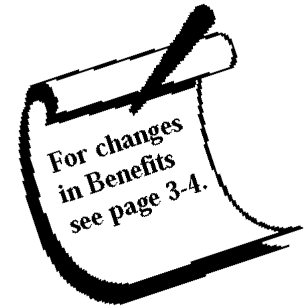
The George Washington University Health Plan 2000

A Health Maintenance Organization



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

Enrollment in this Plan is limited; see page 5 for requirements.

High Option

Enrollment code:
- **E51 Self Only**
- **E52 Self and Family**

Special Notice: The George Washington University Health Plan Standard Option is no longer offered. If you were enrolled in the Standard Option (Enrollment code E54 or E55) in 1999 and do not enroll in another carrier's plan during Open Season, your enrollment will be automatically changed to The George Washington University Health Plan High Option.

Visit the OPM website at http://www.opm.gov/insure
and
our website at http://www.gwhealthplan.com

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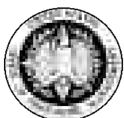

United States Office of
Personnel Management
Retirement and Insurance Service

Federal Employees
Health Benefits Program

RI 73-046

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Introduction

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

This brochure describes the benefits you can receive from The George Washington University Health Plan under its contract (CS1764) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on pages 3-4. Premiums are listed at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to The George Washington University Health Plan, Inc., as "this Plan" or "the Plan" or "we" or "us" or "our" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier. The use of the term "our" in reference to a provider or facility (i.e., doctor or hospital) refers to persons, facilities and other entities with whom this Plan has contracted for services.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not re-written the Benefits section of this brochure. You will find new benefits language next year.

How to Use This Brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. **Health Maintenance Organizations (HMO)**. This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.

2. **How we change for 2000.** If you are a current member and want to see how we have changed, read this section.

3. **How to get benefits.** Make sure you read this section; it tells you how to get services and how we operate.

4. **What to do if we deny your claim or request for service.** This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.

5. **Benefits.** Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.

6. **General exclusions.** Things we don't cover. Look here to see benefits that we will not provide.

7. **Limitations.** Rules that affect your benefits. This section describes limits that can affect your benefits.

8. **FEHB FACTS.** Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organizations

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventive care such as routine office visits, physical exams, well-baby care and immunizations, as well as treatment for illness and injury.

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay copayments and coinsurance amounts listed in this brochure. When you receive emergency services you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us. Our providers follow generally accepted medical practice when prescribing any course of treatment.

The George Washington University Health Plan, Inc., is a not-for-profit organization owned by The George Washington University. The Plan was organized under the District of Columbia Non-Profit Corporation Act on May 16, 1972.

The Plan is licensed in three (3) jurisdictions: the District of Columbia, the State of Maryland and the Commonwealth of Virginia. The Plan renewed its health maintenance organization ("HMO") licenses in Virginia on July 1, 1998; in Maryland on December 1, 1998; and in the District of Columbia on April 15, 1999. The Plan has been federally qualified since 1979 under the Federal HMO Act of 1973.

Section 2. How We Change For 2000

Program-wide changes

To keep your premium as low as possible OPM has set a minimum copay of $10 for all primary care office visits.

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program. (See Section 3, *How To Get Benefits*, for more information.)

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If your health care provider does not give you your records, call us and we will assist you.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Section 2. How We Change For 2000 *continued*

Changes to this Plan

Your share of the non-postal High Option premium will decrease by 28.4% for Self Only or 12.2% for Self and Family. See Back Cover.

The Standard Option will not be offered. Only one option, the High Option, will be available. If you were enrolled in the Standard Option in 1999 and do not make an Open Season change, your enrollment will be automatically changed to the High Option.

How the Plan changes from the former "High and Standard Options"

- The emergency room copayment increased from $30 to $50 per visit. See page 18.
- The 90-day limit for cardiac rehabilitation has been removed. See page 15.
- If a member does not select a primary care physician, one will be chosen for him/her. See page 6.
- You must contact the appropriate Plan Mental Health Administrator to obtain precertification for mental health/substance abuse treatment services. See pages 9 and 20.
- A $5 sterilization fee for each dental office visit applies. See page 24.

How the Plan changes from the former "High Option" Plan

- The copay increases from nothing to $10 for a primary care office visit and urgent care center visits. See page 13.
- The copay increases from nothing to $10 for specialty care office visits including vision care, allergy testing, home health visits, and for each MRI or CT scan. See page 13.
- A Prescription Drug deductible is being added. Each member must pay the first $35 of prescription expense (i.e., deductible) per calendar year. See page 21.

How the Plan changes from the former "Standard Option" Plan

- The copayment decreased from $20 to $10 for specialty care office visits including vision care, allergy testing and for each MRI or CT scan. See page 13.
- The copayments are being reduced from $150 to nothing for each hospital admission and for inpatient care for mental conditions. See page 16.
- The copayment is being reduced from $50 to nothing for each outpatient surgery. See page 13.
- The copayment is being reduced from $20 to $10 for each home health visit. See page 13.
- The calendar year deductible is being reduced from $50 to $35 under the Prescription Drug Benefits. See page 21.
- The maximum out-of-pocket expense has been reduced from $1,000 to $650 per calendar year for Self Only enrollment and from $2,500 to $1,500 per calendar year for Self and Family enrollment. See page 5.

Section 3. How To Get Benefits

What is this Plan's service area?

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

The **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 George's, St. Mary's and Washington.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care. We will not pay for any other health care services.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

How much do I pay for services?

You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services.

NOTE: Be sure to give adequate notice if you are unable to keep an appointment. Plan doctors may charge you $25 if you fail to keep your appointment or cancel with less than 24 hours' notice.

After you pay $650 in copayments or coinsurance for one family member, or $1,500 for two or more family members, you do not have to make any further payments for certain services for the rest of the year. This is called your out-of-pocket maximum. However, copayments or coinsurance for your prescription drugs, dental services, infertility treatment, durable medical equipment, and orthopedic and prosthetic devices do not count toward this maximum and you must continue to make these payments.

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

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Section 3. How To Get Benefits *continued*

Who provides my health care?

Your health care is provided by physicians and other participating providers in the service area who are part of this Plan's independent network. All of the physicians who participate in the network have been carefully screened and credentialed following strict standards.

You and each of your family members must select a *primary care* physician. Primary care includes Family Practice, Internal Medicine and Pediatrics physicians. Each family member can choose a different physician. Your primary care physician is responsible for managing all of your medical care. Your physician refers you for specialty care and special services when necessary and makes arrangements if you need to be hospitalized.

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

If you would like more information about this Plan's doctors, call the Member Services Department at 301-941-2021.

How do I choose a primary care physician?

The Plan's *Directory of Participating Providers* lists primary care physicians (Family Practice, Internal Medicine and Pediatric physicians), their locations, phone numbers, languages spoken and whether or not the doctor is accepting new patients. (Generally, if you are switching plans but keeping the same primary care physician, you are not considered a "new patient.")

Directories are available upon request by calling Member Services at 301-941-2021. They are updated periodically; new physicians are always joining the Plan and occasionally others leave. We cannot guarantee that any doctor, hospital or other provider will remain available. You can call Member Services, or the office of the physician you are interested in to verify whether a particular physician still participates with this Plan.

If you decide to enroll in this Plan, you must choose a primary care physician for you and each member of your family. You can make your selection by filling out and mailing the Physician/Dentist Selection Form in your enrollment packet, or by calling Member Services. *Please note: If you do not choose a primary care physician, we will choose one for you.*

What if I want to change my primary care physician?

You can either call Member Services at (301) 941-2021 or write to us at this address:

Attention: Member Services
The GW Health Plan
4550 Montgomery Avenue, Suite 800
Bethesda, MD 20814

If we receive your request by the 15th of the month, the change will become effective by the first of the following month. If we receive your request after the 15th, the change will become effective the first of the month *after* the next month. For example: If we receive your request on August 10, 2000, the change will become effective on September 1, 2000; if we receive your request on August 16, 2000, the change will become effective on October 1, 2000. We may make an exception to this policy under special circumstances.

You must continue to use your current primary care physician until the change has become effective. If you receive medical care from the new doctor prior to the effective date of the change, the cost of that care will be your responsibility.

How do I start a medical record or transfer one?

On your first visit to your primary care physician, a medical record will be established for you. If you are a new patient, you will need to provide your medical history. It is best to transfer your medical record from your former physician to your new physician's office before your first visit.

To transfer your medical record, you can fill out a *Medical Record Release Form* and send it to your former physician's office or just call the former physician's office and ask them to send the record to your new physician. The physician is allowed to charge a fee for photocopying your record.

Can I review my medical record?

You have the right to review your medical record or get a copy at any time. You also have the right to request that a physician amend (i.e., change, delete from or add to) your medical record if it is not accurate, relevant, or complete. If the physician does not agree to amend the record, you may add a brief statement to the record. Whenever your medical record is shown or transferred, your statement must be included. If you have difficulty obtaining medical records from a provider, call Member Services at 301-941-2021 for assistance.

What do I do if my primary care physician leaves the Plan?

Call us. We will help you select a new one.

What do I do if I need to go into the hospital?

Talk to your Plan physician. If you need to be hospitalized, your primary care physician or specialist will make the necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing facility or other alternative care center.

Section 3. How To Get Benefits *continued*

What do I do if I'm in the hospital when I join this Plan?

First, call us immediately or have someone call for you. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching to us, your former plan will pay for the hospital stay until:

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

These provisions only apply to the person who is hospitalized.

How do I get specialty care?

Your primary care physician will arrange your referral to a specialist. You must always be referred by your primary care physician before consulting a specialist or getting any specialized services, EXCEPT in the following cases:

- In an emergency
- For gynecological or obstetrical care (including annual checkups)
- For your annual routine eye examination
- When your primary care doctor has assigned another doctor (the doctor "on call") to take care of patients because he/she is not available
- When you have already received a referral authorizing long-term treatment.

When your primary care physician refers you, you must take the referral form with you to your specialist appointment. Your physician will write specific instructions on the form about what services you can receive and how many times you may visit the specialist. If the specialist suggests additional services or visits are needed, you must first check with your primary care physician to obtain another referral.

If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician with your specialist and our Medical Management Department, will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Examples of chronic, complex or serious medical conditions would be kidney failure, cancer or diabetes.

What do I do if I am seeing a specialist when I enroll?

First visit or call the primary care physician you selected under this Plan. Your primary care physician will decide whether you need to continue seeing a specialist. Even if you selected the same primary care physician you had before you enrolled in this Plan, you must be referred by the primary care physician to continue specialty care under this Plan.

If the specialist you are already using does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

What do I do if my specialist leaves the Plan?

Call your primary care physician, who will arrange for you to see another specialist. You may receive approval to obtain services from your current specialist until we can make arrangements for another specialist to treat you.

Section 3. How To Get Benefits *continued*

But, what if I have a serious illness and my provider leaves the Plan or this Plan leaves the FEHB Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your current provider if this Plan should drop out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester of pregnancy. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester of pregnancy, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

How do you authorize medical services?

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

This review and approval process is also called *precertification.* Your physician must obtain precertification for the following services:

- Any inpatient hospital admission
- Any inpatient or outpatient surgical procedure
- Physical, occupational, speech or cardiac therapy
- Inpatient skilled nursing care in a facility
- MRIs or CT scans
- Infertility treatment or procedures
- Durable medical equipment and supplies (purchase and rental)
- Home health services
- Hospice care

EXCEPTION: A Mental Health Administrator must precertify all mental health/substance abuse treatment services. You must call the Mental Health Administrator at 1-888-571-0213 <u>before</u> you contact a mental health or substance abuse treatment provider.

Section 3. How To Get Benefits *continued*

How do you decide if a service is experimental or investigational?

The Plan's Medical Director determines what products, procedures, services and supplies are *experimental* or *investigational* in accordance with generally accepted medical practice. *Experimental* and *investigational* products, procedures, services and supplies include those which are: 1) in a testing stage or in field trials on animals or human beings; 2) have not received the required final federal regulatory approval for commercial distribution for the specific purposes and methods of use; 3) with respect to prescription drugs, have not been approved by the U.S. Food and Drug Administration as safe and effective treatment for the member's particular illness or condition except as described below; 4) are not in accordance with generally accepted standards of medical practice; or, 5) have not yet been shown to be consistently effective in diagnosing or treating the member's condition.

A committee, made up of community physicians, Plan staff and experts in the field, will review published literature, and other presentations, to make an informed decision regarding the effectiveness of the service. It is considered *investigational* if it is not yet being used in a clinical trial. It is considered *experimental* if it has moved from investigational to the *clinical trial* state where numbers of humans have been identified and agreed to participate in the *experimental* use of the service or treatment.

Section 4. What To Do If We Deny Your Claim Or Request For Service

If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

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

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

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

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

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious or life threatening condition and you haven't responded to my request for service?

Call us at (301) 941-2021 and we will expedite our review.

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment, too. Alternatively, you can call OPM's health benefits Contract Division 3 at (202) 606-0755 between 8 a.m. and 5 p.m., Monday through Friday.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

1. We did not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.
2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

Section 4. What To Do If We Deny Your Claim Or Request For Service *continued*

What do I send to OPM?

You must send the following information:

1. A statement about why you believe our decision is wrong, based on specific benefit provisions in this brochure;
2. Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
3. Copies of all letters you sent us about the claim;
4. Copies of all letters we sent you about the claim; and
5. Your daytime phone number and the best time to call.

If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and,
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

Where should I mail my disputed claim?

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contract Division III, P. O. Box 436, Washington, DC 20044.

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our decision, your only recourse is to sue.

If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services or supplies.

What laws apply if I file a lawsuit?

Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Medical and Surgical Benefits

What is covered

The Plan covers a comprehensive range of preventive, diagnostic and treatment services when provided by Plan doctors and other Plan providers. This includes all necessary office visits. **You pay** a $10 copayment for office visits to your primary care physician. **You pay** a $10 copayment for office visits to a specialist, for home health visits, allergy testing and for each MRI or CT scan you receive. **You pay** nothing for laboratory tests, X-rays, prenatal care visits, well-child visits through age 6 or for outpatient surgery performed at a hospital or ambulatory care center.

The following services are included:

- Preventive care, including well-baby care and periodic check-ups
- Routine immunizations and boosters
- Diagnostic procedures, such as laboratory tests and X-rays
- Consultations by specialists if referred by your Plan primary care physician
- Allergy testing and treatment, including test and treatment materials (such as allergy serum)
- Self-referral to Plan doctors for gynecological care. **You pay** a $10 office visit copayment for your annual gynecological (well-woman) examination and a $10 office visit copayment 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 Plan doctor or other qualified provider. **You pay** nothing for prenatal or postnatal care visits after the first visit.
- Self-referral to Plan doctors for annual routine eye examination. **You pay** a $10 office visit copayment.
- 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 physician as medically necessary to diagnose your illness.
- 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 cesarean 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 confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only when the infant is covered under a Self and Family enrollment.

What is covered
continued

- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- 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
- Podiatry services related to underlying medical conditions (e.g., diabetic foot problems)
- Surgical treatment of morbid obesity
- Blood products and blood derivatives
- Home health services including: nurses, intravenous fluids and medications, when prescribed by a Plan doctor. The doctor will periodically review the need for continued services.
- Medically necessary medical or surgical care in a hospital or extended care facility provided by Plan doctors and other contracted providers.

Limited benefits

Oral and maxillofacial surgery is provided for non-dental related 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 temperomandibular joint (TMJ) pain dysfunction syndrome, except as covered under Dental Benefits. (See pages 23-25.)

Reconstructive surgery will be provided to correct a condition resulting from a functional defect, from an injury or surgery that has produced a major effect on the member's appearance and only if the condition can reasonably be expected to be corrected by such surgery. A patient and her attending physician may decide whether she should have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.

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. 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 session per day. **You pay** a $10 copayment per outpatient session.

Section 5. Benefits *continued*

Limited benefits
continued

Cardiac rehabilitation following a heart transplant, bypass surgery, myocardial infarction. **You pay** a $10 copayment per outpatient session.

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 and oxygen for home use; 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 when 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. The purchase or rental of DME must be precertified through the Plan's Medical Management Department. **You pay** the first $100 expense per member per year plus 50% of the remaining expense. Your expenses for durable medical equipment, orthopedic devices and prosthetic devices do not count toward your out-of-pocket maximum.

Breast prostheses and surgical bras and their replacements are covered, subject to applicable DME deductible and copayments.

Diagnosis and certain treatments of infertility are covered. **You pay** 50% of the cost of treatment. Copayments for infertility do not count toward your out-of-pocket maximum. Cost of donor sperm is not covered. The following types of artificial insemination are covered: intravaginal insemination (IVI), intracervical insemination (ICI), and intrauterine insemination (IUI). Other assisted reproductive technology (ART) procedures are not covered. 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. **You pay** an $8 copayment for the first five visits, a $14 copayment for the 6th through 20th visits, and a $20 copayment for all visits thereafter. (The $20 copayment will be applicable only 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.)

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 for 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 improvements
- Hearing aids
- Wigs and other hair prostheses
- Eyewear, frames, contact lenses and the fitting of contact lenses
- Homemaker services
- Orthotic devices and specified DME items not covered by this Plan

Section 5. Benefits *continued*

What is not covered *continued*

- Whole blood and concentrated red blood cells
- Organ transplants not listed as covered
- Long-term habilitative and rehabilitative therapy
- Biofeedback
- Sleep therapy
- Radial Keratotomy, LASIK surgery, other vision correction surgeries and visual training exercises
- Routine podiatry services
- Acupuncture, naturopathy and hypnotherapy
- Medical food, nutritional substances, tube and enteral feedings, except intravenous hyperalimentation
- Motorized wheelchairs and carts

Hospital Benefits

What is covered

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. **You pay** nothing.

All medically necessary services are covered, including:

- Semiprivate room accommodations; when 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 as determined by a Plan doctor and approved by the Plan. **You pay** nothing.

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 care and care to manage symptoms of a terminally ill member are 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. **You pay** nothing.

Ambulance service

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

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when your primary care physician 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 physician determines that outpatient management is not medically appropriate. See page 21 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

Emergency Benefits

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of medical symptoms or an injury that you believe endangers your life or could result in serious injury or disability, and therefore 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.

This Plan offers a nurse triage telephone service. ("Triage" is the prioritization of medical treatment.) This service can help you by advising you: 1) whether you need to go to the emergency room; 2) whether your doctor can best treat your particular medical problem; or, 3) how to take care of minor injuries and illnesses yourself. The nurse triage service can be reached, toll-free, at 1-800-667-2571.

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 24 hours unless it is not reasonably possible to do so. It is your responsibility to ensure that the Plan is notified promptly.

If you need to be hospitalized due to the emergency, you must notify the Plan's Medical Management Department within 24 hours or on the first business day following your admission, unless it is 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 a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible and any ambulance charges will be 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 could 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.

You pay . . .

For emergency care services, to the extent such services are covered benefits of this Plan, **you pay** a $50 copayment per visit to a hospital emergency room. (This copayment does not apply if the emergency results in admission to the hospital.)

You pay a $10 copayment per visit to a primary care physician's office or urgent care center. **You pay** a $10 copayment to visit a specialist or for each MRI or CT scan. **You pay** nothing for outpatient surgery. If the emergency results in admission to the hospital, **you pay** nothing.

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

Section 5. Benefits *continued*

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's Medical Management Department must be notified within 24 hours, or on the first business day following your admission, unless it is not reasonably possible to notify the Plan within that time. The toll-free 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 and any ambulance charges will be covered in full.

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.

You pay . . .

For emergency care services to the extent such services are covered benefits of this Plan, **you pay** a $50 copayment per visit to a hospital emergency room. (This copayment does not apply if the emergency results in admission to the hospital.)

You pay a $10 copayment per visit to a primary care physician's office or urgent care center. **You pay** a $10 copayment to visit a specialist, or for each MRI or CT scan. **You pay** nothing for outpatient surgery. If an emergency results in admission to the hospital, **you pay** nothing.

What is covered

- Emergency care at a physician's office or an urgent care center
- Emergency care as an outpatient or inpatient, including physicians' services
- Ground ambulance service when 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 medical evacuation from any foreign country or distant areas of the United States. (Members who wish to protect themselves from this expense are advised to purchase travel insurance.)

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 receipt 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 procedure described in Section 4 of this brochure.

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 get *precertification* from the Mental Health Administrator before you contact a mental health provider. (See *How do you authorize medical services?* on page 9.) The Mental Health Administrator will precertify your treatment if it is medically necessary. Call 1-888-571-0213 to request precertification.

Outpatient care

You pay a $20 copayment for each individual therapy session and a $10 copayment for each group therapy session for the treatment of Mental Conditions.

Inpatient care

Inpatient confinements are covered when determined to be medically appropriate and approved by the Mental Health Administrator. **You pay** nothing.

What is not covered

- Care for psychiatric conditions that in the professional judgment of the Mental Health Administrator are not subject to significant improvement through relatively short-term treatment.
- Psychiatric evaluation or therapy ordered by a court or as a condition of parole or probation.
- Psychological testing (e.g., neuro-psychiatric testing) to determine the appropriate treatment of a short-term psychiatric condition.

Substance Abuse

What is covered

This Plan covers 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. Outpatient visits to participating mental health/substance abuse treatment providers for follow-up care and counseling are covered, as well as medically necessary inpatient services for diagnosis and treatment.

Outpatient care

You pay a $10 copayment for each therapy session for the treatment of Substance Abuse.

Inpatient care

Inpatient confinements are covered when determined to be medically appropriate and approved by the Mental Health Administrator. **You pay** nothing.

What is not covered

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

Prescription Drug Benefits

What is covered

Prescription drugs are covered when obtained at Plan pharmacies and prescribed by Plan doctors in accordance with the Plan's *formulary*. A formulary is a list of medications that have been reviewed and approved by the Plan to be included for coverage. Formulary medications are chosen based on their effectiveness in treating certain conditions and on other criteria.

The Plan's Formulary

Formulary drugs are divided into two categories: *Preferred* and *non-preferred* drugs. The *preferred* drugs category includes generic drugs and brand name drugs. Your prescription will always be filled with a generic drug when one is available. *Preferred* drugs should be prescribed whenever they are appropriate in treating your illness or injury.

Non-preferred and *non-formulary* drugs will be covered when prescribed by a Plan doctor. Your doctor is expected to request an exception to prescribe *non-preferred* and *non-formulary* drugs. Such requests must be submitted in writing by your doctor to the Plan's Pharmacy Director prior to giving you a prescription. Upon approval by the Plan, such exceptions are good for the current calendar year or a specified time period, whichever, is less. Medical justification for the drug is required.

The formulary changes periodically based on findings of the Plan's Pharmacy and Therapeutics (P&T) Committee. The P&T Committee, comprised of Plan doctors and pharmacists, meets quarterly to review the clinical, quality and economic attributes of medications. Members may inquire whether a drug is included in the formulary by requesting a list from the Member Services Department.

Section 5. Benefits *continued*

Prescription Units and Costs

Prescription drugs are dispensed in *prescription units* or *refills*. One prescription unit or refill is defined as up to a 30-day supply. Drugs for *maintenance* purposes can be dispensed for up to a 90-day supply. *Maintenance* drugs are those which your physician anticipates will be required for at least six (6) months to treat a chronic condition, such as hypertension or diabetes.

You and each family member pay the first $35 of prescription drug expense per year; then, for each prescription unit or refill, **you pay** the copayment according to the schedule below:

- **You pay** a $5 copayment for a generic drug.
- **You pay** a $15 copayment for a *preferred* brand name drug on the formulary.
- **You pay** a $25 copayment for a *non-preferred* and/or *non-formulary* drug.
- **You pay** two copayments for up to a 90-day supply of maintenance drugs.

In no event will the copayment exceed the cost for the prescription drug.

Mail-order Prescription Program

Prescription drugs for *maintenance* purposes are dispensed in up to a 90-day supply through the Mail-order program. (For further information, contact Member Services.)

- **You pay** two copayments for up to a 90-day supply of maintenance drugs.

Out-of-the Area

If you need to fill a prescription when outside of our service area, you can go to one of our Plan national pharmacies. Call 1-800-237-6184 to find the nearest Plan pharmacy. You'll pay only your usual copayment and/or deductible. If a Plan pharmacy is not accessible while you are out of the service area, you will need to pay for your drugs and save the receipt. You are responsible for the difference in cost between drugs obtained from a Plan pharmacy and those obtained from a non-Plan pharmacy. Be sure to keep all receipts and information describing the drug, the cost, the prescribing physician and the date purchased. Submit all requests for reimbursement within 60 days. For information about how to request reimbursement for your prescription drugs, call Member Services.

Covered medications and accessories include:

- FDAapproved drugs for which a prescription is required by federal or state law
- Contraceptive drugs (oral, injectible and implantable) and devices (IUDs, diaphragms) approved by the FDAfor use as contraceptives
- Insulin
- Chemotherapy drugs
- 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, are covered only when purchased in accordance with Plan conditions and limitations.
- Growth hormones are covered only when medically necessary and appropriate to treat an illness and if authorized as part of a treatment plan provided to and approved by the Plan Medical Management Department.
- Sexual dysfunction drugs and some other 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 when due to an emergency occurring outside of the service area
- 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
- Drugs to induce weight loss (anorexients)

Other Benefits

Dental Care

What is covered

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** a copayment for the services of a dentist and $50 if you are treated in the emergency room.

Preventive and Restorative Dental Plan

This Plan includes comprehensive dental care services when provided by Plan dentists. The emphasis is on prevention, with most preventive and diagnostic dental services covered with no copayment. Copayments and fees are due at the time of service.

You must select a primary care dentist from a list of participating dentists who provide general dental care for you and your family. All care must be provided by or through your primary care dentist. Your primary care dentist will provide referrals to participating dental specialists when necessary. To select a primary care dentist, complete and send the Physician/Dentist Selection Form included in your enrollment packet. All family members must select the same primary care dentist.

Out-of-area coverage is limited to services for the emergency relief of dental pain, swelling or other urgent conditions not related to accidental injury, and is subject to a maximum reimbursement of $50.

Section 5. Benefits *continued*

Dental Service Copayments

The list below is a partial list of the procedures covered under our Dental Plan with applicable copayments. You can obtain a complete list by calling 301-986-5600.

NOTE: Dentists may charge a $5 instrument sterilization fee at each office visit. Copayments and fees are due at the time of service.

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 month....$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
  - Adults....$2,450

- **You pay** a $25 charge for broken and "no-show" appointments if less than 24-hours' notice to cancel is given.
- **You pay** a $25 surcharge for emergency after-hours visits.

What is not covered

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

- Procedures for cosmetic purposes
- Services and procedures not performed in a dentist's office (when needed as a result of injury and occurring outside of the service area)
- Dental procedures involving treatment of congenital malformations
- Replacement of dentures or bridgework previously provided
- Dental implants
- Other dental services not specifically detailed as a covered service

Vision Care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, an annual routine eye examination (refraction) may be obtained from participating providers. **You pay** a $10 copayment per exam.

What is not covered

- Eyewear, frames, contact lenses (including special contact lenses used in the treatment of certain eye diseases), and their fitting
- Eye exercises
- Radial Keratotomy, LASIK surgery, and other vision correction surgeries
- Visual training exercises

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, 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 procedures.

Vision discounts

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

Discounted membership fees at fitness centers

Members are eligible for discounted membership fees for a variety of health and fitness clubs located throughout the metropolitan area. You do not pay any additional premium for this service. You pay the discounted membership fee directly to the fitness center. Call Member Services at 301-941-2021 for a list of participating centers.

Health information

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

- ***GW Vital Signs* Member Newsletter** – A quarterly publication designed to keep members informed about health issues and Plan news.
- ***"Next Generation Babies"* Program** – A free program to help expectant mothers deliver healthy, full-term babies. Each participant who registers by the 16th week of pregnancy receives a welcome package and risk assessment. Women with high risk pregnancies are assigned to a Case Manager who works with her and her doctor. Each woman who completes 10 prenatal visits and a six-week postnatal visit to her obstetrician receives a valuable gift for herself and her baby. To register, call 1-888-366-2229.
- **Disease Education and Health Education Services** – Education by telephone regarding various diseases, referrals to community resources for information and assistance, classes and programs are provided free to members by calling 301-941-2160.
- **Disease Management Services** – Assistance in learning about certain diseases, in how to control the symptoms and in doing so, to improve or maintain quality of life. Examples are programs in Asthma, Diabetes, Congestive Heart Failure, and High Blood Pressure Management.

Discounts at The GWUMC Center for Integrative Medicine

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

Benefits on this page are not part of the FEHB Contract

Section 6. General Exclusions – Things We Don't Cover

The exclusions in this section apply to all benefits. Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness or condition.

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Care by non-Plan providers except for authorized referrals or emergencies (see *Emergency Benefits*);
- Experimental or investigational procedures, treatments, drugs or devices;
- 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;
- Procedures, services, drugs, supplies related to sex transformations;
- Services or supplies you receive from a provider or facility barred from the FEHB Program;
- Expenses you incurred while you were not enrolled in this Plan.

Section 7. Limitations – Rules That Affect Your Benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSAat 1-800-638-6833.

Section 7. Limitations – Rules That Affect Your Benefits *continued*

Other group insurance coverage

When anyone has coverage with us and with another group health plan, it is called *double coverage*. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' (NAIC) Guidelines.

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Circumstances beyond our control

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. We will cover the cost of treatment that exceeds the amount you received in the settlement. If you do not seek damages, you must agree to let us try. This is called *subrogation*. If you need more information, contact us for our subrogation procedures.

TRICARE

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

Workers' compensation

We do not cover services that:

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

Once the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

We do not cover services and supplies that a local, State, or Federal Government agency directly or indirectly pays for.

Section 8. FEHB FACTS

You have a right to information about your HMO.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call 301-941-2021, or write to Attn: Member Services, GW Health Plan, 4550 Montgomery Avenue, Suite 800, Bethesda, MD 20814. You may also contact us by fax at 301-941-2093, or visit our website at **www.gwhealthplan.com.**

Where do I get information about enrolling in the FEHB Program?

Your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans and other materials you need to make an informed decision about:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- The next Open Season for enrollment.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

When are my benefits and premiums effective?

The benefits in this brochure are effective on January 1. If you are new to this plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin January 1.

What happens when I retire?

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

What types of coverage are available for my family and me?

Self-Only coverage is for you alone. *Self and Family* coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth or add a child to your family. You may change your enrollment 31 days before to 60 days after you marry, give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

Your employing or retirement office will not notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in another FEHB plan.

Are my medical and claims records confidential?

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

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

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

When you receive your ID card, look it over carefully. If it contains any incorrect information, call the Member Services Department immediately to request a new one. When you receive the new card, destroy the old one. If your card is lost or stolen, call our Member Services Department to request a replacement.

You should carry your ID card with you at all times. You will need to show it whenever you receive services from a participating provider. You also will need it whenever you get a prescription filled at a participating pharmacy.

Never let anyone else use your identification card.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

We will not refuse to cover the treatment of a condition that you or a family member had before you enrolled in this Plan solely because you had the condition before you enrolled.

When you lose benefits

What happens if my enrollment in this Plan ends?

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

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

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

What is former spouse coverage?

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get more information about your coverage choices.

What is TCC?

Temporary Continuation of Coverage (TCC). If you leave Federal service or if you lose coverage because you no longer qualify as a family member, you may be eligible for TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct. Get the RI 79-27, which describes TCC, and the RI 70-5, the Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees from your employing or retirement office.

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

NOTE: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an individual policy if:

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

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

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

How can I get a Certificate of Group Health Plan Coverage?

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

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

Inspector General Advisory- Stop Health Care Fraud!

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call **the Plan's Fraud and Abuse Hotline at 301-907-3515 or e-mail to <u>audit@comp.vpt.gwu.edu</u>** and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202-418-3300

U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 20415

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Notes

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Notes

Summary of Benefits for The George Washington University Health Plan – 2000

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, semi-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** nothing	16
	Extended Care	All necessary services, up to 90 days per calendar year. **You pay** nothing	16
	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions. **You pay** nothing	20
	Substance Abuse	Medically necessary medical and hospital services including acute detoxification services. **You pay** nothing	21
Outpatient Care		Comprehensive range of services such as diagnosis and treatment of illness or injury; preventive care, including well-baby care and well-child visits through age 6; periodic check-ups and routine immunizations; complete maternity care; specialty care visits; MRI or CT scan; laboratory tests and X-rays; allergy testing; outpatient surgery. **You pay** a $10 copayment for office visits to your primary care physician. **You pay** a $10 copayment for office visits to a specialist, allergy testing and for each MRI or CT scan you receive. **You pay** nothing for outpatient surgery, laboratory tests, X-rays, prenatal care visits and well-child visits through age 6	13
	Home Health Care	All necessary visits by nurses. **You pay** a $10 copayment per visit	14
	Mental Conditions	**You pay** a $20 copayment for each individual therapy session and a $10 copayment for each group therapy session for Mental Conditions	20
	Substance Abuse	**You pay** a $10 copayment for each outpatient therapy session for the treatment of Substance Abuse	21
Emergency Care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $50 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 visit a primary care doctor or urgent care center. **You pay** a $10 copayment per visit to a specialist	18-19
Prescription Drugs		Prescription drugs prescribed by a participating doctor and obtained at a participating pharmacy. **You and each family member pay** the first $35 of prescription drug expense per year; then, for each prescription unit or refill **you pay** a $5 copayment for a generic drug; **you pay** a $15 copayment for a *preferred* brand drug on the formulary; **you pay** a $25 copayment for a *non-preferred* and/or a *non-formulary* brand drug when written by a Plan doctor. **You pay** two copayments for up to a 90-days supply of maintenance drugs	21-23
Dental care		Accidental injury benefit, **you pay** a copayment for the services of a dentist or $50 if you are treated in the emergency room for restorative services and supplies necessary to repair (but not replace) sound natural teeth. Preventive dental care; comprehensive range of restorative, orthodontic, and other services. **You pay** nothing for most preventive and diagnostic services. **You pay** moderate copayments for other services and a $5 sterilization fee for each dental office visit	23-25
Vision care		An annual routine eye examination (refraction). **You pay** a $10 copayment per visit	25
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	5

2000 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. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees" RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Self Only	E51	$73.10	$24.36	$158.37	$52.79	$86.50	$10.96	$86.50	$10.96
Self and Family	E52	$175.97	$62.91	$381.27	$136.30	$207.74	$31.14	$201.02	$37.86