovarian cancer, and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors, subject to approval by the Plan's Medical Director. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

- Podiatric services related to underlying medical conditions (e.g., diabetic foot problems)
- Surgical treatment of morbid obesity
- Blood products and blood derivatives
- Home health services of nurses, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need.
- All medically necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers.

Limited benefits

Oral and maxillofacial surgery is provided for non-dental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. 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, except as covered under Dental Benefits. (See pages 19-20 and 21.)

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to 90 days per condition if significant improvement can be expected within 90 days; **you pay** a $10 copayment per outpatient session under the High Option. **You pay** a $20 copayment per outpatient session under the Standard Option. Speech therapy is limited to treatment of 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. Treatment is limited to one visit per day.

Cardiac rehabilitation following a heart transplant, bypass surgery or myocardial infarction, for up to 90 days; **you pay** a $10 copayment per outpatient session under the High Option. **You pay** a $20 copayment per outpatient session under the Standard Option.

Durable medical equipment ("DME") is defined as equipment which must be able to withstand repeated use, primarily serve a medical purpose, and be appropriate for use in your home. DME includes items such as non-motorized wheelchairs, hospital beds, oxygen equipment for home use including oxygen; **Orthopedic devices**, such as braces, crutches, and canes; and **Prosthetic devices** such as artificial limbs and ocular lenses following cataract removal. Repair and replacement of prosthetic and orthopedic devices will be provided only after growth necessitates replacement (limited to one replacement only). Repairing, replacing and duplicating DME items are not covered. For a list of specific covered items, call Member Services at 301-941-2021. All DME must be authorized through the Plan's Medical Management Department. **You pay** a $100 annual per member deductible plus 50% coinsurance under the High and Standard Options. Copayments for durable medical equipment, prosthetic and orthopedic devices are not subject to the out-of-pocket maximum.

Diagnosis and treatment of infertility is covered; **you pay** a copayment equal to 50% of the cost of treatment under the High and Standard Options. The following types of artificial insemination are covered: intravaginal insemination (IVI), intracervical insemination (ICI), and intrauterine insemination (IUI); **you pay** a copayment equal to 50% of the cost of treatment under the High and Standard Options; cost of donor sperm is not covered. Other assisted reproductive technology (ART) procedures that enable a woman with otherwise untreatable infertility to become pregnant through other artificial conception procedures such as in vitro fertilization, i.e., Gamete Intra-Fallopian Transfer (GIFT) and Zygote Intra-Fallopian Transfer (ZIFT) and embryo transfer, are not covered. Copayments for infertility treatment are not subject to the out-of-pocket maximum. Fertility drugs are not covered.

Chiropractic services are provided for up to 20 visits per condition per calendar year if significant improvement can be expected within 20 visits. Under the High and Standard Options, **you pay** an $8 copayment for the first five visits, a $14 copayment for the 6th to 20th visit, and a $20 copayment thereafter. (The $20 copayment shall be applicable if the member has had two or more conditions during the calendar year and has already received a combined total of 20 chiropractic visits during the calendar year.)

Medical and Surgical Benefits *continued*

What is not covered

- Physical examinations that are not necessary, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel; immunizations for travel
- Devices available without a prescription or for which there is a nonprescription equivalent available
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- Hearing aids
- Homemaker services
- Orthotic devices and specified DME items not covered by the Plan
- Whole blood and concentrated red blood cells
- Long-term rehabilitative therapy
- Transplants not listed as covered benefits
- Biofeedback
- Sleep therapy
- Radial Keratotomy and visual training exercises
- Routine podiatric services
- Acupuncture, naturopathy and hypnotherapy
- Medical food, nutritional substances, tube and enteral feedings, except intravenous hyperalimentation
- Motorized wheelchair

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor.

High Option – You pay nothing.

Standard Option – You pay a $150 copayment per admission.

All medically necessary services are covered, including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care
- Specialized care units, such as intensive care or cardiac care units

Extended care

The Plan provides a comprehensive range of benefits for up to 90 days per calendar year when full-time skilled nursing care is medically necessary and confinement in a skilled nursing facility is medically appropriate in lieu of hospitalization as determined by a Plan doctor and approved by the Plan. **You pay** nothing under the High Option or Standard Option. **All necessary services are covered**, including:

- Bed, board and general nursing care
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor.

Hospital/Extended Care Benefits *continued*

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when your primary care doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 17 for non-medical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Whole blood and concentrated red blood cells
- Custodial care, rest cures, domiciliary or convalescent care

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Emergency Benefits

What is a medical emergency?

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

The Plan offers a nurse triage telephone service. The nurse triage service can be reached, toll-free, at 1-800-667-2571. This service can help you by: 1) offering you advice about how to care for minor injuries and illnesses yourself and (2) advising you whether a particular medical problem can best be treated during an early appointment with your doctor or if an emergency room visit is necessary.

Emergencies within the service area

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

If you need to be hospitalized, the Plan Medical Management Department **must** be notified within 24 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. The phone number for the Medical Management Department is 301-941-2023. If you are hospitalized in a non-Plan facility and the Plan doctors believe care can be provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Plan pays...

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

Emergency Benefits *continued*

You pay...

For emergency care services, to the extent such services are covered benefits of this Plan, under the High and Standard Options **you pay** a $30 copayment per visit to a hospital emergency room (waived if the emergency results in an admission to a hospital).

High Option – You pay nothing to visit a specialist, for outpatient surgery, or for each MRI and CAT scan. If the emergency results in admission to a hospital, **you pay** nothing.

Standard Option – You pay a $10 copayment per visit to a primary care doctor's office or urgent care center; **you pay** a $20 copayment per visit to a specialist or for each MRI or CAT scan; a $50 copayment per visit for outpatient surgery. If the emergency results in admission to a hospital, **you pay** the hospital inpatient copayment of $150 per admission.

Copayments apply even if the Plan doctor has authorized the emergency service.

Emergencies outside the service area

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

If you need to be hospitalized, the Plan Medical Management Department must be notified within 24 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. The toll-free phone number for the Medical Management Department is 1-800-333-4947. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan and/or provided by Plan providers.

Plan pays...

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay...

For emergency care services to the extent such services are covered benefits of this Plan, under High and Standard Options you pay a $30 copayment per visit to a hospital emergency room (waived if the emergency results in an admission to a hospital).

High Option – You pay nothing to visit a specialist, for outpatient surgery, or for each MRI and CAT scan. If the emergency results in admission to a hospital, **you pay** nothing.

Standard Option – You pay a $10 copayment per visit to a non-Plan primary care doctor's office or urgent care center; **you pay** a $20 copayment to a specialist or for each MRI or CAT scan; **you pay** a $50 copayment per visit for outpatient surgery. If the emergency results in admission to a hospital, **you pay** the hospital inpatient copayment of $150 per admission.

What is covered

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service if approved by the Plan

What is not covered

- Elective care or non-emergency care
- Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area
- Cost of evacuation from any foreign country

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card.

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on pages 22-23.

Mental Conditions/Substance Abuse Benefits

Mental Conditions

What is covered

To the extent shown below, the Plan provides the following medically necessary services for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing that is medically necessary to determine the appropriate treatment of a short-term psychiatric condition
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

You must contact your primary care physician for a referral before seeing a mental health provider. If you select a primary care physician affiliated with the downtown Ambulatory Care Center located at 2150 Pennsylvania Avenue, NW, Washington, DC, you will be referred to mental health providers who are also affiliated with that center.

Outpatient care

Under the High and Standard Option plans **you pay** a $20 copayment per individual visit and a $10 copayment per group visit for the treatment of Mental Conditions; **you pay** a $10 copayment per outpatient visit for the treatment of Substance Abuse.

Inpatient care

Under the High Option plan **you pay** nothing. Under the Standard Option plan, **you pay** a $150 copayment per admission.

What is not covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment

Substance Abuse

What is covered

This Plan provides medically necessary medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition. Services for the psychiatric aspects are provided in conjunction with the Mental Conditions benefits shown above. Outpatient visits to Plan mental health providers for follow-up care and counseling are covered, as well as medically necessary inpatient services for diagnosis and treatment.

What is not covered

- Treatment that is not authorized by a Plan doctor.
- Long-term rehabilitative services for the treatment of alcoholism or drug abuse, including prolonged rehabilitation services in a specialized inpatient or residential facility.

Prescription Drug Benefits

What is covered

Local retail pharmacy – prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed in "prescription units." One prescription unit is defined as a 30-day supply. Maintenance drugs and birth control pills may be dispensed for up to a 90-day supply. Under High and Standard Options, **you pay** two copayments for up to a 90-day supply of maintenance drugs or birth control pills.

Mail-order prescription program – prescription drugs are dispensed up to a 90-day supply. For Mail-order maintenance drugs, under High and Standard Options, **you pay** two copayments. For further information, contact Member Services at 301-941-2021.

Out-of-the-Area – Prescription drugs should be obtained at participating pharmacies. If outside of the service area, members should obtain prescriptions from the Plan's national network of participating pharmacies, when possible. For information or reimbursement for prescription drugs, call 301-941-2021. The member is responsible for the difference in cost between drugs obtained from a Plan participating pharmacy and those obtained from a non-participating pharmacy.

Under the Standard Option plan, Prescription drug benefit is available after first meeting a $50 deductible per member per calendar year.

Under the High and Standard Option plans, for each prescription unit or refill **you pay** a $5 copayment for generic drugs; **you pay** a $15 copayment for formulary preferred brand drugs; **you pay** a $25 copayment for non-formulary/non-preferred brand drugs. However, in no event will the copayment exceed the cost of the prescription drug.

Drug Formulary

Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. Non-formulary/non-preferred brand drugs will be covered when prescribed by a Plan doctor.

A formulary drug is a medication that has been approved by the Plan for inclusion under the prescription drug benefit. When a generic drug exists, the prescription will be filled with the generic equivalent, unless a Plan physician specifies a formulary preferred brand name drug. If no generic equivalent exists, the prescription will be filled using a formulary preferred brand drug.

The formulary is subject to change based on findings of the Plan's Pharmacy and Therapeutics (P&T) Committee. The P&T Committee, comprised of participating Plan physicians and pharmacists, meets quarterly to review the clinical, quality and economic attributes of medications. Providers and members may inquire whether a drug is included in the formulary by requesting a list from the Plan Medical Director's Office, or they can direct formulary questions to the Plan Pharmacy Director's Office.

Covered medications and accessories include:

- Drugs for which a prescription is required by Federal law
- Contraceptive drugs and devices
- Insulin
- Chemotherapy
- Disposable needles and syringes needed to inject covered prescribed medication

Limited Benefits

- Diabetic supplies, including glucometer supplies, for insulin-dependent diabetics and other medically qualified members, when purchased in accordance with Plan conditions and limitations.
- Growth hormones when medically appropriate and necessary if authorized pursuant to a treatment plan by a Plan Medical Management nurse.
- Sexual dysfunction drugs have dispensing limitations. Contact the plan for details.

What is not covered

- Drugs available without a prescription or for which there is a non-prescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Smoking cessation drugs and medication, including nicotine patches
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Drugs for infertility

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Other Benefits

Dental Care

What is covered

This Plan provides the following program of dental coverage through participating Plan dentists. The emphasis is on prevention, with most preventive and diagnostic dental services covered with no copayment under the High Option and a minimal copayment under the Standard Option. The list below is a partial list of procedures and copayments under each category of dental service covered by the Plan. A complete list is available by calling 301-986-5600. All care must be provided by or through your primary care dentist. All family members must select the same primary care dentist.

Accidental injury benefit

Restorative services and supplies necessary to promptly repair sound natural teeth are covered. The need for these services must result from an accidental injury. Replacement of teeth lost as a result of injury is not covered. **You pay** nothing under High Option; **you pay** office visit, emergency and hospital copayments under the Standard Option.

The following dental services are covered when provided by participating Plan dentists.

High Option Copayments†	
Diagnostic services:	
Initial and periodic oral exams	Nothing
All X-rays	Nothing
Preventive services:	
Prophylaxis (cleaning of teeth) every six months	Nothing
Prophylaxis, each additional within six months	$49
Topical fluoride treatment	Nothing
Oral hygiene instruction	Nothing
Restorative services:	
All fillings (silver, composite)	$17-40
Inlay/Onlay, metallic	$110-190
Crown & bridge services:	
Crowns (porcelain to full cast)	$290-315
Recement crown or inlay	$10
Endodontic services:	
Root canal treatment	$220-350
Pulpal therapy	$10-30
Oral surgery services:	
Removal of tooth, simple	$39
Removal of tooth, surgical	$40-135
Surgical treatment for minor pathological problems	Up to $125
Periodontal services:	
Curettage and root planing, per quadrant	$95
Periodontal surgery, per quadrant	$270-455
Occlusal (bite) adjustments	$35-105
Prosthetic services:	
Dentures-complete upper or lower	$375
Partial dentures	$285-420
Denture adjustments	$10
Denture relining	$45-65
Orthodontic services:	
Standard fully banded case	
- Child under 19 years	$1,700
- Adult	$2,450

Standard Option

There is a copayment of $15 per member per visit for any combination of diagnostic services, cleaning and fluoride treatments twice a year. Additional visits for prophylaxis are provided at a member copayment of $58 per visit ($63 at a specialist). The copayments for X-rays at a specialist range from $5-45. See page 21.

† There will be a $5 copayment for each dental office visit in addition to the copayment schedule above.

- There will be a $25 charge for broken appointments unless 24-hour notice is given, and a surcharge of $25 for emergency after-hours visits.
- Out-of-area coverage is limited to the emergency relief of pain, swelling or other urgent conditions not related to accidental injury, and is subject to a maximum reimbursement of $50.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Dental Care *continued*

What is not covered

The following is a summary list of services which are not covered under Dental Benefits:

- Cosmetic procedures
- Services and procedures not performed in a dentist's office (except for covered accidental injury and out-of-area emergency care)
- Dental procedures involving congenital malformations
- Replacement of denture or bridgework previously supplied
- Dental implants
- Other dental services not shown as covered

Vision Care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refractions (which include the written lens prescription for eyeglasses) may be obtained from Plan providers. **You pay** nothing under High Option; **you pay** a $20 copayment per visit under Standard Option.

What is not covered

- Eyeglasses, contact lenses including special contact lenses used in the treatment of certain eye diseases, and their fitting
- Eye exercises
- Eye refractions for contact lenses
- Radial keratotomy
- Visual training exercises

Discounted eyeglasses and contact lenses are available under the non-FEHB Benefits. Please refer to page 21.

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB, but are made available to all enrollees and family members who are members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium; any charges for these services do not count toward any FEHB deductibles, out-of-pocket maximum copayment charges, etc. These benefits are not subject to the FEHB disputed claims procedure.

Vision discounts

Plan members may obtain discounts on the purchase of eyeglasses, contact lenses, and certain other non-covered services. A list of participating optometrists and opticians is located in the Directory of Participating Providers.

Discounted membership at fitness centers

Plan members may obtain discounted membership to a variety of health and fitness clubs located throughout the metropolitan area. There is no additional premium to the Plan, but members must pay the discounted fitness center membership fee.

Health information

The Plan is pleased to offer FEHB members the following services:

- **Member Newsletter –** A quarterly publication designed to keep members informed about health issues and Plan news.
- **Health education –** Seminars, workshops, and classes including asthma and diabetes management, nutrition and weight control are available to members.

Discounts at GWU Center for Integrative Medicine

The GW Health Plan gives you access to services at the new GW University Center for Integrative Medicine (CIM). The CIM is staffed by highly trained practitioners who offer programs in alternative and complementary medicine including acupuncture, body work, guided imagery, massage therapy and more. *These services are not covered under your contract, but if you wish to pay for them yourself, you will receive a 20 percent discount on full charges at the CIM.*

Dental benefits for Standard Option members

A full range of dental services are available for Standard Option members including restorative, crowns and bridges, oral surgery, periodontal, prosthetic and orthodontic services.

The following dental services are covered when provided by participating Plan dentists. This copayment schedule is for services performed by a general dentist only. Services provided by a dental specialist will be slightly higher.

Standard Option Copayments†

These services are covered as a non-FEHB benefit

Diagnostic services:
- Initial and periodic oral exams $15*
- All X-rays $5-45*

Preventive services:
- Prophylaxis (cleaning of teeth) every six months ... $15*
- Prophylaxis, each additional within six months ... $58-63
- Topical fluoride treatment $15*
- Oral hygiene instruction $15*

Restorative services:
- All fillings (silver, composite) $34-80
- Inlay/Onlay, metallic $210-350

Crown & bridge services:
- Crowns (porcelain to full cast) $350-420
- Recement crown or inlay $20

Endodontic services:
- Root canal treatment $265-490
- Pulpal therapy $10-50

Oral services:
- Removal of tooth, simple $47
- Removal of tooth, surgical $175
- Surgical treatment for minor pathological problems ..... Up to $175

Periodontal services:
- Curettage and root planing, per quadrant $110-115
- Periodontal surgery, per quadrant $200-594
- Occlusal (bite) adjustments $25-125

Prosthetic services:
- Dentures – complete upper or lower $475
- Partial dentures $350-505
- Denture adjustments $20
- Denture relining $40-130

Orthodontic services:
- Standard fully banded case
  - Child under 19 years $2,000
  - Adult $2,450

† There will be a $5 copayment for each dental office visit in addition to the copayment schedule above.

* There is only one $15 copayment per member per visit for any combination of these services.

- There will be a $25 charge for broken appointments unless 24-hour notice is given, and a surcharge of $25 for emergency after-hours visits.
- Out-of-area coverage is limited to the emergency relief of pain, swelling and other urgent conditions not related to accidental injury, and is subject to a maximum reimbursement of $50.

Benefits on this page are not part of the FEHB contract

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Member Services Department at 301-941-2021 or you may write to the Plan at 4550 Montgomery Avenue, Suite 800, Bethesda, MD 20814. You may also contact the Plan by fax at 301-941-2093.

Disputed claims review

Plan reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing and within six months of the date of the denial, to reconsider its denial before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided.

Within 30 days after receipt of your request for reconsideration, the Plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If the Plan asks a provider for information it will send you a copy of this request at the same time. The Plan has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Plan will base its decision on the information it has on hand.

OPM review

If the Plan affirms its denial, you have the right to request a review by OPM to determine whether the Plan's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review should state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (if the Plan failed to respond, provide instead (a) the date of your request to the Plan, or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim (such as doctors' letters, operative reports, bills, medical records, explanation of benefit (EOB) forms, etc.); and
- Your daytime phone number.

Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, P.O. Box 436, Washington, D.C. 20044.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the

lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement – If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Plan to determine if the Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan in support of OPM's decision on the disputed claim.

How this Plan Changes January 1999

Do not rely on this page; it is not an official statement of benefits.

Program-wide changes

- Several changes have been made to comply with the President's mandate to implement the recommendations of the Patient Bill of Rights.
- Women may see their Plan gynecologist for their annual routine examination without a referral from their primary care doctor. Members may refer themselves to a participating Plan specialist. It is the member's responsibility to ensure that a physician participates in the Plan. (See page 12.)
- If you have a chronic, complex, or serious medical condition that causes you to frequently see a Plan specialist, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct access visits with that specialist, without the need to obtain further referrals. (See page 8 for details.)
- A medical emergency is defined as the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. (See page 15.)
- The medical management of mental conditions will be covered under this Plan's Medical and Surgical Benefits provision. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits.

Changes to this Plan

- **Under the High and Standard Options**, the prescription drug copayments increased from $3 to $5 for generic; the copayment increased from $9 to $15 for formulary preferred brand; the copayment increased from $15 to $25 for non-formulary/non-preferred brand. See page 18.
- **Under the High and Standard Options**, a prescription drug unit has decreased from a 34-day supply to a 30-day supply. See page 18.
- **Under the High and Standard Options** for prescription drugs, members may purchase up to a 90-day supply of maintenance drugs instead of a 68-day supply from a local retail pharmacy and through the Mail-Order Prescription program for two copayments. See page 18.
- **Under the High and Standard Options** for prescription drugs, members are no longer required to pay 50% of prescription drug charges above $3,000. See page 18.
- **Under the High and Standard Options,** coverage for durable medical equipment has been amended to clarify that the Plan will cover non-motorized wheelchairs. See page 13.
- **Under the High and Standard Options**, referrals are no longer required for gynecological and obstetrical care. See page 12.
- **Under the High and Standard Options**, referrals are no longer required to obtain an annual routine eye examination. See page 12.
- **Under the High Option**, the out-of-pocket maximum has been reduced from $1,000 to $650 per Self Only enrollment and from $2,500 to $1,500 per Self and Family enrollment per calendar year. See page 9.
- **Under the High Option**, the $50 deductible for prescription drugs has been eliminated. See page 18.
- **Under the High Option**, the $10 copayments for specialty care visits, allergy testing, for each MRI or CAT scan, and for urgent care visits have been eliminated. See page 12.
- **Under the High Option**, the $25 copayment for outpatient surgery has been eliminated. See page 12.
- **Under the High Option**, the $50 copayments for hospitalization and Mental inpatient services have been eliminated. See pages 14 and 17.
- Coverage for drugs for sexual dysfunctions is shown under *Prescription Drug Benefits*. See page 18.

Changes to this Plan *continued*

- Blood products and derivatives, except for whole blood and concentrated red blood cells, are now covered. See page 13.
- Home health services will be provided, when medically necessary, by nurses, but not health aides. See page 13.
- Prescription drug coverage language has been expanded to describe the Plan policy that prescriptions must be filled with generic equivalent drugs unless the Plan physician specifically orders a formulary preferred brand drug. Non-formulary/non-preferred brand drugs will be covered when prescribed by a Plan physician. See page 18.
- Language has been added to the prescription drug section that explains that the member is responsible for paying the difference in cost between drugs obtained from a participating Plan pharmacy and those obtained from a non-Plan pharmacy. See page 18.
- Diabetic supplies, including glucometer supplies, will be covered for all diabetic and other medically qualified members when they use supplies for glucometers specified by the Plan. These glucometers will be provided by the Plan free of charge to qualifying members upon request. See page 18.
- If you select a primary care physician affiliated with the downtown Ambulatory Care Center located at 2150 Pennsylvania Avenue, NW, Washington, DC, you will be referred to specialty providers who are also affiliated with that center.

Summary of Benefits for
The George Washington University Health Plan High Option — 1999

Do not rely on this chart alone. All covered benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.**

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** nothing	14-15
	Extended Care	All necessary services, up to 90 days per calendar year. **You pay** nothing	14
	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions. **You pay** nothing.	17
	Substance Abuse	Covered under Mental Conditions	17
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury; preventive care, including well-baby care, well-child visits through age 6; periodic checkups and routine immunizations; specialty care visits; MRI or CAT scan; laboratory tests and X-rays; allergy testing; outpatient surgery; complete maternity care. **You pay** nothing.	12-14
	Home Health Care	All necessary visits by nurses. **You pay** nothing	13
	Mental Conditions	**You pay** a $20 copayment per individual visit and a $10 copayment per group visit for Mental Conditions; **you pay** a $10 copayment per outpatient visit for Substance Abuse.	17
	Substance Abuse	Covered under Mental Conditions	17
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $ 30 copayment to the hospital for each emergency room visit and any charges for services that are not covered by this Plan. **You pay** nothing to visit a specialist	15-16
Prescription drugs		Prescription drugs prescribed by a Plan doctor. **You pay** a $5 copayment for generic or a $15 copayment for formulary preferred brand or a $25 copayment for non-formulary/non-preferred brand drugs for each prescription unit or refill	18
Dental care		Accidental injury benefit, **you pay** nothing. Preventive dental care; comprehensive range of restorative, orthodontic, and other services. **You pay** copays for most services and a $5 copayment for dental office visits.	19-20
Vision care		Refractions (eyeglasses only). **You pay** nothing.	20
Out-of-pocket maximum		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $650 per Self only or $1,500 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copayment maximum does not include copayments for prescription drugs, DME devices, infertility services or dental benefits.	9

Summary of Benefits for The George Washington University Health Plan Standard Option — 1999

Do not rely on this chart alone. All covered benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.**

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** a $150 copayment per admission	14-15
	Extended Care	All necessary services, up to 90 days per calendar year. **You pay** nothing.	14
	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions. **You pay** a $150 copayment per admission	17
	Substance Abuse	Covered under Mental Conditions	17
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury; preventive care, including well-baby care; periodic checkups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** nothing for prenatal office visits and well-child visits through age 6; **you pay** a $10 copayment for primary care and allergy treatment visits; **you pay** a $20 copayment for specialty care visits, allergy testing and for each MRI or CAT scan. **You pay** a $50 copayment per visit for outpatient surgery	12-14
	Home Health Care	All necessary visits by nurses. **You pay** a $20 copayment per visit	13
	Mental Conditions	**You pay** a $20 copayment per individual visit and a $10 copayment per group visit for Mental Conditions; **you pay** a $10 copayment per outpatient visit for Substance Abuse	17
	Substance Abuse	Covered under Mental Conditions.	17
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $30 copayment to the hospital for each emergency room visit and any charges for services that are not covered by this Plan. **You pay** a $10 copayment to a primary care doctor or urgent care center for each visit; **you pay** a $20 copayment per visit to a specialist	15-16
Prescription drugs		Prescription drugs prescribed by a Plan doctor. After first meeting a $50 per member per calendar year deductible, **you pay** a $5 copayment for generic or a $15 copayment for formulary preferred brand or a $25 copayment for non-formulary/non-preferred brand drugs for each prescription unit or refill.	18
Dental care		Accidental injury benefit; **you pay** office, emergency and hospital copays. Diagnostic and preventive services limited to twice per year; **you pay** a $20 copay per visit	21
Vision care		Refractions (eyeglasses only). **You pay** a $20 copayment per visit	20
Out-of-pocket maximum		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $1,000 per Self only or $2,500 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copayment maximum does not include copayments for prescription drugs, DME devices, infertility services or dental benefits	9

1999 Rate Information for
The George Washington University Health Plan

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

Postal rates apply to most career U.S. Postal Service employees, but do not apply to non-career Postal employees. Postal retirees, certain special Postal employment categories or associate members of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHB Guide for that category.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option							
Self Only	E51	$72.06	$34.04	$156.13	$73.75	$84.98	$21.12
Self and Family	E52	$160.39	$71.69	$347.51	$155.33	$183.29	$48.79
Standard Option							
Self Only	E54	$58.52	$19.51	$126.80	$42.27	$69.25	$8.78
Self and Family	E55	$127.46	$42.48	$276.15	$92.05	$150.82	$19.12