GHI Health Plan

www.EMBLEMHEALTH.com

877-VIA-EMBLEM (877-842-3625)

an EmblemHealth company

2021

A Prepaid Comprehensive Medical Plan.

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 3 for details. This plan is accredited.

Standard Option Plan Serving: New York City plus most New York Counties, and Northern New Jersey

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 12 for requirements.

IMPORTANT
- Rates: Back Cover
- Changes for 2021: Page 14
- Summary of Benefits: Page 74

Enrollment codes for this Plan:

804 Standard Option – Self Only
806 Standard Option - Self Plus One
805 Standard Option – Self and Family

***Special Notice: Plan code 81 High Deductible Health Plan (HDHP) will not be offered for 2021**

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-007

Important Notice from the GHI Health Plan About

Our Prescription Drug Coverage and Medicare

Office of Personnel Management has determined that the GHI Health Plan's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 thru December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE (1-800-633-4227),(TTY 1-877-486-2048).

Table of Contents

Introduction

This brochure describes the benefits of Group Health Incorporated (GHI) under contract (CS 1056) with the United States Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. Customer service may be reached at (877) 842-3625 or through our website: www.emblemhealth.com. The address for GHI administrative offices is:

Group Health Incorporated
55 Water St.
New York, NY 10041

This brochure is the official statement of benefits. No verbal 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 Plus One or 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, 2021, unless those benefits are shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2021, and changes are summarized beginning on page 16. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee and each covered 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.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program 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 that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your health care providers, authorized health benefits 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) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure you have not been billed for services you did not receive.
- 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 (877) 842-3625 and explain the situation.
- If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- 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)

  - Your child age 26 or over (unless he/she is disabled and incapable of self-support prior to age 26)

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

GHI complies with applicable Federal civil rights laws, Title VII of the Civil Rights Act of 1964.

You can also file a civil rights compliant with the Office of Personnel Management by mail at: Office of Personnel Management Healthcare and Insurance Federal Employee Insurance Operations, Attention: Assistant Director FEIO, 1900 E Street NW, Suite 3400 S, Washington, DC 20415-3610

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medication or give your doctor and pharmacist a list of all the medication and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what you doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of test or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the health care you need.

- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak UP patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/ The Agency for Healthcare Research and Quality provides information about patient safety, choosing quality health care providers, and improving the quality of care you receive.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Event")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a health care facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct Never Events, if you use GHI providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specificout-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance/healthcare for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions and give you 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. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

  Self Only coverage is for you alone. Self Plus One coverage is for you and one eligible family member. Self and Family coverage is for you and one eligible family member, or your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

  If you have a Self Only enrollment, you may change to a Self Plus One or 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 Plus One or 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 Plus One or 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 are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they can not be enrolled in or covered as a family member by another enrollee in another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance//lifeevents. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage and same sex domestic partners) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact you human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

Office of Personnel Management has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the 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 in Self Plus One or 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 Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- 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 Plus One or Self and Family, as appropriate, 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 Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

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 does not 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 cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective 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. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2021 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2020 benefits until the effective date of your coverage with your new plan. 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.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **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.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

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

Upon divorce

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 provide health coverage to you. However, you may be eligible for your own FEHB coverage under either 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 additional information about your coverage choices. You can also visit OPM's website at www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Temporary Continuation of Coverage (TCC)

If you leave Federal service, Tribal employment or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn age 26, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

Converting to individual coverage

We will provide you with assistance in finding a non-group contract available inside or outside the Marketplace if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decide 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 or Tribal service, your employing office will notify you of your right to convert**.** You must contact us in writing 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 contact us in writing 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, waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 1-800-624-2414 or visit our website at www.emblemhealth.com.

Health Insurance Marketplace

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace

Section 1. How This Plan Works

This Plan offers one Standard Option Exclusive Provider Organization (EPO) benefit package. GHI seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, we can afford to offer a comprehensive range of benefits.

We strongly encourage you to select a personal GHI participating doctor who will provide your care within the Plan's participating provider network. This will ensure that you pay only the designated deductible, copayment, or coinsurance for all covered services. GHI is solely responsible for the selection of the providers in our service area. Please contact us for a copy of our most recent provider directory or visit us online at www.emblemhealth.com/federal for the most up-to-date information on our provider network.

In addition to providing comprehensive health care services for illness and injury, we emphasize preventive benefits such as routine office visits, physicals, immunizations, and well-baby care. We encourage you to seek 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.

You should join a plan because you prefer the plan's benefits, not because a particular provider may be available. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us. You cannot change plans because a provider leaves our Plan.

General Features of our Standard Option

The enrollment codes for the Standard Option are 804 (Self Only) 806 (Self Plus One) 805 (Self and Family). If you are enrolled in our Standard Option, you have access to covered care only from within our network participating providers under our Exclusive Provider Organization (EPO). We will not cover care that you receive from non-network (non-participating) providers. Contracted providers within our EPO network have agreed to accept our schedule of allowances or negotiated rate as payment in full for a covered service. Our EPO offers a network of participating providers and uses provider selection standards, utilization management, and quality assessment techniques to complement negotiated fee reductions as an effective strategy for long term cost savings. Since you must seek care from within the EPO network, you will only owe your deductible, copayment and/or coinsurance for covered services. You are not responsible for balances that exceed our payment for covered services from EPO network providers. This Plan will only cover services received out of network if it was the result of an accidental injury or emergency.

Preventive care services

Preventive care services are generally covered with no cost-sharing and are not subject to copayments,deductibles or annual limits when received from a network provider.

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.

When you use a participating hospital, keep in mind that the professionals who provide services to you in the hospital may not all be participating providers. When you receive emergency and non-emergency services at a participating hospital but are seen by a non-participating anesthesiologist, radiologist, pathologist, or assistant surgeon, we will calculate payment based on an allowance that we determine under the GHI Plan Options. GHI will determine reimbursement for emergency services from non-participating providers based on a lesser of 100% of the 90th percentile of FAIR Health Prevailing Healthcare Charges System for Emergency Professional charges and Emergency Admission Professional Charges or the provider's billed charge. Our allowance may not cover the full charges and you will owe that portion of the charges that exceeds our payment. This policy does not apply to services that you receive at non-participating hospitals.

Under the Standard Option we do not cover care from non-participating providers and will not pay them for covered services even if Medicare is your primary health insurance coverage. To get full maximum use of the plans you must use GHI's participating EPO provider network for all covered services.

Surprise Bills. If your claim was for services from a non-participating provider, the claim may be for a "surprise bill," giving you protection from out-of-pocket costs in excess of what you would have paid in-network for the services. Please contact us at the number on the back of your member ID card or visit our website at **emblemhealth.com/outofnetwork** for more information about what constitutes a "surprise bill" and what you should do if you think your claim was for a "surprise bill."

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits out-of-pocket expenses for covered services obtained from participating providers, including deductibles and copayments, to no more than $7,000 for Self-Only enrollment, or $14,000 for a Self Plus One or Self and Family. The out-of-pocket limits for these Plans may differ from the IRS limit, but cannot exceed that amount.

Your rights and responsibilities

OPM requires that all FEHB Plans provide certain information to their FEHB members . You may get information about us, our networks, and our providers. 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 has been in continuous existence for over eighty (80) years.
- GHI is a Not for Profit New York company.

You are also entitled to a wide range of consumer protection and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting the EmblemHealth website, www.emblemhealth.com. You can also contact us to request that we mail a copy to you.

If you want more information about us, call (877) 842-3625, or write to GHI, PO Box 1701, New York, NY 10023-9476. You may also visit our website at www.emblemhealth.com/federal.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit the EmblemHealth website at www.emblemhealth.com/federal to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service area

To enroll with us, you must live or work in our service area. Our service area is: New York City (the Boroughs of Manhattan, Brooklyn, Bronx, Queens, and Staten Island) all of Nassau, Suffolk, Rockland, Westchester Broome, Cayuga, Chemung, Columbia, Cortland, Delaware, Dutchess, Franklin, Greene, Hamilton, Herkimer, Jefferson, Lewis,Madison, Oneida, Onondaga, Orange, Oswego, Otsego, Putnam, St. Lawrence, Schuyler, Steuben, Sullivan, Tioga, Tompkins, Ulster, New Jersey counties of Bergen, Essex, Hudson, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex and Union.

In this Plan 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.

If you or a covered family member moves 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 moves, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2021

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

Changes for 2021:

- Your share of the non-Postal premium will increase for Self Only, Self Plus One, and Self and Family. See the back of the brochure for 2021 premium rate information.
- Standard Option catastrophic maximum increases to $8,150 for Self Only and $16,300 for Self Plus One or Self and Family
- Elimination of coverage for Acupuncture
- Hearing Aids covered for children to age 26, no adult coverage.
- Generic prescription copay increase from $15 to $20
- The HDHP option (Plan Code 81) is eliminated for 2021.

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. Your member ID card will indicate the provider network that is applicable to your coverage. 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 electronic enrollment system (such as 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, contact us at (877) 842-3625 or Group Health Incorporated (GHI) 55 Water Street, New York, NY 10041. You may also request replacement cards through the GHI website: www.emblemhealth.com/federal

Where you get covered care

You get care from "Plan providers" and "Plan facilities." Network providers file claims for you and we reimburse them directly for covered services. You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims. Under the Standard Option coverage, we will not provide benefits for services that you receive from non-network providers.

- **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.

Your ID card will indicate the GHI network for your coverage. We list Plan providers in the provider directory, which we update periodically. The list is also on our website. We recommend that you confirm that the provider is a participating network provider prior to seeking services or upon scheduling an appointment.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. Your ID card will indicate the GHI network for your coverage. We list Plan facilities in the provider directory, which we update periodically. The list is also on our website. We recommend that you confirm that the plan facility is a participating network provider prior to seeking services or upon scheduling an appointment.

- **Covered Providers**

We provide benefits for the services of covered professional providers, as required by Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

Covered professional providers are medical practitioners who perform covered services when acting within the scope of their license or certification under applicable state law and who furnish, bill, or are paid for their health care services in the normal course of business. Covered services must be provided in the state in which the practitioner is licensed or certified.

What you must do to get covered care

Under the Plan, you are free to choose any participating provider within your Plan's GHI network. We strongly encourage you to select a doctor within the GHI network who will provide your care.

- **Specialty care**

You may see the specialist whenever you and your family feel you need care. You do not need a referral to see a specialist.

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 hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (877) 842-3625. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

You must get prior approval for certain services. Failure to do so will result in a $125 per day up $250 penalty for hospital admissions. Members that do not receive prior approval for certain medical services will be responsible for all charges.
The pre-service claim approval processes for inpatient hospital admissions (called precertifcation) and for other services are detailed in this section. A pre-service claim is any claim, in whole or in part, that requires approval from us in advance of obtaining medical care or services. In other words, a pre-service claim for benefits (1) requires precertification, prior approval or referral and (2) will result in a reduction of benefits if you do not obtain precertification, prior approval, or referral.

- **Inpatient hospital admission**

Pre-certification is the process by which - prior to your inpatient hospital admission - we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition. We perform pre-admission review for all non- emergency hospitalizations and must be notified of emergency hospital admissions within a specified time frame. GHI's Coordinated Care Department will review the proposed hospital confinement to determine the length of stay in addition to confirming the medical necessity of hospitalization.

Your physician must obtain precertification for the following services:

- Skilled Nursing Facility
- All elective or non-emergency hospital admissions

You do not need precertification in the following situations:

- You have another group health insurance policy that is the primary payer for the hospital stay.
- Your Medicare Part A is the primary payor for the hospital stay. **Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we will become the primary payer and you do need precertification.**

Warning: If no one contacts us for precertification and we determine that the hospital admission is not medically necessary, we will only pay for covered medical services and supplies that are otherwise payable on an outpatient basis.

- **Other services**

For certain services, you or your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, is medically necessary, and follows generally accepted medical practice. If your physician does not contact us, we will not pay for the services. You or your physician must also obtain prior approval for the following services:

- Organ/tissue transplants
- High-tech radiology
- High-tech nursing
- Infusion therapy
- Mental Health and Substance Abuse
- Chemotherapy and Radiation
- Bariatric Surgery
- Growth Hormone Therapy
- Gender Reassignment Surgery (GRS)
- Infertility Services

How to request precertification for an admission or get prior approval for Other services

When you use a network provider for covered services, the network provider will initiate the precertification or prior approval process on your behalf. You, a family member, or your physician must contact GHI's Coordinated Care Program at (800) 223-9870 for precertification of the hospital admission:

- At least ten (10) days prior to the date of admission of elective procedures, or as soon as reasonably possible;
- Within two (2) business days of an emergency admission, or as soon as reasonably possible.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

  If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgement of a prudent layperson that possesses an average knowledge of health and medicine.

  If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

  We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

  You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at (877) 842-3625. You may also call FEHB 2 at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, then call us at (877) 842-3625. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim.)

- **Concurrent care claims**

  A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

  If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

- **The Federal Flexible Spending Account Program – FSAFEDS**

  Health Care FSA (HCFSA) – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **Emergency inpatient admission**

  If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

  You do not need pre-certification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for pre-certification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for pre-certification of additional days.

  Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **If your treatment needs to be extended**

  If your physician requests an extension of an ongoing course of treatment at lease 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

Failure to comply with pre - admission review or the concurrent review will result in the following reductions in health benefit reimbursment: $125 per day to a maximum of $250 per confinment as long as we determine that the inpatient admission or service was medically necessary.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a post-service claim and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

  Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

  1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
  2. Ask you or your provider for more information. 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.
  3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

  In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditions methods.

- **To file an appeal with OPM** — After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your Cost for Covered Services

This is what you will pay out-of-pocket for covered care:

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Copayments

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

Example: When you see your primary care physician you pay a copayment of $50 per office visit, and $10 per office visit for dependent children to age 26, under the Standard Option.

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 them.

Under the **Standard Option** the calendar year deductible for certain services is:.

- For orthopedic and prosthetic devices, oxygen and other covered durable medical equipment you pay $100 calendar year deductible per individual.

There are no other calendar year deductibles under Standard Option.

Note: If you change plans during open enrollment season and the effective date of the new plan is after January 1 of the next year, you do not have to start a new deductible under your prior 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.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

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.

Example: Under **Standard Option**, under Durable Medical Equipment, after the applicable deductible is met you pay 20% of the Plan's fee schedule for a participating provider.

Differences between our Plan allowance and the bill

When you use network providers, you are not responsible for differences between GHI's allowance and the provider's charge. Non-network providers do not have an agreement with GHI to accept the GHI allowance as payment in full.

Our "Plan allowance" is the amount we use to calculate our payment for covered services. Fee-for-service plans arrive at their allowances in different ways, so their allowances vary. For more information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10. Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the provider you use.

Your catastrophic protection out-of-pocket maximum

Standard Option: After your (copayments deductibles and coinsurance) total **$8,150** for Self Only or **$16,300** for Self Plus One, or **$16,300** per Self and Family enrollment in any calendar year, you do not have to pay any more for covered services.

Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum

Carryover	If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.
If we overpay you	We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.
When Government facilities bill us	Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Benefits

See page 13 for how our benefits changed this year and page 113 for a benefits summary. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. Standard Option Benefits Overview

We offer one Standard Option plan. We describe the available benefits under this package in Section 5 of this brochure. Make sure that you review the benefits that are available under the option in which you are enrolled. The enrollment codes for Standard Option are 804 (Self Only) and 806 (Self Plus One) and 805 (Self and Family).

Please read the important things you should keep in mind at the beginning of the subsections. Also read the General exclusions in Section 6; they apply to the benefits in the following subsections. To obtain more information about the Standard Option benefits, contact us at 800-624-2414 or on our website at www.emblemhealth.com.

Standard Option features:

- Access to GHI's Exclusive Provider Option (EPO) network
- $50 copayment per office visit to participating network doctors
- No copayment for United States Preventive Task Force (USPSTF) recommended preventive care services
- $10 copayment for dependent children who are under the age of 26 as long as the services are performed by a participating network provider.
- $500 per day up to a maximum of $1,000 per admission for covered inpatient hospital admissions
- No copayment for up to 30 days of GHI approved skilled nursing facility benefit
- With the exception of durable medical equipment, there is no calendar year deductible

Standard Option also offers the following unique features:

- Flexible benefit options
- Large Case Management
- Disease Management
- Customer Service Answer Line
- Services for deaf and hearing impaired
- Coverage for high risk pregnancies
- Centers of excellence for transplants/heart surgery/etc.
- Travel benefit/services overseas

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should 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.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- 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.
- In vitro fertilization benefits are not covered for Standard Option.
- With the exception of durable medical equipment, there is no calendar year deductible.

Benefit Description	You pay
Diagnostic and treatment services	**Standard Option**
Professional services of physicians • In physician's office • At home • Professional services of physicians - Office medical consultations - Second surgical opinion - Routine physical examination every year - Advance care planning	$50 per office visit $10 per office visit for children (under age 26) All charges for non-participating providers
• During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment	Nothing for participating providers All charges for non-participating providers
Telehealth Services	**Standard Option**
If your provider offers covered services using telehealth: • Covered services will include the use of electronic information and communication technologies by a provider to deliver covered services to you while your location is different than your providers location. • Provider consultations are for non-emergency medical conditions only. • Subject to the Prescription Drug section, if necessary the telehealth physician may write a prescription and send it to an in-network participating retail pharmacy. Prescriptions are subject to cost sharing where applicable. Telehealth services are administered by Teladoc *Note: Covered services are subject to the same utilization review and quality assurance requirements and other terms and conditions of this plan.*	$10 for consultations from physicians providing Telehealth services

Benefit Description	You pay
Lab, X-ray and other diagnostic tests	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	$50 per each diagnostic x-ray + laboratory test performed by a participating provider (a maximum of two diagnostic copays will apply per date of service) $10 copayment per each diagnostic x-ray + laboratory test for children (under age 26) when performed by a participating provider (a maximum of two diagnostic copays will apply per date of service) All charges for non-participating providers.
Preventive care, adult	**Standard Option**
• Routine Physical every year The **following** preventive services are covered at the time interval recommended at each of the links below. • Immunizations such as Pneumococcal, influenza, shingles, tetanus/DTaP, and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ • Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org • Well woman care such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of Well Women preventive care services go to the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/Individual counseling on prevention and reducing health risks	Nothing for preventive care performed by a participating provider All charges for non-participating providers
• Routine mammogram – covered for women:	Nothing for preventive services performed by a participating provider All charges for non-participating providers
• Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing for preventive services performed by a participating provider All charges for non-participating providers
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. • 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	Nothing for preventive services performed by a participating provider All charges for non-participating providers

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**Standard Option**
• Varicella (Chickenpox) - for all persons aged 19-49 • Tetanus, Diphtheria and Pertussis (TDAP) - for persons aged 19-64, with a booster every 10 years • Shingles vaccine, age 50 and over Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: www.healthcare.gov/preventive-care-benefits/ CDC:www.cdc.gov/vaccines/schedules/index.html	Nothing for preventive services performed by a participating provider All charges for non-participating providers
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	
Preventive care, children	**Standard Option**
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics.For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org • Immunizations such as DTaP, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html • You may also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at https://www.uspreventiveservicestaskforce.org •	Nothing for participating providers All charges for non- participating providers
Examinations, limited to: • Examinations for amblyopia and strabismus - limited to one screening examination (ages 3 through 5) • Ear exams to determine the need for hearing correction • Examinations done on the day of immunizations (ages 3 up to age 19)	Nothing for participating providers All charges for non-participating providers
Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance and deductible.	

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**Standard Option**
Maternity care	**Standard Option**
Complete maternity (obstetrical) care, such as: • Screening for gestational diabetes for pregnant women • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not have to precertify your vaginal delivery; see page 19 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal 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 Plus One or 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. • Hospital services are covered under Section 5(c) and Surgical benefits (Section 5b). Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.	$50 copay for first visit only (for all prenatal and postnatal care). You pay nothing thereafter. All charges for non-participating providers
• Breastfeeding support, supplies and counseling for each birth	Nothing
Family planning	**Standard Option**
Contraceptive counseling on an annual basis	Nothing
A range of voluntary family planning services for women, limited to: • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms • Tubal ligation Note: We cover oral contraceptives under the prescription drug benefit.	Nothing for participating providers All charges for non-participating providers
Voluntary family planning services for men, limited to: • Voluntary sterilization (e.g. Vasectomy) (See Surgical procedures Section 5b)	$50 per visit All charges for non-participating providers
Not covered:	*All charges*

Family planning - continued on next page

Benefit Description	You pay
Family planning (cont.)	**Standard Option**
• *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*
Infertility services	**Standard Option**
Diagnosis and treatment of infertility, except as shown in *Not covered.*	$50 per visit All charges for non-participating providers **Note:** Subject to Prior Approval, see section 3
Not covered: • *Infertility services after voluntary sterilization* • *Fertility drugs* • *Assisted reproductive technology (ART) procedures, such as:* *Artificial insemination (AI)* *In vitro fertilization (IVF)* *Embryo transfer and gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* *Intravaginal insemination (IVI)* *Intracervical insemination (ICI)* *Intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg.*	*All charges*
Allergy care	**Standard Option**
• Testing and treatment • Allergy injections • Treatment materials (such as allergy serum)	$50 per office visit $10 per office visit for children (under age 26) All charges for non-participating providers
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 43. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis	Nothing in a participating provider doctor's office Note: Subject to prior approval, we will provide up to ten out of area hemodialysis treatments performed by a non participating provider. You are responsible for all charges that exceed our allowable charges

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	**Standard Option**
• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 32 sessions.	Nothing in a participating provider doctor's office Note: Subject to prior approval, we will provide up to ten out of area hemodialysis treatments performed by a non participating provider. You are responsible for all charges that exceed our allowable charges
• High-tech nursing and infusion therapy - IV infusion therapy - Parenteral and enteral therapy - Other home IV therapies Note: Contact us at (800) 223-9870 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 All charges for non-participating providers
• Growth hormone therapy (GHT). Note: This benefit is provided under our Prescription Drug Benefits. Please see Section 5(f) Prescription Drug benefits for information on growth hormone. Note: We only cover GHT when we preauthorize the treatment before you begin treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Other services under You need prior to Plan approval for certain services on page .	Applicable prescription drug copay
Not covered: • *Treatment for experimental or investigational procedures*	*All charges*
Physical and occupational therapies	**Standard Option**
Rehabilitation Up to 60 visits per condition if significant improvement can be expected for the services of each of the following: • Qualified physical therapists • Occupational therapists Note: We only cover therapy when a physician orders the care. **Habilitation** Up to 60 visits per condition if significant improvement can be expected for the services for	$50 per visit $10 per visit for children (under age 26) All charges for non-participating providers

Physical and occupational therapies - continued on next page

Benefit Description	You pay
Physical and occupational therapies (cont.)	**Standard Option**
• Health care services that help a person keep, learn or improve skills and functioning for daily living including: • the management of limitations and disabilities • services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. Note: We cover Habilitation Services in the outpatient department of a Facility or in a Health Care Professional's office.	$50 per visit $10 per visit for children (under age 26) All charges for non-participating providers
Not covered: • *Long-term rehabilitative and habilitation therapy* • *Exercise programs*	*All charges*
Speech therapy	**Standard Option**
Rehabilitation Up to 60 visits of speech therapy each calendar year for services from the following: • Licensed or certified speech therapists **Habilitation** Up to 60 visits of speech therapy each calendar year for services for: • Speech therapy services that help a person keep, learn or improve skills and functioning for daily living. including: • the management of limitations and disabilities • services or programs that help maintain or prevent deterioration in cognitive function. Note: We Cover Habilitation Services in the outpatient department of a Facility or in a Health Care Professional's office.	$50 per visit $10 per visit for children (under age 26) All charges for non-participating providers
Hearing services (testing, treatment, and supplies)	**Standard Option**
• Diagnostic and treatment services for disease or medical conditions affecting hearing • For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or Audiologist • External hearing aids for children to age 26 (See "Orthopedic and Prosthetic devices")	$50 per visit $10 per visit for children (under age 26) All charges for non-participating providers
Not covered: Hearing services that are not listed as covered	*All charges*

Benefit Description	You pay
Vision services (testing, treatment, and supplies)	**Standard Option**
• Medical and surgical benefits for diagnosis and treatment of diseases of the eye	$50 per visit $10 per visit for children (under age 26) All charges for non-participating providers
• 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 This benefit is administered by EyeMed -www.eyemed.com	Nothing for services provided by participating opticians, optometrists and vision centers All charges for non-participating providers
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	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes, including the routine treatment of corns, calluses, and bunions, and the partial removal of toenails Note: There is a limit of 4 visits per calendar year.	$50 per visit All charges for non-participating providers
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery) • *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)* • *Orthotics devices for the feet*	*All charges*

Benefit Description	You pay
Orthopedic and prosthetic devices	**Standard Option**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • External hearing aids for children up to age 26 **(Once every two years)** • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Orthopedic devices, such as braces • Ostomy supplies • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	20% of the Plan's fee schedule for a participating provider All charges for non-participating providers Note: $100 annual deductible applies per individual.
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)	**Standard Option**
We cover rental or purchase of durable medical equipment at our option, including repair and adjustment. Covered items include: • oxygen • dialysis equipment • hospital beds • wheelchairs • crutches • walkers • blood glucose monitors • diabetic pumps Note: Call us at 800-223-9870 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 All charges for non-participating providers Note: $100 annual deductible applies per individual.

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	**Standard Option**
Not covered: • *Air purification devices* • *Alarm and Alert Services*	*All charges*
Home health services	**Standard Option**
Services include: • 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 **In order for us to cover home health care services, the following conditions must be met:** 1) 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; 2) You must remain under the care of a medical doctor; 3) The services are provided according to a plan of treatment approved by the attending medical doctor; and 4) Medical evidence substantiates that you would have required further inpatient care had the home health care not been available.	Nothing for a participating provider All charges for a non-participating provider
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* • *Nursing care requested by or for the convenience of the patient's family and/or private duty nursing*	*All charges*

Benefit Description	You pay
Chiropractic	**Standard Option**
• Manipulation of the spine and extremities • Adjustment procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$50 per visit $10 per visit for children (under age 26) All charges for non-participating providers
Not covered: • *chiropractic services not shown as covered*	*All charges*
Alternative Treatments	**Standard Option**
No Benefits	*All charges*
Educational classes and programs	**Standard Option**
Coverage is limited to: • Diabetes self-management • Cholesterol Management • Arthritis • Asthma • Hepatitis C • Multiple Sclerosis • Depression • Osteoporosis • Nutritional Counseling • Childhood obesity education	Nothing For diabetes self management call Diabetes Health Solutions at (800) 881-4008 For arthritis and osteoporosis information call Arthritis Foundation NYC Chapter at (212) 984-8713 To enroll in our Asthma program call (212) 615-0363
Tobacco Cessation Program The Program is provided in partnership with the American Cancer Society's Quit For Life (ACSQFL). Participation is initiated by a phone call to the call center. Under the program, you have access to the following: • Unlimited telephonic access to professional counselors; • Educational information tailored to the member's stage of readiness to quit; • Access to ACSQFL Web site; and • Full coverage for smoking cessation pharmaceutical products (Nicotine Patch, Gum, Lozenge, Bupropion (generic Zyban®) and Chantix™). Note - See Section 5(f) Prescription Drug Benefits for information on physician prescribed smoking cessation medication. See Section 5(e) for information on group and individual psychotherapy.	Nothing

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals

Important things you should 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.
- If you are enrolled in the Standard Option EPO, you must use participating providers within the EPO network.
- 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 services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3, page 19, to be sure which services require precertification and identify which surgeries require precertification.
- With the exception of durable medical equipment, there is no calendar year deductible.

Benefit Description	You pay
Surgical procedures	**Standard Option**
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 (bariatric surgery)– see services requiring our prior approval on page 18. • Insertion of internal prostethic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns	$50 per office visit based surgical procedure $10 per office visit based on surgical procedure for children under age 26
Not covered: • *Reversal of voluntary sterilization* • *Stand-by services* • *Routine treatment of conditions of the foot (see Foot care)*	*All charges*

Benefit Description	You pay
Reconstructive surgery	**Standard Option**
• 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. • Gender Reassignment Surgery (GRS) when all Plan criteria are met. Pre-authorization is required for all services.	$50 per office based procedure All charges for non-participating providers See Section 5(c) for outpatient hospital or ambulatory surgical center copayments
• 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; or - 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.	$50 per office based procedure All charges 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*	*All charges*
Oral and maxillofacial surgery	**Standard Option**
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.	$50 per office based procedure All charges for non-participating providers
Not covered: • *Oral implants and transplants*	*All charges*

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay
Oral and maxillofacial surgery (cont.)	**Standard Option**
• *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	**Standard Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. See Other services under You need prior Plan approval for certain services on page xx: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs such as the liver, stomach, and pancreas • Kidney • Kidney/Pancreas • Lung: single/bilateral/lobar • Liver • Pancreas	$50 per office based procedure $10 per office procedure for children (under age 26) Nothing for a participating provider in the hospital or a participating ambulatory surgical center All charges for non-participating providers
The tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by Plan. Refer to Other services in Section 3 for prior authorization procedures. Autologous tandem transplants for • AL Amyloidosis • Multiple myeloma (de nova and treated) • Recurrent germ cell tumors (including testicular cancer)	$50 per office based procedure $10 per office procedure for children (under age 26) Nothing for a participating provider in the hospital or a participating ambulatory surgical center All charges for non-participating providers
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for: - Sickle cell anemia • Autologous transplants for - Acute lymphocyic or non- lymphocyic (i.e. myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis	$50 per office based procedure $10 per office procedure for children (under age 26) Nothing for a participating provider in the hospital or a participating ambulatory surgical center All charges for non-participating providers

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard Option**
- Breast cancer - Epithelial ovarian cancer - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	$50 per office based procedure $10 per office procedure for children (under age 26) Nothing for a participating provider in the hospital or a participating ambulatory surgical center All charges for non-participating providers
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other Services* in Section 3 for prior authorization procedures: Allogeneic transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Acute myeloid leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) • Myelodyplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Severe combined immunodeficiency • Severe or very severe aplastic anemia Autologous transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Neuroblastoma	$50 per office based procedure $10 per office procedure for children (under age 26) Nothing for a participating provider in the hospital or a participating ambulatory surgical center All charges for non-participating providers
These blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health **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.	$50 per office based procedure $10 per office procedure for children (under age 26) Nothing for a participating provider in the hospital or a participating ambulatory surgical center All charges for non-participating providers

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard Option**
If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans and hospitalization related to treating the patients condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination - Early state (indolent or non advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myelodysplasia/Myelodysplastic Syndromes - Multiple sclerosis - Myeloproliferative disorders (MDDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for - Advanced Childhood kidney cancers	$50 per office based procedure $10 per office procedure for children (under age 26) Nothing for a participating provider in the hospital or a participating ambulatory surgical center All charges for non-participating providers

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard Option**
- Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin's lymphoma - Breast cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphom - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	$50 per office based procedure $10 per office procedure for children (under age 26) Nothing for a participating provider in the hospital or a participating ambulatory surgical center All charges for non-participating providers
Note: • *We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor screening tests for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in additiona to the testing of family members. Donor coverage is provided 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.*	A maximum of $150 per person per day and $10,000 per lifetime.
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*

Benefit Description	You pay
Anesthesia	**Standard Option**
Professional services provided in – • Hospital (inpatient)	Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers
Professional services provided in – • Hospital (outpatient) • Skilled nursing facility • Ambulatory surgical center • Office	Nothing for a participating provider in the hospital or a participating ambulatory surgery center All charges for non-participating providers
Not covered: • *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 things you should 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.
- Under Standard there is a $500 copay per day up to a maximum of $1000 per admission.
- A participating provider must provide or arrange all inpatient Hospital care and you must be hospitalized in a participating facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOU OR YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS. FAILURE TO DO SO WILL RESULT IN A MINIMUM $125 PENALTY UP TO A MAXIMUM OF $250** Please refer to Section 3, page 19, to be sure which services require precertification.
- With the exception of durable medical equipment, there is no calendar year deductible.

Benefit Description	You pay
Inpatient hospital	**Standard Option**
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.	$500 per day up to a maximum of $1,000 per inpatient admission Note: Except for medically necessary emergency admissions you pay all charges for an inpatient admission at a non-particating facility.
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing (included in the inpatient hospital copay) Note: Except for medically necessary emergency admissions you pay all charges for an inpatient admission at a non-particating facility
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**Standard Option**
• *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	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • 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 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. For approved inpatient admissions, you are responsible for the applicable hospital admission copay (see inpatient hospital benefits).	\$150 copayment per visit All charges for a non-participating provider
• Diagnostic laboratory tests, X-rays, and pathology services	\$50 copayment per visit All charges for non-participating providers
• Chemotherapy and radiation	Nothing for chemotherapy and radiation provided in a participating facility All charges for non-participating providers Note: Prior Approval Required, see Section 3
Not covered: Blood and blood derivatives replaced by the member	*All charges*
Skilled nursing facility benefits	**Standard Option**
Skilled nursing facility (SNF) care is limited to 30 days per calendar year and includes the following: • 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 All charges for a non-participating provider
Not Covered: • *Custodial care*	*All charges*

Benefit Description	You pay
Hospice care	**Standard Option**
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 for a participating provider
Not covered: Independent nursing, homemaker services	*All charges*
End of life care	**Standard Option**
Acute care provided in a licensed Article 28 facility or acute care facility that specializes in terminally ill patients, for members diagnosed with advanced cancer with less than sixty (60) days to live.	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	**Standard Option**
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. Note: We will not pay more than $100 for covered ambulance services.
Not covered: • *Air ambulance* • *Ambullette services*	*All charges*

Section 5(d). Emergency Services/Accidents

Important things you should 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.
- GHI will determine reimbursement for emergency services from non-participating providers based on a lesser of 100% of the 90th percentile of FAIR Health Prevailing Healthcare Charges System for Emergency Professional charges and Emergency Admission Professional Charges or the provider's billed charge.
- With the exception of durable medical equipment, there is no calendar year deductible.

What is emergency care? Emergency care means care for a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect that absence of immediate medical attention to result in:

- placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;
- serious impairment to such person's bodily functions;
- serious dysfunction of any bodily organ or part of such person; or
- serious disfigurement of such person.

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

Note: If you are admitted to the hospital from the Emergency Room, we waive the emergency care copay. A participating GHI provider must provide your follow-up care. We cover care provided by a non-participating provider at 100% of the Plan's fee schedule.

Benefit Description	You pay
Emergency within our service area	**Standard Option**
• Emergency medical/surgical care at a doctor's office • Emergency medical/surgical care at an urgent care center	$50 per office visit for a participating provider. $75 per visit to urgent care center Any difference between our allowance and the billed amount for a non-participating provider.
• Emergency care as an outpatient at hospital 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.	$200 copay per hospital emergency room visit plus all charges that exceed the emergency allowance for non-participating hospitals.
Not covered: Elective care or non-emergency care	*All charges*

Benefit Description	You pay
Emergency outside our service area	**Standard Option**
• Emergency medical/surgical care at a doctors' office • Emergency medical/surgical care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services	$50 per office visit for a participating provider. $75 per visit to urgent care center Any difference between our allowance and the billed amount for a non-participating provider.
Not covered: Elective care or non-emergency care	*All charges*
Ambulance	**Standard Option**
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 Note: We do not pay more than $100 for covered ambulance services.
Not covered: air ambulance and ambullette services	*All charges*

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should 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.
- Under the Standard Option, you must obtain care from within the participating provider network.
- With the exception of durable medical equipment, there is no calendar year deductible.
- 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.
- 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.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.

Benefit Description	You pay
Mental Health and Substance Use Disorder Benefits	**Standard Option**
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	Nothing for outpatient mental health care.
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing
Not Covered • *Services we have not approved* • *Facility charges of a non-participating general hospital or facility* • *Treatment by a non-participating professional 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. Note: See Section 5(d) Emergency Benefits for information on emergency services	*All charges*

Benefit Description	You pay
Autism Spectrum Disorders	**Standard Option**
Inpatient and Outpatient Coverage for the Treatment of Autism Spectrum Disorder Coverage is provided for medically necessary and appropriate services associated with the screening, diagnosis and treatment of Autism Spectrum Disorder. Services must be provided by an in-network provider through Beacon Health Options. There are no age, visit or annual benefit limits. Treatment includes the following care and assistive communication devices prescribed or ordered for an individual diagnosed with Autism Spectrum Disorder by a licensed physician or a licensed psychologist: • Behavioral Health Treatment; • Psychiatric Care; • Psychological Care; • Medical care provided by a licensed health provider; • Therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative; • Assistive Communication Devices; • Applied Behavioral Analysis *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.*	Nothing
Not covered: • *Services we have not approved.* • *Services received from out-of-network providers*	

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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.
- Members must make sure their prescribers obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- We will send each new enrollee a description of the prescription drug program and a mail order form/ patient profile and a pre-addressed reply envelope. You may use your Plan identification card to access the prescription drug benefits.
- Federal law prevents the pharmacy from accepting unused medications.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.

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

- **Who can write your prescription**. A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them**. You may fill the prescription at a participating pharmacy by presenting your Plan Identification Card. You must obtain certain generic maintenance drugs or name brand formulary drugs by mail order.
- **We use a formulary.** Our formulary is a list of effective medications and other items that we have approved for our members' use. A special committee of medical and pharmacy professionals reviews the formulary annually. We add or delete items on the list based on their findings. We have found that the drugs on our formulary are safe, effective, and therapeutic in the treatment of disease or illness. Please call GHI Pharmacy Services 1-877-793-6253 for a copy of our formulary.
- **These are the dispensing limitations.** A participating pharmacy will provide up to a 30-day supply of your prescription. Under the Standard Option you pay $20 for generic formulary drugs, $50 for name brand formulary drugs, $100 for non-formulary drugs or 25% coinsurance up to a maximum of $200 per script for specialty drugs.
- **Maintenance Medication by mail-order**. Your prescription coverage includes a mail order program for all maintenance medications. You must obtain a new prescription from your provider for a 90 day supply, to be sent to GHI Pharmacy Services. Please call GHI Pharmacy Services at 1-877-793-6253 . Specialty drugs and Sexual dysfunction drugs are not available by mail-order and require prior approval.
- **Step Therapy Prior Authorization Program.** For prior authorization, your physician or you should call GHI Pharmacy Services at 877-444-3614. Step Therapy programs apply edits to drugs in specific therapeutic classes at the point of service. Coverage for second-line therapies is determined at the member level based on the presence or absence of first-line drugs in the member's claims history. Step Therapy coverage criteria are automated whenever possible so that rejects are further reduced. Only claims for members whose histories do not show use of first-line drugs are rejected for payment at the point of service and online messaging is sent to the pharmacy indicating that prior authorization is required for coverage of the second-line therapy.
- **Drug Quantity Management Program.** The Drug Quantity Management program manages prescription costs by ensuring that the quantity of units supplied for each copayment is consistent with clinical dosing guidelines. The program is designed to support safe, effective, and economic use of drugs while giving patients access to quality care. Clinicians maintain a list of quantity limit drugs, which is based upon FDA-approved dosing guidelines and medical literature. Online edits help make sure optimal quantities of medication are dispensed per copayment and per days' supply.
- **Diabetic Supplies Close Category Program.** The Diabetic Supplies Category Program refers only to prescriptions for test strips and meters. You will be granted authorization for test strips and meters when you present a prescription for a covered diabetic supply product (Roche and J&J products are covered).

- **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 difference in cost between the name brand drug and the generic.
- You will be able to choose from pharmacies in the Express Advantage Network (EAN), provided by Express Scripts. This is a smaller network that is available in addition to the larger ESI network of pharmacies you can choose from that are included in your GHI FEHB plan. By choosing an EAN pharmacy, you could see smaller copays.

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. Please call GHI Pharmacy Services 1-877-793-6253 and we will send you a claim form. Under normal circumstances, you do not have to file prescription drug claims. You simply present your GHI card to the participating pharmacy and pay the appropriate copay.

Benefit Description	You pay
Covered medications and supplies	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from either a Plan pharmacy or through our mail order program: • Drugs for which a prescription is required by Federal law of the United States • FDA approved prescription drugs and devices for birth control • Insulin • Drugs to treat sexual dysfunction (with Prior authorization) • Disposable needles and syringes needed for the administration of covered medication • Intravenous fluids and medications for home use through our Participating Provider network for home infusion therapy • Nutritional supplements for the treatment of phenylketonuria, branched chain ketonuria, galactosemia, and homocystinuria	**Network Retail:** $20 generic $50 brand name listed on the preferred prescription drug formulary $100 brand name drug not listed on the preferred prescription drug formulary. 25% coinsurance up to a maximum of $200 per prescription for specialty drugs **Network Mail Order: 90 day supply** $40 generic $125 brand name listed on the preferred prescription drug formulary $170 brand name drug not listed on the preferred prescription drug formulary **Express Advantage Network (EAN)** $10 generic $45 brand name listed on the preferred prescription drug formulary $95 brand name drug not listed on the preferred prescription drug formulary
Women's contraceptive drugs and devices including the "morning after pill" as an over-the-counter (OTC) emergency contraceptive drug. Note: Over-the counter contraceptive drugs and devices approved by the FDA require a written prescription by an approved provider.	Nothing
Not covered • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications medicines* *Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation programs benefit. (See page 86.)*	*All charges*

Benefit Description	You pay
Preventive Medications	**Standard Option**
The following drugs and supplements are covered without cost-share, even if over the counter, are prescribed by a health care professional and filled at a network pharmacy. • Aspirin (81 mg) for men age 45-79 and women age55- 79 and women of childbearing age • Folic acid supplements for women of childbearing age (400 & 800 mcg) • Liquid iron supplements for children 6 monthsto 1 year • Vitamin D supplements (prescription strength)(400 & 1000 units) for members 65 or older • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 years. Note: To receive this benefit a prescription from a doctor must be presented to the pharmacy. The following are covered: • Low to moderate dose Statin for the primary prevention of Cardiovascular Disease (CVD)for adults without a history of (CVD) when all of the following criteria are met: • Low to moderate dose Statin for the primary prevention of Cardiovascular Disease (CVD)for adults without a history of (CVD) when all of the following criteria are met: • The member is aged forty (40) to Seventy-five(75) years; • They have one (1) or more CVD risk factors (ie: dyslipidemia, diabetes, hypertension, or smoking); and • They have a calculated ten (10)- year risk of a cardiovascular event of 10% or greater Note: Preventive medications with a USPSTF recommendation of A and B are covered without cost-share when prescribed by a health care professional and filled by a network pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicetaskforce.org/BrowseRec/Index/browse-recommendations	Nothing
Not covered: *• Drugs and supplies for cosmetic purposes* *• Drugs and supplies for cosmetic purposes* *• Drugs to enhance athletic performance* *• Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* *• Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them*	*All charges*

Preventive Medications - continued on next page

Benefit Description	You pay
Preventive Medications (cont.)	**Standard Option**
• *Nonprescription medications* *Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation program benefit. (See page 45).*	*All charges*

Section 5(g). Dental Benefits

Important things you should 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.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We will cover dental care for accidental injury only as indicated within the benefits description.
- We cover hospitalization for 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.
- **This Plan provides routine preventive dental coverage only.** The emphasis is on prevention, with preventive and minor 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. **This Plan does not provide benefits for minor restorative or major restorative dental services, prosthodontics, endodontics, orthodontics, etc.**
- 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.

Benefit Desription	You Pay
Accidental injury benefit	**Standard Option**
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*
Routine Dental Services	**Standard Option**
Examinations (maximum 2 per calendar year)	Nothing for a participating provider All charges for non-participating providers.
Prophylaxes (under age 12 - maximum 2 per calendar year)	Nothing for a participating provider All charges for non-participating providers
Prophylaxes (over age 12 - maximum 2 per calendar year)	Nothing for a participating provider All charges for non-participating providers
Emergency visits for relief of pain (1 per calendar year)	Nothing for a participating provider All charges for non-participating provider
X-rays (Full-mouth series, 1 every 3 years)	Nothing for a participating provider All charges for non-participating providers

Routine Dental Services - continued on next page

Benefit Desription	You Pay
Routine Dental Services (cont.)	**Standard Option**
Bitewings (4 per calendar year)	Nothing for a participating provider All charges for non-participating providers
Space maintainers	Nothing for a participating provider All charges for non-participating providers
Fluoride Treatments – dependent children to age 26	Nothing for a participating provider All charges for non-par provider

Section 5(h). Wellness and Other 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 regular contract benefits as a less costly alternative • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we do not 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. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, than you may dispute our regular contract benefits decision under the OPM disputed claim process (see section 8).
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 1-877-842-3625.
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.emblemhealth.com.
High risk pregnancies	The Plan provides an intensive case management program to identify and manage high risk pregnancies as described in large case manangement 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.

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. These programs and materials are the responsibility of the Plan, all appeals must follow their guidelines. For additional information contact the Plan at (877) 842-3625 or visit their website at www.emblemhealth.com/federal

Weight Loss Services- Save on programs including Jenny Craig.

Vitamins and Natural Supplements - Order online and save 45%.

Registered Dietitians - Save 25% on nutrition counseling from credentialed dietitians.

Vision Affinity Discount Program - Receive discounts up to 20% at participating Davis Vision Centers.

Massage Therapy - Save up to 25% on therapeutic massage.

Acupuncture Therapy - Save up to 25% on acupuncture therapy.

Laser Vision Care- Save as much as 25% on laser vision correction.

Services included in EmblemHealth's Healthy Discounts program are available only through participating vendors. These discount programs are not health care benefits and we do not insure them.

For more about these services, visit www.emblemhealth.com/goodhealth.

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

Section 6. General Exclusions – Services, Drugs and Supplies We Do Not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 When you need prior approval for certain services.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- 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 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

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received. See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, 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 emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

How to claim benefits

To obtain claim forms, claims filing advice or answers about our benefits, contact us at 877-842-3625, or at our website at www.emblemhealth.com

In most cases, providers and facilities file claims for you. Your provider must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form.

When you must file a claim – such as for services you received overseas or when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Patient's name, date of birth, address, phone number and relationship to enrollee
- Patient's Plan identification number
- Name and address of person or company providing the service or supply
- Dates that services or supplies were furnished
- Diagnosis
- Type of each service or supply
- Charge for each service or supply

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

In addition:

- If another health plan is your primary payor, you must send a copy of the explanation of benefits (EOB) form you received from your primary payor (such as the MedicareSummary Notice (MSN)) with your claim.
- Bills for home nursing caremust show that the nurse is a registered or licensed practical nurse.
- If your claim is for the rental or purchase of durable medical equipment; private duty nursing; and physical therapy, occupational therapy, or speech therapy, you must provide awritten statement from the provider specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugsand supplies must include receipts that show the prescription number, name of drug or supply, prescribing provider name, date, and charge.

We will provide translation and currency conversion services for claims for overseas (foreign) services.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Records

Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

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. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. Once we pay benefits, there is a five year limitation on the re-issuance of uncashed checks.

Overseas claims

For covered services you receive by providers and hospitals outside the United States and Puerto Rico, send a completed HCFA 1500 Claim Form and the itemized bills to: GHI PO Box 3000 New York, NY 10116-3000. Obtain Claim Forms from: www.emblemhealth.com. If you have questions about the processing of overseas claims, contact 877-842-3625.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

The Secretary of Health and Human Services has identified counties where at least 10 percent of the population is literate only in certain non-English languages. The non-English languages meeting this threshold in certain counties are Spanish, Chinese, Navajo and Tagalog. If you live in one of these counties, we will provide language assistance in the applicable non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes and its corresponding meaning, and the treatment code and its corresponding meaning).

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post service claim (a claim where services, drugs or supplies have already been provided). In Section 3 If you disagree with our pre-service claim decision, we described the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing EmblemHealth Customer Service, 55 Water Street, New York, NY 10041 calling 877-842-3625.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgement (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgement and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: GHI Customer Service Department, 55 Water St. , New York, NY 10041; 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. e) Include your email address (optional for members), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision or reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or

	c) Ask you or your provider for more information. 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.
3	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: United States Office of Personnel Management, Insurance Operations, FEHB 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; • Your daytime phone number and the best time to call; and • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. 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. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	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 file a lawsuit, 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 file a lawsuit 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 you did not indicate that your claim was a claim for urgent care, then call us at (800) 223-9870. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 2 at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Worker's Compensation Programs if you are receiving Worker's Compensation benefits.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has 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 payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.emblemhealth.com.

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

When we are the secondary payor, 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.

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 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 TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

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 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

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damaged claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB Plans already cover dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone 1-877-888-3337 (TTY 1-877-889-5680), you will be asked to provide information on your FEHB Plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. We do not cover these costs.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. We do not cover these costs.

When you have Medicare

For more detailed information on “What isMedicare?” and “Should I Enroll inMedicare?” please contactMedicare at 1-800- MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov

- **The Original Medicare (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

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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.

Claims process when you have The Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we processes your claim first.

When Original Medicare is the primary payor, 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 (877) 842-3625, or access our website at www.emblemhealth.com/federal.

We do not waive any costs if the Original Medicare Plan is your primary payor.

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

You can find more information about how our plan coordinates benefits with Medicare at www.emblemhealth.com

Benefit Description	Member Cost without Medicare	Member Cost with Medicare Part B
Deductible	$0	$0
Out-of- Pocket Maximum	$8,150 Self Only/ $16,300 Self Plus One or Self and Family	$8,150 Self Only/ $16,300 Self Plus One or Self and Family
Primary Care Physician	$50	$0
Specialist	$50	$0
Inpatient Hospital	$500 copay per day to a maximum of $1,000	$0
Outpatient Hospital	$150	$0
Incentives Offered	N/A	N/A

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

• **Medicare prescription drug coverage (Part D)**	When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) 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) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

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.

Clinical Trials Cost Categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial.

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

See Section 4 page 22

Copayment

See Section 4 page 22

Covered services

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

Deductible

See Section 4 page 22

Exclusive Provider Option (EPO)

Coverage that utilizes a network(s) of providers and uses provider selection standards, utilization management, and quality assessment techniques to complement negotiated fee reductions as an effective strategy for long-term health care costs savings.

Experimental or investigational service

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.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity

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.

Network Provider

A network provider is a participating provider who has a contract with GHI and has agreed to accept GHI's schedule of allowances or negotiated rate(s) as payment in full for covered services and who participates in the GHI network that applies to your coverage.

Plan allowance

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

For participating providers, the Plan allowance is the fee schedule or negotiated rate that GHI uses as payment in full for covered services rendered by participating providers. For non-participating providers, the allowance is the amount that we determine based on certain data.

Precertification/Prior approval

Certain covered services must be precertified by contacting GHI for approval prior to treatment. GHI's advance approval for these services may result in a reduction of benefits and/or payments.

Preferred Provider Option (PPO)

Coverage that offers a network(s) of providers and uses provider selection standards, utilization management, and quality assessment techniques to complete negotiated fee reductions as an effective strategy for long-term health care cost savings. Enrollees retain the freedom of choice of providers but have financial incentives (i.e., lower out-of-pocket costs) to use the PPO network.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a worker's compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as result of payment, to reimburse the carrier out of the payment to the extent of benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a worker's compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or

- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at (877)842-3625. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We Us and We refer to Group Health Incorporated

You You refers to the enrollee and each covered family member.

Index

Summary of Benefits for the Standard Option of the GHI Health Plan - 2021

- **Do not rely on this chart alone.** This is a summary. All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at: www.emblemhealth.com/Federal.
- 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.
- You must use participating providers under the Standard Option coverage. We do not cover services from non-participating providers.

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	$50 per visit $10 per visit for dependent children (under age 26) All charges for non-participating providers.	24
Services provided by a hospital:		
• Inpatient	$500 per day inpatient admission up to a maximum of $1,000 per admission.	43
• Outpatient	$150 copayment for outpatient hospital or ambulatory facility and $50 copayment for diagnostic labs, x-rays, and pathology. $10 copayment for dependent children (under age 26) for diagnostic labs, x-rays and pathology.	44
Emergency benefits:		
• In-area	$200 per hospital emergency room visit and charges that exceed the Plan's emergency fee schedule.	46
• Out-of-area	$200 per hospital emergency room visit for non-participating facilities plus charges that exceed our allowance.	46
Mental health and substance use disorder treatment:	Same cost-sharing as for other illnesses or conditions	48
Prescription drugs:		
• Retail pharmacy - Up to a 30-day supply per prescription unit or refill (limit of two refills per prescription at a participating pharmacy)	$20 copay for generic drugs, $50 copay for brand preferred drugs, $100 copay for brand non-preferred drugs, 25% coinsurance up to $200 maximum per script for speciality drugs.	50
• Mail order - For a 90-day supply of maintenance medication	$40 copay for generic drugs, $125 copay for brand preferred drugs or $170 copay for generic or brand non-preferred drugs	50
Dental care: Routine preventive care	Nothing to participating providers	54

Standard Option Benefits	You pay	Page
Vision care: Limited to one annual eye refraction	Nothing to participating providers	31
Special features: Large Case Management , High Risk Pregnancies, Centers of Excellence for organ/tissue transplants, Heart Surgery, etc.	Copays or coinsurance as indicated	56

2021 Rate Information for GHI Health Plan

To compare your FEHB health plan options please go towww.opm.gov/fehbcompare**.**

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, contact the agency that maintains your health benefits enrollment.

Postal rates apply to certain United States Postal Service employees as follows:

- **Postal Category 1** rates apply to career bargaining unit employees who are represented by the following agreements: NALC
- **Postal Category 2** rates apply to career bargaining unit employees who are represented by the following agreement: PPOA.

Non-Postal rates apply to all career non-bargaining unit Postal Service employees and career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NPMHU, NPPN and NRLCA. Postal rates do not apply to non-career Postal employees, Postal retirees, and associate members of any Postal employee organization who are not career Postal employees.

If you are a Postal Service employee and have questions or require assistance, please contact:

USPS Human Resources Shared Service Center: 1-877-477-3273, option 5, Federal Relay Service 1-800-877-8339

Premiums for Tribal employees are shown under the monthly non-Postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
New York / New Jersey							
Standard Option Self Only	804	$241.58	$238.35	$523.42	$516.43	$234.99	$224.93
Standard Option Self Plus One	806	$517.46	$598.88	$1,121.16	$1,297.58	$591.69	$570.13
Standard Option Self and Family	805	$562.25	$602.08	$1,218.21	$1,304.51	$594.27	$570.85