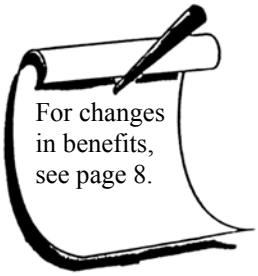
GHI Health Plan

http://www.ghi.com

2003

A Prepaid Comprehensive Medical Plan with a Point of Service Product

Serving: *All of New York and Northern New Jersey*



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

This Plan has full accreditation from URAC
See the 2003 Guide for more information on accreditation.

Enrollment codes for this Plan:

801 Self Only
802 Self and Family

Authorized for distribution by the:

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

RI73-007

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

Kay Coles James
Director

Notice of the Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.

- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice will be effective April 14, 2003.

Table of Contents

Introduction

This brochure describes the benefits of Group Health Incorporated under our contract (CS 1056) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for GHI administrative offices is:

Group Health Incorporated
441 Ninth Avenue
New York, NY 10001

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and changes are summarized beginning on page 8. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

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

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

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program (FEHB) premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud - Here are some things you can do to prevent fraud:

- Be wary of giving your plan identification (ID) over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.

- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
    - Call the provider and ask for an explanation. There may be an error.
    - If the provider does not resolve the matter, call us at 1-888-456-3728 and explain the situation.
    - If we do not resolve the issue:

CALL -- THE HEALTH CARE FRAUD HOTLINE
202-418-3300

OR WRITE TO:
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

- Do not maintain as a family member on your policy:
    - your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
    - your child over age 22 unless he/she is incapable of self support.
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed or with OPM if you are retired.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Section 1. Facts about this Prepaid Plan with a Point-of-Service product

This Plan is a prepaid medical plan that offers a point of service, or POS, product. Within the Plan's network you are encouraged to select a personal doctor who will provide or arrange your care and you will pay minimal amounts for comprehensive benefits. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

Because the Plan emphasizes care through participating providers 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 more comprehensive range of benefits than many insurance plans.

In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan emphasizes 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. Whenever you need services, you may choose to obtain them from your personal doctor within the Plan's provider network or go outside the network for treatment. When you choose a non-Plan doctor or other non-Plan provider, you will pay a substantial portion of the charges, and the benefits available may be less comprehensive.

You should join a prepaid plan 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.

We also have Point-of-Service (POS) benefits:

Our Prepaid Plan offers Point-of-Service (POS) benefits. This means you can receive covered services from a non-participating provider. These out-of-network benefits have higher out-of-pocket costs than our in-network benefits.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Your Rights

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

- GHI is URAC-accredited and is licensed under Article 43 of the New York State Insurance Law as a health services corporation.
- GHI has been in continuous existence for over sixty (60) years
- GHI is a not-for-profit New York corporation

If you want more information about us, call 212/501-4GHI (4444), or write to GHI, PO Box 1701, New York, NY 10023-9476. You may also visit our website at www.ghi.com.

Service area

To enroll with us, you must live or work in our service area. This is where our providers practice. Our service area is: all of New York and the New Jersey counties of Bergen, Essex, Hudson, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex and Union.

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 benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

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

Section 2. How we change for 2003

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

Program-wide changes

- A Notice of the Office of Personnel Management's Privacy Practices is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

Changes to this Plan

- Your share of the non-Postal premium will increase by 28% for Self Only or 26% for Self and Family.
- We clarified services requiring our prior approval to show that High-Tech Radiology requires prior approval.
- Under the Prescription Drug benefit section, prescription drugs must be filled at an Express Scripts PERxCare Retail Pharmacy. All maintenance medications must be sent to Express Scripts Mail Service Pharmacy.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 212/501-4GHI (4444). You may also request replacement cards through the GHI website, www.ghi.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims. If you use our point-of-service program, you can also get care from non-Plan providers, or from participating providers without a required referral, but it will cost you more.

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

- **Plan facilities**

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

What you must do to get covered care

Within the Plan's network, you are encouraged to select a personal doctor who will provide or arrange your care, in which case you will pay minimal amounts for comprehensive benefits. When you choose a non-Plan doctor or other non-Plan provider, you will pay a substantial portion of the charges, and the benefits available may be less comprehensive.

- **Primary care**

You may seek care from covered, doctor, dentist, podiatrist, qualified clinical psychologist, optometrist, chiropractor, nurse, certified midwife, nurse practitioner/clinical specialist, or qualified clinical social worker and any other duly-licensed, registered or certified practitioner or privately-operated facility permitted to perform or render care or service described in this brochure.

- **Specialty care**

You may see the specialist of your choice, whenever you and your family feel you need care. Here are other things you should know about specialty care:

- If you have a chronic or disabling condition and lose access to your specialist because we:
  - Terminate our contract with your specialist for other than cause; or

- Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
- Reduce our service area and you enroll in another FEHB Plan

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

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 212/501-4GHI (4444). If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

Circumstances beyond our control

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

Services requiring our prior approval

For certain services, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, is medically necessary, and follows generally-accepted medical practice.

We call this review and approval process precertification. Your physician must obtain precertification for the following services:

- High-tech radiology
- High-tech nursing
- Infusion therapy
- Mental Health and Substance Abuse
- Non-emergency hospital admissions
- All inpatient hospital admissions for maternity care and skilled nursing facilities
- Infertility Services

Section 4. Your costs for covered services

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

• Copayments

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

Example: When you see a participating provider you pay a copayment of $15 per office visit and when you go in the hospital, you pay nothing.

• Deductible

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

The calendar year deductible for certain services is:

- For nursing service, you pay an annual deductible of $150 per individual or family.
- For appliances, oxygen or equipment, you pay an annual deductible of $100 per individual or family.
- For referred ambulatory, laboratory tests and diagnostic x-rays, you pay a $25 deductible per referral.

Note: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

And, if you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

• Coinsurance

Any amount in excess of 50% of the Plan's fee schedule for POS services provided by non-participating providers.

Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

After your out-of-pocket expenses total $5000 per person in any calendar year for covered services provided by a non-participating provider, GHI will then pay catastrophic benefits at 100% of reasonable and customary charges as determined by the Plan. Out-of-pocket expenses are calculated based upon the reasonable and customary charge for covered catastrophic services.

Covered catastrophic services include: 1) surgery, 2) administration of anesthesia, 3) chemotherapy and radiation therapy, 4) covered in-hospital service and diagnostic services, and 5) maternity. However, expenses for the following services do not count toward your catastrophic protection out-of-pocket maximum:

- Home and office visits and related diagnostic services
- Nursing, Appliances, Oxygen and Equipment
- Dental services
- Vision services
- Prescription drugs

Section 5. Benefits -- OVERVIEW

(See page 8 for how our benefits changed this year and page 62 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 212/501- 4444 or at our website at www.ghi.com.

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan providers or non-Plan providers can provide or arrange your care. Limit out-of-pocket costs by using participating providers.
- The calendar year deductible for certain services is:
  - For nursing services, you pay an annual deductible of $150 per individual or family.
  - For appliances, oxygen or equipment, you pay an annual deductible of $100 per individual or family.
  - For referred ambulatory laboratory test and diagnostic x-rays, you pay a $25 deductible per referral.

  We added asterisks - * - to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services*	
Professional services of physicians • In physician's office	$15 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Professional services of physicians • In an urgent care center • Office medical consultations • Second surgical opinion	$15 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
• During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment	No copay for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.

Diagnostic and treatment services continued on next page

Diagnostic and treatment services* (*continued*)	**You pay**
At home	$15 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Lab, X-ray and other diagnostic tests*	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	$10 per each diagnostic x-ray + laboratory test performed by a participating provider. A maximum of two diagnostic copays will apply per date of service POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount.
Preventive care, adult*	
Routine screenings, such as: • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including – Fecal occult blood test	$10 per each diagnostic x-ray + laboratory test performed by a participating provider. A maximum of two diagnostic copays will apply per date of service POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount.
– Sigmoidoscopy, screening – every five years starting at age 50	$15 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	$10 per each diagnostic x-ray + laboratory test performed by a participating provider. A maximum of two diagnostic copays will apply per date of service POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount.

Preventive care, adult* (*continued*)	
Routine Pap test	$10 per each diagnostic x-ray + laboratory test performed by a participating provider. A maximum of two diagnostic copays will apply per date of service POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount.
Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	$10 per each diagnostic x-ray + laboratory test performed by a participating provider. A maximum of two diagnostic copays will apply per date of service POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount.
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Routine immunizations, limited to: • Tetanus-diptheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine annually • Pneumococcal vaccine, age 65 and over	$15 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Preventive care, children*	**You pay**
• Childhood immunizations recommended by the American Academy of Pediatrics	No copay for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
• Well-child care charges for routine examinations, immunizations and care (through age 22)	No copay for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
• Examinations, such as: - Eye exams to determine the need for vision correction - Ear exams to determine the need for hearing correction	$15 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.

Preventive care, children* *(continued)*	**You pay**
• Examinations done on the day of immunizations (through age 22)	No copay for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Maternity care*	**You pay**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You must precertify your normal delivery. Maternity admissions should be precertified no later than the second trimester. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical Benefits, not maternity benefits, apply to circumcision if this is the case. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	A single $15 copay for all pre- and post-natal care from a participating provider. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Not covered: Routine sonograms to determine fetal age, size or sex.	*All charges.*
Family planning*	
A range of voluntary family planning services, limited to: Voluntary sterilization (See Surgical procedures Section 5b) • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	$15 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Not covered: reversal of voluntary surgical sterilization, genetic counseling.	*All charges.*

Infertility services*	You pay
Diagnosis and treatment of infertility, such as: • In vitro fertilization (limited to three transfers per lifetime) • Embryo transfer • Artificial insemination – Intravaginal insemination (IVI) – Intracervical insemination (ICI) – Intrauterinal insemination (IUI) • Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	$15 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Not covered: Cost of donor sperm	*All charges.*
Allergy care*	**You pay**
Testing and treatment Allergy injections Treatment materials (such as allergy serum)	$15 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges.*
Treatment therapies*	**You pay**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 24. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis	In a doctor's office, nothing for a participating provider. POS: In a doctors office, 50% of the Plan's fee schedule, for non-participating providers, and any difference between our fee schedule and the billed amount.
• High-tech nursing and infusion therapy - IV infusion therapy - Parenteral and enteral therapy - Other home IV therapies Note: Contact us at (212) 615-4662 prior to receiving services to ensure coverage. • Intermittent home nursing service - Provided by a Registered Nurse or Licensed Practitioner - Authorized and supervised by a doctor - Intermittent visits less than 2 hours per day	Nothing for a participating provider. POS: All charges for non-participating providers.

Treatment therapies* (*continued*)	**You pay**
• Growth hormone therapy (GHT). This benefit is provided under our Prescription Drug Benefits.	Generic drug: $10 copay per prescription or refill Name brand drug, listed on formulary: $20 copay per prescription or refill Name brand drug not on formulary: $50 copay per prescription or refill
Not covered: • *Treatment for experimental or investigational procedures.* • *Therapy necessary for transsexual surgery.*	*All charges.*
Physical and occupational therapies*	**You pay**
• 60 visits per condition for the services of each of the following: – qualified physical therapist; – occupational therapist. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other daily living activities. Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction.	$15 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges.*
Speech therapy	
• 60 visits per condition	$15 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Hearing services (testing, treatment, and supplies)*	
• Hearing testing	$15 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Not covered: hearing aids, testing and examinations for them	*All charges.*

Vision services (testing, treatment, and supplies)*	You pay
• Medical and surgical benefits for diagnosis and treatment of diseases of the eye.	$15 per visit for participating provider. For non-participating providers, you pay 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount.
• Examination of the eyes to determine if glasses are required: once each calendar year. • One set of single vision or bifocal lenses (toric kryptok or flat top 22mm): once each calendar year. • One pair of basic frames from available styles: one every two years. • Contact lenses for certain unusual medical conditions (such as post cataract surgery or keratoconus treatment). • Replacement of broken lenses with lenses of the same prescription and material originally supplied.	Nothing for services provided by participating opticians, optometrists and vision centers. POS: For non-participating providers, you pay any difference between our fee schedule and the billed amount.
Not covered: • *Frames at any time unless lenses are also provided.* • *Replacement or repair of frames.* • *Certain bifocals and trifocals, tinted, plastic and oversized lenses and sunglasses and frames other than basic frames; contact lenses for cosmetic purposes.* • *Charges in excess of the maximum GHI allowance.*	*All charges.*
Foot care*	
Podiatric services, including the routine treatment of corns, calluses, and bunions, and the partial removal of toenails, are limited to 4 visits per calendar year.	$15 per visit for participating provider. For non-participating providers, you pay 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount.
Not covered: • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Orthodic devices for the feet.*	*All charges.*

Orthopedic and prosthetic devices	You pay
• Artificial limbs and eyes; stump hose. • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy. • Orthopedic devices, such as braces. • Ostomy supplies. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy.	20% of the Plan's fee schedule for a participating provider. POS: 50% of the Plan's fee schedule and any difference between our allowance and the billed amount for a non-participating provider. Note: $100 deductible applies per individual or family. There is a combined maximum of $25,000 per year per person with these benefits and private duty nursing.
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *corrective appliances for treatment of tempormandibular joint (TMJ) pain dysfunction syndrome.*	*All charges.*
Durable medical equipment (DME)	**You pay**
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • hospital beds; • wheelchairs; • crutches; • walkers; • blood glucose monitors; and • insulin pumps. Note: Call us at (212) 615-4662 as soon as your Plan physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	20% of the Plan's fee scheduled for a participating provider. POS: 50% of the Plan's fee schedule and any difference between our allowance and the billed amount for a non-participating provider. Note: $100 deductible applies per individual or family. There is a combined maximum of $25,000 per year per person with these benefits and private duty nursing.
Not covered • *Hearing aids and air purification devices* • *Alarm and Alert Services*	*All charges.*

Home health services*	You pay
The following conditions must be met: • Home health care must be provided and billed by a certified home health agency, which has an agreement with GHI to provide home health care services. • You must remain under the care of a medical doctor. • The services are provided according to a plan of treatment approved by the attending medical doctor. • Medical evidence substantiates that you would have required further inpatient care had the home health care not been available. The following services are covered: • Part-time or intermittent nursing care by a registered professional nurse (R.N.) or a home health aide under the supervision of a registered professional nurse. • Physical therapy. • Respiration or inhalation therapy. • Prescription drugs. • Medical supplies which serve a specific therapeutic or diagnostic purpose. • Other medically necessary services or supplies that would have been provided by a hospital if the subscriber were still hospitalized.	Nothing for a participating provider. POS: All charges for a non-participating provider.
• Private Duty Nursing services rendered at home or in the hospital by a registered nurse (R.N.) or when an R.N. is not available by a licensed practical nurse (L.P.N).	Nothing for a participating provider. POS: 50% of the Plan's fee schedule and any difference between our allowance and the billed amount for a non-participating provider. Note: $150 annual deductible applies per person or family. There is a combined maximum of $25,000 per calendar year per person with these benefits and Durable Medical Equipment.
Not covered: • *Homemaking services, including housekeeping, preparing meals, or acting as a companion or sitter.* • *Services and supplies related to normal maternity care.* • *Services and supplies provided following a noncovered hospital admission or admission to a facility that is not a participating facility.* • *Services and supplies provided when the subscriber would not have required continued inpatient care.* • *Services and supplies provided by a non-participating facility for home health care.* • *High-tech nursing and infusion therapy*.	*All charges.*

Chiropractic*	
• Manipulation of the spine and extremities • Adjustment procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application.	$15 per visit for participating providers. POS: 50% of the Plan's fee schedule for non-participating providers, and any difference between our fee schedule and the billed amount.
Not covered: • *naturopathic services* • *hypnotherapy* • *biofeedback* • *acupuncture*	*All charges.*
Alternative treatments	**You pay**
• No Benefit	*All charges*
Educational classes and programs	
Coverage is limited to: • Diabetes self-management • Cholestoral Management • Arthritis • Asthma • Hepatitis C • Multiple Sclerosis • Depression • Osteoporosis	*Nothing* For diabetes self management call (888) 881-4008 For arthritis and osteoporosis information call (212) 984-8713 To enroll in our asthma program call (212) 615-0363
• Smoking Cessastion	*All charges in excess of $100*

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look at Section 5 (c) for charges associated with facility (i.e., hospital, surgical center, etc.).
- **YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

IMPORTANT

Benefit Description	You pay
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No Benefit" when it does not apply.	
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity – a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prostethic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information.	$15 per office procedure for a participating provider. Nothing for a participating provider in a hospital or a participating ambulatory surgery center. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.

Surgical procedures (*continued*)	**You pay**
• Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns	$15 per office procedure for participating providers. Nothing for a participating provider in the hospital or a participating ambulatory surgery center. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.
Not covered: • *Reversal of voluntary sterilization.* • *Stand-by services.*	*All charges.*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: – the condition produced a major effect on the member's appearance and – the condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.	$15 per office procedure for participating providers. Nothing for a participating provider in the hospital or a participating ambulatory surgery center. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.
• All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance on the other breast - treatment of any physical complications, such as lymphedemas - breast prostheses and surgical bras and replacements (see Prosthetic devices). Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$15 per office procedure for participating providers. Nothing for a participating provider in the hospital or a participating ambulatory surgery center. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*

Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures, and • Removal of impacted teeth • Other surgical procedures that do not involve the teeth or their supporting structures.	$15 per office procedure for participating providers. Nothing for a participating provider in the hospital or a participating ambulatory surgery center. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in the treatment of teporomandibular joint (TMJ) pain dysfunction syndrome.*	*All charges.*

Organ/tissue transplants	You pay
Limited to: • Cornea • Human Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas. • National Transplant Program (NTP) – We will cover transplants approved as safe and effective for a specific disease by the Federal Drug Administration (FDA) or National Institute of Health, or which our Medical Director determines is medically necessary, appropriate and advisable on a case-by-case basis. We will cover the medical and hospital services, and related organ acquisition costs. Eligibility for transplants will be determined and approved in advance solely by our Medical Director upon recommendation of your PCP. Additionally, all transplants must be performed at hospitals specifically approved and designated by us to perform these procedures. Specialty physician experts from our designated centers of excellence will provide clinical review and support to the Medical Director's decision. Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.	$15 per office procedure for participating providers. Nothing for a participating provider in the hospital or a participating ambulatory surgery center. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.

Organ/tissue transplants (*continued*)	**You pay**
We cover: • We cover related medical and hospital expenses of the donor when we cover the recipient up to a maximum of $10,000 per transplant. • Travel expenses up to a maximum of $150 per person per day and $10,000 per lifetime of the recipient if the recipient patient lives more than 75 miles from the transplant center. This includes food and lodging for the recipient patient and one adult family member (two, if the recipient is a minor) to the city where the transplant takes place. Note: The benefit period begins five (5) days prior to surgery and extends for a period of up to one year from the date of surgery. There is a separate lifetime maximum benefit up to $1,000,000 per recipient for each type of covered transplant.	See previous page.
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient)	Nothing for a participating provider in the hospital or a participating ambulatory surgery center. POS: Any difference between our fee schedule and the billed amount for non-participating providers
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Hospital ambulatory surgical center	Nothing for a participating provider in the hospital or a participating ambulatory surgery center. POS: Any difference between our fee schedule and the billed amount for non-participating providers.
Not covered: • *Office* • *Services administered by the same practitioner performing surgery*	*All charges*

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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the facility charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are addressed in Section 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing for a Plan facility.
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	Nothing for a Plan facility

Inpatient hospital (*continued*):	**You pay**
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Non-covered facilities, such as nursing homes and schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Long term rehabilitation*	*All charges.*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service	Nothing for a Plan facility.
• Diagnostic laboratory tests, X-rays, and pathology services	$25 copayment
• Chemotherapy and radiation	Nothing for chemotherapy and radiation provided in a participating facility. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers.
Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. Conditions for which hospitalization would be covered include hemophilia, impacted teeth, and heart disease; the need for anesthesia, by itself, is not such a condition.	
Not covered: blood and blood derivatives not replaced by the member	*All charges*

Extended care benefits/skilled nursing care facility benefits	You pay
Skilled nursing facility (SNF): Limited to 30 days: • Bed, board and general nursing care • Drugs, biologicals, supplied and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by your doctor as governed by Medicare guidelines.	Nothing for a participating provider. POS: All charges for a non-participating provider.
Not covered: • *custodial care*	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member in the home or hospice facility. Services include: • inpatient/outpatient care; and • family counseling under the direction of a doctor. Note: Your provider must certify that you are in the terminal stages of illness, with a life expectancy of approximately six months or less. The hospice must have an agreement with us or recognized by Medicare as a hospice.	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
• Ambulance services for each trip to or from a hospital for medically necessary services. This includes the use of an ambulance for emergency outpatient care and maternity care, to the nearest facility.	All charges in excess of $100.
Not covered: • *Air ambulance* • *Ambullette services*	*All charges*

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

If you are in an emergency situation, please call your 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. It is your responsibility to ensure that the Plan has been promptly notified.

Emergencies within the service area: Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

Emergencies outside the service area: Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

Note: If you were admitted to the hospital from the Emergency Room the $50 copay is waived.
A participating GHI provider must provide your follow-up care. We cover care provided by a non-participating provider at 50% of the Plan's fee schedule.

Benefit Description	You pay
Emergency within our service area	
• Emergency medical/surgical care at a doctor's office • Emergency medical/surgical care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: Copay waived if admitted to the hospital. If private physicians who are not hospital employees provide the emergency care, you may receive a separate bill for these services, which we will process as a medical benefit.	$15 per office visit for a participating provider. POS: Any difference between our fee schedule and the billed amount for a non-participating provider. $50 copay and any charges that exceed the emergency fee schedule.
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
• Emergency medical/surgical care at a doctor's office • Emergency medical/surgical care at an urgent care center	$15 per visit for a participating provider. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for non-participating providers
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: Copay waived if admitted to the hospital. If private physicians who are not hospital employees provide the emergency care, you may receive a separate bill for these services, which we will process as a medical benefit.	POS: $50 copay and 20% of charges per hospital emergency room visit or urgent care center visit for non-participating facilities. Note: For emergency services billed for by a doctor, you pay any difference between our fee schedule and the billed amount
Not covered: • *Elective care or non-emergency care*	*All charges.*
Ambulance	
Professional ambulance service to or from a hospital for medically necessary services. This includes the use of an ambulance for emergency outpatient care and maternity care, to the nearest facility. See 5(c) for non-emergency service.	All charges in excess of $100.
Not covered: air ambulance and ambullette services	*All charges.*

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

IMPORTANT

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.
- Participating providers must provide all care.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services obtained from a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$15 per visit for outpatient mental health care.
• Diagnostic tests	Nothing
• Services provided by a Plan hospital or other Plan facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility based intensive outpatient treatment	Nothing

Mental health and substance abuse benefits (*continued*)	
Not covered: • *Services we have not approved.* • *Facility charges of a non-participating general hospital or facility.* • *Treatment by a non-participating provider.* *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Preauthorization	To be eligible to receive these benefits you must follow your treatment plan and all of our network authorization processes on pages 9 and 32. Contact us at 1-(800) 692-7311
Limitation	There are no benefits if you do not obtain a treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** A licensed doctor must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a pharmacy that participates under the program through Express Scripts PERxCare Retail Pharmacy Program. You must fill the prescription at a Plan pharmacy, or by mail for a maintenance medication.
- **We use a formulary.** The formulary is a list of preferred, clinically effective prescription drugs that are also cost-effective. Express Scripts acts on behalf of GHI to provide affordable access to clinically sound, high quality pharmacy benefits for you. The formulary is developed using an evaluation process. The process begins with an assessment of the drug's clinical effectiveness by an independent panel of physicians and pharmacists, also known as the Pharmacy and Therapeutics Committee. If the panel determines that the drug is clinically effective, the drug is further evaluated on an economic basis.

  We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 1-877- 534-3682.
- **These are the dispensing limitations.** Prescription drugs prescribed by a doctor and obtained at a pharmacy that participates under the program through Express Scripts PERxCare Retail Pharmacy Program. Drugs are prescribed by doctors and dispensed in accordance with the Plan's drug formulary. You pay a $10 copay for a generic drug, a $20 copay per prescription unit or refill for a name brand drug listed on the preferred prescriptions drug formulary and a $50 copay per prescription unit or refill for a name brand drug not listed on the preferred prescription drug formulary. A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified "dispense as written" for the name brand drug, you have to pay the brand name copay.
  - **Mandatory Mail**: Your prescription coverage also includes a mandatory mail program. All maintenance medications must be sent to Express Scripts Mail Service Pharmacy. Two refills per prescription will be allowed at any local "preferred" Express Scripts PERxCare Pharmacy. When a new maintenance medication is prescribed the patient should request 2 prescriptions. The initial for a 31-day supply to be filled at a retail pharmacy, and the second, for up to a 90-day supply, to be submitted to Express Scripts Mail Service Pharmacy. For all existing maintenance medications at a retail pharmacy, the patient is required to obtain a new prescription, for up to a 90-day supply, to be sent to Express Scripts Mail Service Pharmacy.

– **Maintenance Drug Program**: The maintenance drug program permits long-term prescriptions to be filled for up to a 90-day supply. You pay a $20 copay for a generic drug, and a $40 copay per prescription unit for a name brand drug listed on the preferred prescriptions drug formulary and a $60 copay per prescription unit or refill for a name brand drug not listed on the preferred prescription drug formulary.

- **Why use a generic drug?**

  - Generic drugs may have unfamiliar names, but they are safe and effective.
  - Generic drugs contain the same active ingredients, in the same dosage form as their brand name counterparts, and are manufactured according to the same strict federal regulations.
  - Generic drugs may differ in color, size, or shape, but they have the same strength, purity, and quality as the brand-name alternatives.
  - Prescriptions filled with generic drugs often have lower co-payments. Therefore, you may be able to get the same health benefits at a lower cost. You should ask your physician or pharmacist whether a generic version of your medications is available. By using a generic drug, you may be able to receive the same high-quality medication but reduce your expenses.

- **When you have to file a claim.** In an emergency, a direct reimbursement claim form must be filed for prescriptions that you obtained through a non-participating retail pharmacy. Upon filling your prescriptions through non-participating pharmacies:

  - You must pay the full cost of the prescription.
  - You must complete a direct reimbursement claims form, and submit it to Express Scripts. This form can be obtained by calling Express Scripts at 1-877-534-3682.
  - Express Scripts will reimburse you for the amount the medication would have cost your benefits plan at a participating pharmacy, minus the co-payment you would have paid.

Benefit Description	You pay
Covered medications and supplies	
Each new enrollee will receive a description of our prescription drug program, a combined prescription drug/Plan identification card, a mail order form/patient profile and a preaddressed reply envelope. We cover the following medications and supplies prescribed by a physician and obtained from either a Plan pharmacy or by mail. Note: Mandatory mail requirements apply for maintenance drugs: • Drugs for which a prescription is required by law. • FDA-approved prescription drugs and devices for birth control. • Fertility drugs. • Drugs to treat sexual dysfunction (Viagra is limited to six tablets per every thirty-one days). • Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape. • Disposable needles and syringes needed for injection of covered prescribed medication. • Smoking cessation drugs and medication, including nicotine patches (up to 90-day supply). • Intravenous fluids and medications for home use through our Participating Provider network for home infusion therapy	Network Retail: $10 generic $20 brand name listed on the preferred prescription drug formulary $50 brand name drug not listed on the preferred prescription drug formulary. Network Mail Order: $20 generic $40 brand name listed on the preferred prescription drug formulary $60 brand name drug not listed on the preferred prescription drug formulary.
• A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified "dispense as written" for the name brand drug, you have to pay the brand name copay. • We administer an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call Express Scripts at 1-877-534-3682.	
Not covered: • *Nonprescription medications* • *Drugs obtained at a non-participating pharmacy, except for emergencies.* • *Vitamins and nutritional substances that can be purchased without a prescription.* • *Medical supplies such as dressings and antiseptics.* • *Drugs for cosmetic purposes.* • *Drugs to enhance athletic performance.*	*All Charges*

Section 5 (g). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Large Case Management	The Plan provides a large case management program that seeks to provide alternatives for improving the quality and cost effectiveness of care. The large case management program focuses on catastrophic illnesses — for example, major head injury, high-risk infancy, stroke and severe amputations. The large case management process begins when we are notified that you or covered family member has experienced a specific illness or injury with potential long-term effects or changes in lifestyle. Case Managers evaluate individual needs, and the full range of treatment and financial exposures, from the onset of a condition or illness to recovery or stabilization. They review the efforts of the health care team and family with the goal of helping the patient return to pre-illness/injury functioning or of lessening the burden of a chronic or terminal condition. Case Managers provide the family with support and advice ranging from referral to family counseling. If it is determined that involvement of a Case Manager would be both care- and cost-effective, we will obtain the necessary authorization from the patient to proceed. Throughout the process, we will maintain strict confidentiality.
Customer Service AnswerLine	For information and assistance 24 hours a day, 7 days a week, access our automated telephone AnswerLine at 212/501-4GHI (4444).
Services for deaf and hearing impaired	If you have a question concerning Plan benefits or how to arrange for care, contact (212) 721-4962 (Hearing impaired — TDD) or you may write to us at Post Office Box 1701, New York, NY 10023-9476 or contact our office nearest you. You may also contact the Plan at its website at http://www.ghi.com.
High risk pregnancies	The Plan provides an intensive large case management program as described above.

Centers of excellence	We have a special network of hospitals that perform a broad range of cardiac care and organ transplants. These centers are recognized leaders in their respective specialties and their services are available to you at no out-of-pocket expense. Call GHI Managed Care at least 10 days before the hospital admission to pre-certify coverage and for details on how to use this program.
Travel benefit/ services overseas	As a GHI subscriber, you are not restricted to just using members of our provider network. However, if you go outside the network, your out-of-pocket expenses will increase significantly. You will receive 50% of our fee schedule if you use a non-participating provider — you are responsible for the balance of the provider's charge. Also, unlike when you use a network provider, you are responsible for paying the non-participating provider up front and filing a claim form with us for reimbursement.

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We cover hospitalization for certain dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; see section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below. We will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia, impacted teeth, and heart disease; the need for anesthesia, by itself, is not such a condition.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit	You Pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury caused by external means and services must be completed within one year.	Any difference between our fee schedule and the actual charges.
Not covered: • *Therapeutic service.* • *Other dental services not shown as covered.* • *Charges which exceed the Plan's fee schedule.*	*All charges*

Dental benefits

This Plan provides the following program of dental coverage. The emphasis is on prevention, with preventive and diagnostic dental services covered with no copayments through Participating Plan Dentists. Services by non-participating dentists are covered in accordance with the fees listed below.

Service	You Pay
Examinations (maximum 2 per calendar year)	Nothing for a participating provider. POS: All charges in excess of $10.00
Prophylaxes (under 12 years - maximum 2 per calendar year)	Nothing for a participating provider. POS: All charges in excess of $7.00
Prophylaxes (over 12 years maximum 2 per calendar year)	Nothing for a participating provider. POS: All charges in excess of $10.00
Emergency visits for relief of pain (1 per calendar year)	Nothing for a participating provider. POS: All charges in excess of $10.00
X-rays (Full-mouth series, 1 every 3 years)	Nothing for a participating provider. POS: All charges in excess of $20.00

Dental benefits continue on the next page.

Dental benefits (*continued*)	
Service	**You pay**
Bitewings (4 per calendar year)	Nothing for a participating provider. POS: All charges in excess of $2.50 per each bitewing
Space maintainers	Nothing for a participating provider. POS: All charges in excess of $65.00
Fluoride Treatments – dependent children to age 22	Nothing for a participating provider. POS: All charges in excess of $5.00

Section 5 (i). Point of service benefits

Point of Service (POS) Benefits

Facts about this Plan's POS option
At your option, you may choose to obtain benefits covered by this Plan from non-participating doctors and hospitals whenever you need care, except for those benefits listed below which are available only through plan providers. Benefits not covered under Point of Service must be received from Plan doctors to be covered.

What is covered

All services are covered under our POS except:

- High-tech nursing and infusion therapy
- Skilled nursing care facility confinements
- Home health care services
- Mental conditions and substance abuse
- Prescription drugs

Remember, only participating providers have agreed to accept the Plan's allowance, except for any applicable copayments, as payment in full. If you choose to receive benefits not covered through non-participating or out-of-network providers, you will be reimbursed at the POS level that in most cases is 50% of the Plan's allowance.

Covered POS benefits are available whether the services are received within or outside the GHI Health Plan's Service Area.

All non-emergency hospital admissions including inpatient admissions for maternity care and skilled nursing facilities must be pre-certified.

There is a $150 annual deductible for nursing services and a $100 annual deductible for appliances, oxygen and equipment. There is also a $25 deductible, per referral, for ambulatory laboratory test and diagnostic X-rays.

In most cases, the POS coinsurance is any amount in excess of 50% of the Plan's fee schedule. The Plan's fee schedule is set at approximately 50% of the New York State 1999 HIAA mean. Members, when receiving POS services, will be responsible for 50% of the Plan's fee schedule plus any difference between our fee schedule and the billed amount.

After your out-of-pocket expenses total $5000 per person in any calendar year for covered services provided by a non-participating provider, GHI will then pay catastrophic benefits at 100% of reasonable and customary charges as determined by the Plan. Out-of-pocket expenses are calculated based upon the reasonable and customary charge for covered catastrophic services. Covered catastrophic services include: 1) surgery, 2) administration of anesthesia, 3) chemotherapy and radiation therapy, 4) covered in-hospital services and diagnostic services, and 5) maternity. However, expenses for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay coinsurance and deductibles for these services:

- Home and office visits and related diagnostic services
- Nursing, appliances, oxygen and equipment
- Dental services
- Vision services
- Prescription drugs

If you are in a true emergency situation, POS benefits are available within or outside the GHI's Health Plan's service area.

Emergencies within the service are:

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

Plan pays Emergency fee schedule for emergency care services to the extent the services would have been covered if received from Plan providers.

You pay $50 per hospital emergency room visit or urgent care center visit for emergency services that are covered benefits of this Plan. You also pay charges that exceed the Plan's emergency fee schedule. If the emergency care is provided by private physicians who are not hospital employees, you may receive a separate bill for these services, which will be processed as a medical benefit.

Emergencies outside the service area:

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

Plan pays full emergency fee schedule for emergency care services to the extent the services would have been covered if received from Plan providers; 80% of charges from a non-participating hospital.

You pay $50 plus 20% of charges per hospital emergency room visit or urgent care center visit for non-participating facilities and nothing for emergency services billed for by a doctor, except charges which exceed the Plan's emergency fee schedule, for services which are covered benefits of this Plan. If the emergency care is provided by private physicians who are not hospital employees, you may receive a separate bill for these services, which will be processed as a medical benefit.

What is covered

- Emergency care at a doctor's office or an urgent care center.
- Ambulance service (see page 30).
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services.

If the medical/surgical care received from non-participating providers is not due to a medical emergency as defined above, the Plan will pay 50% of its fee schedule. Follow-up care after an emergency is covered in full only if received from participating providers.

Section 5 (j). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums.

Dental services are available at reduced fees
If you should require additional dental services, a GHI dental provider participating in the benefit offer will provide these services at reduced fees. All reduced fees for dental services must be paid directly to the participating dental provider. You must verify that your provider is still participating in the program.
Dental services available in the reduced fee program include:

	DOWNSTATE* **You Pay**	UPSTATE** **You Pay**
DIAGNOSTIC RESTORATIVE (Fillings)		
Resin (anterior) 1 surface	$52.00	$38.00
Resin (anterior) 2 surface	$69.00	$48.00
Resin (anterior) 3 surface	$86.00	$59.00
PROSTHODONTICS REMOVAL		
Complete denture (upper or lower)	$660.00	$441.00
Partial denture resin base (Bilateral Chrome)	$664.00	$453.00
Add tooth to existing partial	$65.00	$54.00
Add clasp to existing partial	$73.00	$59.00
PROSTHODONTICS FIXED		
Bridge pontic (cast metal)	$520.00	$409.00
Porcelain fused to metal	$510.00	$399.00
Full cast crown with porcelain, veneer backing	$552.00	$432.00
ORAL SURGERY		
Extraction (completely covered by bone)	$269.00	$210.00
Soft tissue extraction	$172.00	$118.00
PERIODONTICS (Gum Treatment)		
Gingivectomy (per quadrant)	$200.00	$169.00
Osseous Surgery (per quadrant)	$470.00	$382.00
ENDODONTICS (Root Canal)		
Therapeutic pulpotomy	$82.00	$50.00
Root canals (3 canals)	$466.00	$466.00
Apicoectomy (first root)	$306.00	$314.00
ORTHODONTICS (Braces)		
Diagnostic and planning fee	$912.00	$686.00
Active Treatment Maximum	$2,220.00	$1,680.00

Benefits on this page are not part of the FEHB contract.

* Downstate includes New York, Bronx, Kings, Queens, Richmond, Nassau, Suffolk, Putnam, Orange, Rockland and Westchester Counties and New Jersey

** Upstate includes Eastern, Central, and Western New York Counties.

Section 6. General exclusions -- things we don't cover

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

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan
- Services, drugs, or supplies that are not medically necessary
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice
- Experimental or investigational procedures, treatments, drugs or services
- Services, drugs, or supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies related to sex transformations, or
- Services or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive services from non-plan providers. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file the form HCFA-1500, Health Insurance Claim Form. Facilities will file the UB-92 form. For claims questions and assistance, call us at (212) 501-4GHI (4444).

When you must file a claim, submit the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Submit your claims to: Group Health Inc.
P.O. Box 3000
New York, New York 10116-3000

Prescription drugs

For drugs obtained at a non-participating pharmacy in an emergency call 877-534-3682 to obtain a claim form.

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: 88 West End Avenue, New York, NY 10023; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Health Benefits Contracts Division 2, 1900 E Street, NW, Washington, D.C. 20415-3620.

Send OPM the following information:

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

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

NOTE: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at (212) 615-4662 and we will expedite our review; or

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Benefits Contracts Division II at (202) 606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under another group health plan or have automobile insurance that pays health expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

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

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

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium free part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, part B premiums are withheld from your monthly Social Security check or your retirement check.

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

• The Original Medicare Plan (Part A or Part B)

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

When you are enrolled in Original Medicare along with this plan, you still need to follow the rules in this brochure for us to cover your care.

We will waive some copayments, coinsurance, and deductibles as follows:

Medical services and supplies provided by physicians and other health care professionals. If you are enrolled in Medicare Part B, we will waive the $15 copay for office visits and deductible and coinsurance for durable medical equipment.

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 212/501-4GHI (4444), or access our web site at http://www.ghi.com

We waive some costs if the Original Medicare Plan is your primary payer – We will waive some out-of-pocket costs, as follows:

- Medical services and supplies provided by physicians and other health care professionals. If you are enrolled in Medicare Part B, we will waive the $15 copay for office visits and deductible and coinsurance for durable medical equipment.

The following chart illustrates whether Original Medicare Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when…		
a) The position is excluded from FEHB, or….	……..✓	
b) The position is not excluded from FEHB…….	……..	……✓
(Ask your employing office which of these applies to you.)		
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or	✓	
b) Are an active employee or		✓
c) Are a former spouse of an annuitant or	✓	
d) Are a former spouse of an active employee	✓	✓

•Medicare managed care plan

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

If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and another plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care plan's service area.

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

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

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the program.

Workers' Compensation

We do not cover services that:

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

Once OWCP or a similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 11.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 11.

Covered services

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

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 11.

Medically Necessary Services

Medically necessary services are services; supplies or equipment provided by a hospital or covered provider of the health care services that the carrier determines:

- are appropriate to diagnose or treat the patient's condition, illness, or injury;
- are consistent with standards of good medical practice in the United States;
- are not primarily for the personal comfort or convenience of the patient, the family, or the provider;
- are not part of or associated with scholastic education or vocational training of the patient; and
- in case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that a covered provider has prescribed, recommended, or approved a service, supply or equipment does not, in itself, make it medically necessary.

Experimental or investigational services

Experimental treatment is a treatment that has not been tested in human beings; or that is being tested but has not yet been approved for general use; or that is subject to review or approval by an Institutional Review Board.

Investigational treatment includes, but is not limited to, services or supplies which are under study or in a clinical trial to evaluate their toxicity, safety and efficiency for a particular diagnosis or set of indications.

Clinical trials include, but are not limited to, controlled experiments having a clinical event as an outcome measurement involving persons having a specific disease or health condition; or involving the administration of different study treatments in a parallel treatment design done to evaluate the efficacy and safety of a test measurement. Clinical trials include Phase I, Phase II, and Phase III studies. Clinical trials also include randomized trials or studies.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. We determine our allowance as follows:

The Plan allowance is the fee schedule or negotiated rate that GHI uses as payment in full for covered services rendered by participating providers.

Us/We

Us and we refer to Group Health Incorporated

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you *A Guide to Federal Employees Health Benefits Plans,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

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

Types of coverage available for you and your family

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

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the Federal Employees Health Benefits (FEHB)

Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option,
- if you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- if you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot make any changes after retirement. Contact you employing office for further information.

When benefits and premiums start

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

Your medical and claims records are confidential

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

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

When you retire

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

When you lose benefits

•When FEHB coverage ends

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

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

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

• Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's website www.opm.gov/insure.

• Temporary Continuation of Coverage (TCC)

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

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from *www.opm.gov/insure*. It explains what you have to do to enroll.

• Converting to individual coverage

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

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

If you leave Federal service, your employing office will notify you of your right to convert; You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify

you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

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

- **Getting a Certificate of Group Health plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a Federal law that offers limited federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans. For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB website (www.opm.gov/insure/health); refer to the "TCA and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Still Available!

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, your premiums are based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called "custodial care", long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

You Can Also Apply Later, But…

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action – you won't receive an application automatically. You must request one through the toll-free number or website listed below.
- Open Season ends December 31, 2002 – act NOW so you won't miss the abbreviated underwriting available to employees and their spouses, and the July 1 "age freeze"!

Find Out More – Contact LTC Partners by calling **1-800-LTC-FEDS (1-800-582-3337) (TDD for the hearing impaired: 1-800-843-3557)** or visiting www.ltcfeds.com to get more information and to request an application.

Index

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

Summary of benefits for the GHI Health Plan - 2003

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	$15 per visit for a Participating Provider. POS: 50% of the Plan's fee schedule and any difference between our fee schedule and the billed amount for a non-participating provider.	13
Services provided by a hospital: • Inpatient • Outpatient	Nothing Note: $25 deductible per referral for ambulatory laboratory test and diagnostic X-rays when referred and rendered.	28 29
Emergency benefits: • In-area • Out-of-area	$50 per hospital emergency room visit or urgent care center visit and charges that exceed the Plan's emergency fee schedule. $50 plus 20% of charges per hospital emergency room visit or urgent care center visit for non-participating facilities.	31 31
Mental health and substance abuse treatment	Regular cost sharing.	33
Prescription drugs prescribed by a doctor and obtained at a participating pharmacy Mandatory Mail	$10 copay for generic drugs; $20 copay per prescription unit or refill for name brand drugs listed on the preferred prescription drug formulary, and $50 copay per prescription unit or refill for a name brand drug not listed on the preferred prescription drug formulary. For mail-order maintenance you pay a $20 copay for generics and a $40 copay for name brand name drug listed on the preferred prescription drug formulary and $60 copay for a name brand drug not listed on the preferred prescription drug formulary All maintenance medications must be sent to Express Scripts Mail Service Pharmacy. Two refills per prescription will be allowed at any local "preferred" Express Scripts PERxCare.	35
Dental Care	Nothing for preventive services provided by Participating Providers. For non-participating providers, you pay any difference between GHI's fee schedule and the billed amount.	40
Vision Care	One refraction annually. Lenses (annually) and frames (every two years). Nothing to Participating Vision Centers.	19
Special features: Large Case Management, High Risk Pregnancies, Centers of Excellence for Transplants/Heart/Surgery/etc., Travel Benefits/Services Overseas		38
Point-of-Service benefits -- Yes		42
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after $5,000 per person per year Some costs do not count toward this protection	11

2003 Rate Information for GHI Health Plan

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	801	$109.30	$59.35	$236.82	$128.59	$129.03	$39.62
Self and Family	802	$249.62	$171.98	$540.84	$372.63	$294.70	$126.90